

DECLARATION

I, **Frederick Anyan**, do hereby declare that except for references to other people's work, which have been duly acknowledged, I single handedly undertook this research work under the supervision of **Birthe Loa Knizek (Prof., PhD)** at the Institute of Psychology of the Norwegian University of Science and Technology (NTNU), Trondheim, during the 2011/2012 academic year. This work has neither been submitted in whole nor in part for any degree in this University or elsewhere.

Signed.....

Date.....

Frederick Anyan

(Student)

This work has been submitted for examination with my approval.

Signed.....

Date.....

Supervisor /Advisor

Birthe Loa Knizek

(PhD: Professor)

DEDICATION

This thesis is humbly dedicated to the course of fighting Hypertension in Ghana, Africa and the world. I specially dedicate this study to all the respondents who partook in the research.

I dedicate this thesis also to my mother, Juliana Oduraa Wiredu whose care, compassion and believe in me has seen me through the success of this achievement. To my father Dominic Oburoni Anyan, I am not oblivious of the several assistances you have given me.

Finally to Nana A. K. Addo, Elizabeth A. Mensah, Emmanuel A. Mensah and Shiphrah Mensah this dedication serves to motivate you to reach for the greatest.

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“Call to me and I will answer you, and show you great and mighty things which you do not know” –Jeremiah 33:3. The Lord God almighty be praised and glorified for His mercies in pointing out the beginning and directing the progress, and helping in the completion of this work.

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ABSTRACT

This study explores gender differences in essential hypertension patients' understanding of illness, their reaction to diagnosis, their health motivation and how they cope and deal with their condition by drawing on recorded interviews in a qualitative methodology. A semi-structured interview guide was used. Interpretative phenomenological analysis of the data indicated both men and women respondents conceptualised illness in terms of impairment in physiological functioning, as well as a loss of strength and capacity to work by men respondents and a loss of social exploration by women respondents. In health motivation, women respondents were somewhat relatively motivated differently from men respondents. Women respondents reacted less negative and admitted symptomatology upon learning about their diagnosis while men respondents dismissed symptomatology even though they recognised the validity of the diagnosis. Women respondents seemed to have a stronger perceived health competence than men respondents. Implications of the findings for intervention are discussed such as the practice of preventive health behaviour, physicians' attentiveness to their role in the therapeutic process and the advancement of religious practices and faith in whole-person medicine practice.

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LIST OF ABBREVIATIONS

ACCORD	Austrian Centre for Country of Origin and Asylum Research and Documentation
AIDS	Acquired Immune Deficiency Syndrome
GHAFTRAM	Ghana Federation of Traditional Medicine Practitioners Association
HBM	Health Belief Model
HIV	Human Immunodeficiency Virus
IPA	Interpretative Phenomenological Analysis
KBTH	Korle Bu Teaching Hospital, Ghana
KBP	Korle Bu Polyclinic, Ghana
MoH	Ministry of Health, Ghana
NHIS	National Health Insurance Scheme, Ghana
NIH	National Institute of Health, USA
TMPC	Traditional Medicine Practice Council, Ghana
TPB	Theory of Planned Behaviour
WHO	World Health Organization

Chapter One

INTRODUCTION

1.1 Background to the Study

Sick-role Behaviour is the activity undertaken by those who consider themselves ill for the purpose of getting well (efforts by people who are already affected by disease and attempt to reduce resultant disability to restore normalization and functionality) (Rosenstock, 2005).

Prof. Charles Yankah, in 2008, asserted there was only 10% of survival rate among Ghanaians suffering from hypertension while there was 60% in Europeans. This is partly because Ghanaian patients delay in reporting and (taking on activities directed in compliance with the medical system to restore normalization and functionality) as a result of their ignorance of the illness; and suffer interruptions where they take on such activities and therefore results in inadequate efforts to get well (Addo, Amoah, & Koram, 2006; Amoah, 2003). It is thus necessary that research uncovers what issues come to play in the aspect of sick role concerned with “an acceptance that the state of being ill is not desirable, and an accompanying obligation to want to get well” (Emke, 2002. p. 82). Dr. Osafo, Medical Director of Komfo Anokye Teaching Hospital¹, in 2007 asserted that hypertension and its heart related diseases, if unchecked will result in a lot more deaths than the deadly HIV/AIDS (see 1.5) since it is on the increase, with interruptions in medical regimen, and low levels of awareness in Ghana (Bosu, 2010; Addo et al, 2006). Hypertension patients need to be encouraged in their sick role behaviours to enable them improve in their attempt to subject their loss of teleonomic capacity to proper management, restore normalization and functionality.

¹ Komfo Anokye Teaching Hospital: The second-largest hospital in Ghana, named in honour and memory of a powerful and legendary fetish priest, Komfo Anokye.

1.2 Statement of the Problem

Parsons' sick role model argues that for the sick in the sick role "shopping around is not an option" because by way of incapacitation, disease apprehends one's autonomy and disables one's social explorations and contributions (Parsons, 1964; Varul, 2010. p. 78). According to Varul (2010) patients in the sick role accept violations of personal and bodily integrity when prescriptions and medical regimens have been recommended; the ill is not allowed to make free choices of treatments, "they are not consumers deciding according to their individual preferences" (p.78). Parsons (1964) contended that the sick role provides an avenue for the sick to contaminate the *un-sick*², because the sick without productive contribution receives sustenance and care which can serve as motivational contagion to the *un-sick* to fall ill (Varul, 2010).

The sick renounces his/her individual autonomy in the sick role only because it is relinquished solely to redeem a fully healthy status (Varul, 2010) to be able to achieve normalization which is disenabled during illness. Hence, it is also true to argue that the sick has a strong incentive for normalization; –a return to normal role performance regardless the impairments of the illness (ibid). The sufferer of an illness in a society of universalistic achievement values may not consider it a privilege to be exempted from relations of reciprocal efficiencies.

Hitherto the period of illness the sick was not under obligations alien to him/her, thus, having to seek "technically competent help" in the most cases, a physician (Emke, 2002. p. 82) to prevent being labelled as "reckless" (Radley, 1994. p. 157). Therefore, the motivation of wanting to get well and re-enter normal reciprocities and to sequestrate the dual citizenship in the world of health and illness is vital for the sick (Radley, 1994; Varul, 2010).

² The *un-sick*: In this study, I mean the healthy person or one who is not sick.

However, patients who are encouraged to modify their lifestyle for the better question if such efforts will eventually improve their subjective health, they get irritated for being reminded of the risk of the disease, and are dissatisfied with their efforts which they may perceive as inadequate (Meland, Laerum & Maeland, 1996). To assist convalescents to restore their health, the goal of understanding their behaviours should necessarily and appropriately precede the goal of attempting to persuade them to modify their health practices. Thus, “efforts to modify behaviours will ultimately be more successful if they grow out of an understanding of causal processes” (Rosenstock, 2005. p. 1). Hence, the present study, to puzzle out the world of hypertension patients to facilitate their sick role behaviour.

1.3 Aims of the Study

The following are the specific aims to which the present study sought to pursue with respect to the gender difference(s) that underlined each one.

- To determine how hypertension patients react to diagnosis and interpret their status in the sick role.
- To determine the approach adopted to cope and deal with the condition with regards to being a hypertension patient in the sick role.
- To explore and report the health motivation of hypertension patients in the sick role.
- To explore what hypertension patients are doing to get well.

1.4 Significance of the Study

The foremost rationale for this study is to produce empirical findings which will enhance and facilitate an effective guide to health education, and promotion programme particularly directed to reducing the pervasiveness of hypertension in Ghana.

In Ghana, hypertension is the major cause of admissions at Korle-Bu Hospital, with complications such as heart attack, kidney failure, chronic renal failure and stroke.

Hypertension was considered non-existent or rare in most African societies, but has emerged as a challenging force to reckon with particularly in sub-Saharan Africa (Agyemang, 2006).

Recent scholarly investigations indicate that blood pressure levels and hypertension rates in Ghana are among the highest in Africa which is partly due to the delay in reporting of hypertension patients to the hospitals to be checked, and most worrying is that the largest part of Ghanaians living with hypertension are unaware of the condition (Cappucio, Micah, Emmett, Kerry, Samson, Martin-Peprah, Philips, Plange-Rhule & Eastwood, 2004; Addo et al, 2006). Ghanaian patients often report late with complications such as heart failure, stroke and chronic renal failure (Amoah, 2003; Addo et al, 2006). Data at Korle-Bu shows that hypertension contributes to about 67% of deaths, mostly through stroke. Hypertension and its complications have now become a huge burden on the health system. It does not only pose threats to the families but also to the health institutions (Dr. Alfred Doku, Resident Cardiologist at Korle-Bu, 2007). In a recent publication it was estimated that there was 236,151 prevalence of HIV/AIDS in adults of the same age category as against 3,500,000 adults prevalence of Hypertension yet HIV/AIDS has more publicity and public outreach programmes and national response than hypertension which actually is as deadly as HIV/AIDS, if not curbed (Bosu, 2010).

The aforementioned situations necessitate the need to investigate the life-world of hypertension patients, and to draw up appropriate interventions to enhance and facilitate their sick role behaviours, health motivation and eventually their normalization process.

1.5 Motivation for the Study

Parsons formulation of the sick role posits that the sick person is in a deviant role, -a social threat; because the sick person is relieved of personal and social responsibilities relative to the nature and severity of the illness. According to Varul (2010) the assumption of innocence and a discountenance of the deviant role by the sick person can only be upheld if the sick person complies with the obligations that come with the sick role. That is, the obligation to seek technically competent help and to want to get well.

The present study was informed by divulging this aspect of the sick role. The motive was to interrogate the health motivation of hypertension patients. In doing so, I sought to explore the sick role behaviour of hypertension patients with regards to what they are doing for themselves in anticipation of restoring their teleonomic capacity. In probing what the patients do aside the medical regimen, I considered it prudent to also unravel what the patients think of their own efforts and whether it is perceived adequate or inadequate for the restoration of their teleonomic capacity. A further motive was to look at how the patients controlled, coped with and interpreted their status as hypertension patients in the sick role.

1.6 Research Questions

- Do women and men differ in their reaction to diagnosis of essential hypertension?
- Do women and men differ in the interpretation of their status as hypertension patients?
- Do women and men differ in the approach adopted to cope and deal with their condition of being hypertensive?

Chapter Two

THEORETICAL BACKGROUND AND LITERATURE REVIEW

2.1 Theoretical Framework

The goal of theory in research is basically to serve as a lens for finding answers to the research question as well as providing broad explanations (Creswell, 2009). Therefore the Health Belief Model (HBM) serves as the explanatory framework for this study with borrowed constructs from the Theory of Planned Behaviour (TPB) as has been done elsewhere by Roden, (2004). However, the Sick Role Behaviour which is a systemic variation subjective to the assumptions of HBM will be emphasised. This is because, the entirety of HBM will not be of interest to the present study but some selected constructs in the HBM and TPB. This will be supported by the theoretical underpinnings of Coping within the Social Learning Theory.

2.1.1 Health Belief Model and Theory of Planned Behaviour

The HBM with its theoretical underpinnings well established is one of the first models to explain the subjective states of an individual's health and the related health behaviours (Rosenstock, 2005). Elements from this model have proven prolific in explaining health behaviours and "can ultimately be applied as well as to explaining illness behaviour and sick role behaviour of people" (Ibid, p. 5). The HBM has been used in application of broad range of health behaviours. Conner and Norman (1996) have identified three broad areas as:

- Preventive health behaviours, health promotion (e.g. exercise) and health risk behaviours (e.g. smoking) as well as vaccination and contraceptive practices.
- Sick role behaviours in respect of compliance to medical regimens, usually following professional diagnosis of an illness.

- Clinical use, which includes physician visits for a variety of reasons.

The focus of HBM in application is to link the present subjective states of the individual to himself or herself and the current health behaviour which grows out of two classes of variables as the “psychological state of readiness to take specific action and the extent to which a particular course of action is believed, on the whole, to be beneficial in reducing the threat” to restore normalization and functionality (Rosenstock, 2005. p. 6). Here, readiness to act is not defined in the physician’s view of reality consequent to his or her professional competence but defined in terms of one’s opinion of chances of contracting a condition (Ibid).

According to HBM, perceived susceptibility refers to an individual’s subjective belief of contracting a condition. In a moderate position an individual may admit the possibility of occurrence of such contraction but to whom this possibility has little reality and who dismisses it will happen to him or her. Perceived seriousness/severity refers to feelings and thoughts about medical, clinical or social consequences for contraction of a condition, so that for a given individual it may include such broader implications as the effects of the contraction on his or her job, on his family life and on his social relation (Ibid). This together with perceived susceptibility is what forms the perceived threat (Champion & Skinner, 2008).

Perceived benefits and barriers refer to the direction of impending action resulting from the perceived threat. In a case of perceived threat, whether that perception will lead to a behaviour change is influenced by the individual’s perceived benefits of the available actions to reducing threat or restoring normalization and functionality. According to Rosenstock (2005), if the readiness to take action is high and the negative consequences (such as expensive medication, strict medical regimen) are relatively low, the action in question is likely to be taken. On the other hand, the negative aspects may function as barriers when

readiness to act is subdued by the negative consequences, in which situations, the negative aspects of health actions arouse conflicting motives of avoidance. Perceived barriers act as impediments to taking recommended actions and comes with it a cost-benefit analysis, wherein the individual weighs the action's expected benefits with perceived barriers (Champion & Skinner, 2008). Perceived threat initiates the force and energy to act and the perception of benefits (minus barriers) provides a preferred path of action (Rosenstock, 2005).

Cues to action refer to factors that instigate the action upon readiness to act. Such factors or cues may be internal (e.g. perception of bodily state) or external (e.g. the impact of media communication) (Ibid). The sufficiency of the required intensity of cue to trigger behaviour varies with differences in the level of readiness, so that with low psychological readiness (i.e. low acceptance of perceived threat) a rather intense cue is needed to instigate an action, and with relatively high levels of readiness, a slight cue is needed (Ibid). For people to succeed in behaviour change, as theorized in the HBM, people must feel threatened by their current behavioural pattern (perceived threat) and believe that a specific kind of change will result in a valued outcome at an acceptable cost (perceived benefit) and they must also feel themselves competent (self-efficacious) to execute the change by overcoming perceived barriers (Champion & Skinner, 2008).

The HBM regardless its achievements has been challenged for various reasons. Rosenstock (1990) argued that the HBM assumption that individuals undertake health behaviours in a conscious way may not always be true. The HBM lacks evidence to support the belief-behaviour relationship as well as provides insufficient elucidation on modifying belief and therefore lacks suggestions of strategies which otherwise can enhance a behaviour change. HBM focuses on individual factors in terms of health interventions rather than

considering socio-environmental factors and attempts to moderate individuals into preventive health behaviours without considering the implications for future behaviours.

The TPB basically outlines three determinants that influence an individual's intention to perform behaviour. According to Roden (2004) the individual's attitude whether positive or negative is the first determinant towards performing the behaviour in question. The belief about the importance significant others such as co-workers and partners place on the performance of the behaviour which is subjective to the belief of the individual, forms the second determinant. The degree of perceived behavioural control which is the ease or difficulty in performing the given behaviour is the third determinant, which also distinguishes the TPB from the theory of reasoned action (Ibid). The central aspect of TPB which has merited its place in this present study is the emphasis the TPB places on personal motivation towards behavioural control and the influence of social network.

The TPB with its determinant construct of perceived behavioural control which reflects a subjective locus of control for the individual much emphasizes the theme of sick role behaviour (Roden, 2004) which is of importance to this present study. Thus, given the construct of perceived susceptibility and perceived seriousness of the disease in HBM, in a theme of sick role behaviour it changes to perceived behavioural control as indicated in the TPB. Further, perceived threat of the disease in HBM also changes to perceived notion of health. The fundamentals of these modifications are necessary to reflect a merger of HBM and TPB as a holistic theoretical framework for this present study, which concerns an individual's health behaviour after accepting the symptomatology and diagnosis of a medically established illness.

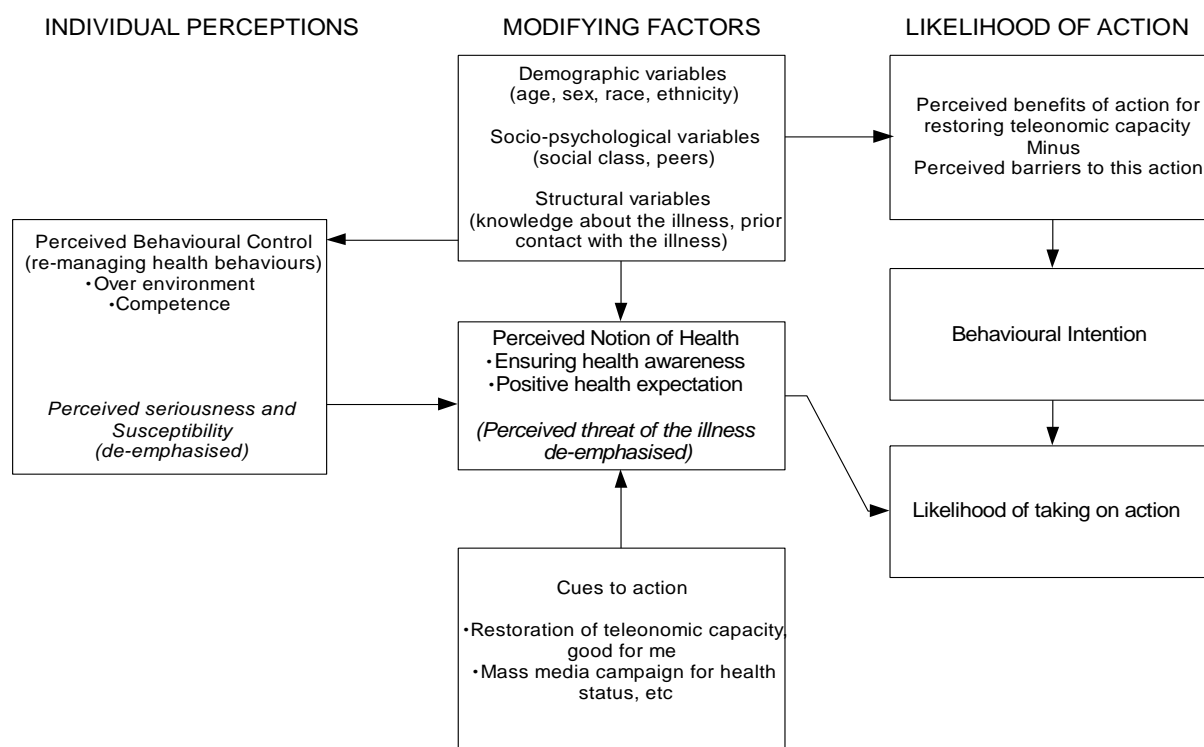


Fig. 3.0 A merger of HBM and TPB, adopted and modified from Roden, 2004

According to these expectancy-value theories (HBM and TPB), performance of behaviour is jointly influenced by the expectation that taking on a particular behaviour will result in a given outcome and the desirability of that given outcome. Taking on behaviour is then explained to be influenced by the related efficacy beliefs and types of performance outcomes (Bandura, 1997).

2.1.2 The Sick Role Behaviour Model

The understanding of Parsons sick role model posits that when individuals consider themselves ill they take on behaviours compliant with medical regimen to get well. Parsons' argument is that the sick role behaviour accepts the symptomatology and diagnosis of the established medical care system, and thus allows the individual to take on behaviours compliant with the expectations of the medical system. Like all roles, the sick role provides responsibilities and privileges for the sick (Emke, 2002). This is because "illness is not

merely a state of the organism (person)...but comes to be an institutionalized role” (Parsons, 1978. p. 21). This role results in the suspension of the individual’s everyday obligations, responsibilities and rights which are replaced by a “set of sick role specific rights and responsibilities” (Varul, 2010. p. 77). According to the model the rights of the sick person include temporal exemption from normal personal and social roles and responsibilities which are usually legitimized by a physician. The more severe the illness the more one is expected to be exempted which is matched by the sick person’s obligation to withdraw from normal daily life to isolate oneself from the world of the *un*-sick. This obligation according to Parsons is enforced by role partners such as significant others. In this withdrawal role, the sick makes no productive contribution to a society of universalistic achievement and reciprocal efficiencies. Therefore Parsons argues that the sick should be “insulated” as “disturbing element” in the society to prevent a motivational contagion from the sick (whom without productivity receives sustenance and care) to the *un*-sick (Parsons 1964. p. 259). The sick also has the right of innocence in the sick role. The sick if genuine and not malingering cannot be held responsible for his or her condition in an institutionalized measure of incapacity, -illness (Parsons, 1978) but is “a victim of forces beyond his or her control” (Ibid, p. 21). This right therefore requires that the sick be assisted in getting help and to be taken care of.

The obligations that follow from the rights include the sick accepting that the state of being ill is inherently undesirable and an accompanying responsibility to want to get well. This obligation legitimizes the assumption of innocence since the context of exemption from normal personal and social responsibilities is considered temporal and contingent upon wanting to get well (Emke, 2002). Following from an undesirable state of illness, the sick is obliged to seek “technically competent” help in most cases, a physician and collaborate to facilitate recovery (Ibid, p. 82) to prevent being labelled as “reckless” (Radley, 1994. p. 157).

Parsons argued that the role of the physician and therapeutic agencies is the “recovery of the sick person” which is asymmetrical to the role of the sick as a patient (Parson, 1978. p. 18).

2.1.3 Health Belief Theory and Sick Role Behaviour

Marshall H. Becker (1974) argued that in the case of sick-role, a diagnosis of an illness is already done and this leads the individual to question and interpret the accuracy of the disease; where the disease is threatening, where there is lack of confidence in the physician or the diagnostic procedure, and where there exist erroneous health beliefs, the patient may reject the conclusions of the physician and maintain a distorted view. In this regard, one’s opinion of chances of getting or acquiring an illness (the concept of perceived susceptibility) should extend to the individual’s estimate of perceived re-susceptibility, thus the recurrence of the incipient illness or relapsing (Ibid). In a further extension with regards to the fusion of HBM and TPB in the present study, then, one’s opinion of chances of re-susceptibility will be matched by one’s belief about access to the resources needed to act and the perceived successes of those resources, thus perceived behavioural control.

The acceptance and presence of symptomatology in the sick role may exert an elevating or realistic effect on perceived severity which may serve to motivate the patient to comply with the physician’s instructions and therapeutic agencies (Rosenstock, 2005), to restore normalization and functionality or to avert the recurrence of another illness. In the sick role behaviour perceived benefits or barriers serve to influence the direction of action by the sick. Barriers, according to Becker may demotivate the sick who in the sick role according to Parsosns accepts that illness is inherently an undesirable state and therefore wants to get well. In the presence of symptomatology, not only would an individual want to get well when s/he is threatened by an illness but also the individual’s positive health motivation may serve as an impetus for wanting to get well. In this regard, perceived threat of

the illness (i.e. the combination of perceived seriousness/severity and susceptibility) may not serve as an appropriate factor of behaviour when a study is interested in investigating an established medical illness, unless susceptibility as argued earlier is extended to re-susceptibility. However, perceived notion of health and illness may be an appropriate factor in substitution for perceived threat of the illness for a study focussing on an already medically established illness.

In taking on behaviours which are purposely directed towards the restoration of one's health status, Roden (2004) contended that "modifying factors remain an important construct" in the health belief model (p. 6). She argued that patient-physician relationship in terms of deviation from normative doctor-patient relationship influences the direction of action by the sick in the sick role. Champion and Skinner, (2008) observed that other variables such as demographic and personality variables in the health belief model influences one who has accepted symptomatology and diagnosis of an illness and thus takes on an activity to restore normalization and functionality.

2.1.4 Locus of Control, Coping and Health Belief Theory

In responding to diagnosis for possible coping, patients of hypertension may initiate cognitive processes by asking themselves what is hypertension? What does hypertension means to me? Why me? Why now? And how does hypertension relate to my sense of self? Patients who construct realistic concept formations such as identifying situations, giving oneself time to grasp situations, perceiving a behavioural control, being objective about what happened, and following directions may result in effective coping and adaptation (Zhan, 2000). According to Bandura (1997) efficacy mediates the distress which contributes to dysfunction, incongruence and unhealthy psychosocial functioning. Locus of control is explained to differ from self-efficacy since the former is a general concept about the self

while the latter is situation specific which focuses on ones beliefs about personal abilities with regards to a specific setting (Ibid). Outcome expectation and response efficacy which is a person's estimate that a given behaviour will lead to a certain outcome and whether a given course of action will result in a particular attainment respectively are similar to HBM concept of perceived benefit (Bandura, 1997; Clark, Rosenstock, Hassan, Evans, Wasilewski, Feldman & Mellins, 1988). Locus of control relates more to outcome expectations than to efficacy expectations which is the belief that one is capable of performing a behaviour required to influence an outcome (Clark et al, 1988). In this regard, internality unlike externality reflects that personal behaviour influences behaviour outcomes and disregard the question whether one feels capable of performing that behaviour (Bandura, 1997).

Glanz and Schwartz (2008) observed that when a stressor is appraised as controllable and a person has favourable beliefs about self-efficacy and efficacy expectation, "he or she is more likely to use [approach] effective coping strategies" (p. 218). Examples of approach coping strategies include active coping, planning problem solving, information seeking, and making use of social support. Fitzgerald (2000) noted that coping combines perception, performance, appraisal, correction and a directed motivated behaviour to confront the stressful stimuli with a goal of mastery, control and resolution. The major coping processes are problem-focused and emotion-focused coping which are elements of the cognitive adaptation model (Lazarus & Lazarus, 2006). The model describes two processes:

- Appraisal, is how an individual views an event and,
- Coping, refers to thoughts and behaviours used to regulate distress.

In problem-focused coping, individuals focus attention on what can be done to change the situation or reduce the stress (Ibid). This process of coping enables individuals enumerate choices by comparing in terms of cost and benefits and finally making a choice (Miller,

2000). This process of coping has an approach behaviour where there is the intention to confront the realities of the threat with “an awareness of personal reactions and feelings, and an attempt to deal with these feelings” (Ibid, p. 36). Emotion-focused is prevalent when a person makes no effort to alter the stressful situation (Lazarus & Lazarus, 2006) and conclude that s/he cannot control the stressful stimuli (Miller, 2000). Emotion-focused coping has an avoidance behaviour that protects the person from conscious confrontation with the stressful stimuli (Ibid).

2.2 Review of Related Studies

Researches on gender and behaviours relative to seeking health predominantly centre on the differences in access to health care between men and women due to gender inequalities particularly in Africa (Hausmann-Muel, Ribera, & Nyamongo, 2003). Some researchers including Annandale and Hunt (1990) and Nathanson (1975) contend the sick role behaviour is more compatible with women’s role and responsibilities than men and as such women assume the sick role more often than men do, and men are psychologically more willing to relinquish the sick role earlier than women.

2.2.1 Gender Differences in Sick Role Behaviour

Cappuccio, Micah, Emmett, Kerry, Antwi, Martin-Peppprah, Phillips, Plange-Rhule & Eastwood (2004) observed that detection and activities directed in purpose for treatment and control are suboptimal in both men and women. Buabeng, Matowe & Plange-Rhule (2004) concluded that hypertension prevalence in Ghana is a consequent of unaffordable drug prices for standard hypertension medication for both men and women. Buabeng et al. discussed that poor remuneration renders most patients unable to afford the prices of standard medications for hypertension. They further contended that in the case of female patients who mostly are housewives or sometimes with petty trading, dependence on their husbands for financial

support and upkeep kept them distanced from compliance to medication and medical routines. In Africa women on the whole, compared to men have limited access to cash money which is needed for coping with illness costs. Economic decisions which affect the household lie mostly with men, making women dependant on men for accessing health care facilities for themselves and sometimes for their children (Hausmann-Muel et al, 2003). Even though women are often the first in perceiving illness and severity they often lack the means to adequately act because of their dependence on men who control the funds (Ibid).

Courtenay (2000) asserted that men are less likely to engage in behaviours which are directed to promoting health, linked with health and longevity and getting better. Instead men according to Courtenay are more likely than women to adopt health beliefs and behaviours that increase their health risks (Ibid). Health beliefs and other social practices that undermine men's health are often signifiers of masculinity and instruments that men use in the negotiation of social power and status. Annandale and Hunt (1990) argued that the notion of masculinity which influenced individuals to perceive themselves of having less illness symptoms was not good for them and blamed this on the hazardous influences of the masculine gender role orientation. On the other hand, women sometimes adopt unhealthy beliefs and behaviours to demonstrate femininities, such as dieting to attain a culturally defined body ideal of slimness. Nonetheless, the striving for cultural standards of femininity leads women to engage more in healthy than unhealthy behaviours (Courtenay, 2003).

The various social transactions, institutional structures and contexts that both women and men encounter in their everyday lives elicit different demonstrations of health beliefs and behaviours which provide different avenues to conduct this form of demonstrating gender differences (Courtenay, 2003). Courtenay (2000) maintained that while the personal practice of participating in health care is constructed as feminine, the institutional practice of

conducting, researching or health care delivery is believed to be masculine and defined in the domain of masculinity. Courtenay further maintained that the social practices required for demonstrating femininity and masculinity are associated with different health benefits and risk so that a man may consider the expression of emotional or physical pain to be unacceptable with other men, but acceptable with a spouse or girlfriend. Courtenay (2003) asserted that it is indeed the pursuit of power and status that lead men to harm themselves. The acquisition of power by men for example requires that men “suppress their needs and refuse to admit to or acknowledge their pain” (p. 1388), and in efforts to preserve their masculinity, men often work diligently to hide their disabilities. The inability of men to readily show pain or emotions such as fear of illness also makes men report late to physicians so as not to show weakness and not to be seen as feminine when they have to comply with health (Hausmann-Muel et al, 2003).

Male physicians maintain power and control over the bodies of men and women who are not physicians as well as over male and female health professionals in lesser positions of power, such as a nurse (Courtenay, 2000). Consequently, because physicians share general cultural sex role stereotypes and expectations, sex differences might be reinforced, but as a result of professional norm, sex differences are muted. Brown, Buchana and Hsu (1978), maintained that generally, men were discharged slightly earlier than women and achieved self-sufficiency in bathing somewhat earlier than women. This goes to confirm the view that men may be psychologically more willing to relinquish the sick role as argued by Annandale and Hunt (1990). It is worthwhile to observe that when men are discharged to the home, they are more likely to be cared for by the women in the family while women may not have the same magnitude of care received by men. It is therefore true to say that the support that men receive in the home may partly play a role in their earlier achievement self-sufficiency.

In a research by Courtenay (2003), the conclusions were that, men have smaller social networks and fewer intimate friendships which limit their level of social support. This can influence men's level of coping and restoring health since social support and social network are important in the coping process and also the ability to perform a coping behaviour which forms the second determinant of TPB. Courtenay argued that men with lower levels of social support in the coping process are 2 to 3 times more likely to die than if they had a higher social support, particularly after heart diseases, cancer and stroke. Men respond to stress in less healthy ways and are more likely to use avoidant coping strategies such as denial, distraction and less likely to acknowledge that they need help (Ibid). Men sometimes deny their physical and emotional stress and attempt to conceal their illness and disabilities (Charmaz, 1995; Sutkin & Good, 1987). Men are less likely to perceive themselves as susceptible to risk for illness and injury (Gustafson 1998; DeJoy, 1992) and believe that their health is very good and rate their health better than women (Ross & Bird, 1994). In controlling their conditions men believe less strongly that they have control over their future health or that personal actions contribute to healthful outcomes (Furnham & Kirkcaldy, 1997; Wilson & Elinson, 1981). Therefore given their locus of control and coping in the sick role behaviour it is true to argue that men are more externalized than internalized in terms of controlling their condition in the sick role behaviour. As a result of the underuse of health care facilities by men, men are less knowledgeable in health matters than women, that is also to say because men are less knowledgeable about health than women, men underuse healthcare facilities (Courtenay, 2000c).

2.2.2 Initial Reaction to Diagnosis of an Illness

Purshon, Skirrow and Murphy (2009) maintained that earlier studies and explanations to individual's reaction to diagnosis have been heavily criticized because those studies and explanations confined the individual's reaction(s) and pathologized differing reactions from

the norm. As a result recent models have suggested that an individual's reaction to diagnosis is cognitively mediated and allows for more individual responses. Pushon et al. argued that Taylor's cognitive adaptation model, for example, suggests that positive adjustment involves three mechanisms which are:

- A cognitive search for meaning (why the event happened and what the impact will be)
- An attempt to gain a sense of control over the illness
- A downward comparison with others which may eventually increase self-esteem.

The Clinical Centre of the National Institute of Health (NIH, USA, 2011) observed that an illness provokes a number of reactions to individuals after being diagnosed. Emotional reactions may range from shock to relief and everything in between. While shock may be the first reaction to learning of a diagnosis, denial is also common, as are anger and grief over the loss of health. Some people become unconcerned about what goes on around them and others may sleep, cry, withdraw to themselves or stop thinking about their illnesses. Others may refuse acceptance of the diagnosis right away which gives a chance to regroup but that is only to gather enough strength to confront the illness.

However, in a recent study by Young, Bramham, Gray and Rose (2007) they contended that, for instance, in adulthood, immediately after diagnosis patients in their study described an initial sense of relief and elation that their lifelong quest for an explanation of their difficulties had finally come to an end. This relief also stemmed from the fact that the diagnosis provided an avenue for them to relocate blame for their previous difficulties and failures to the illness, which fostered a shift from an internal attribution that they were responsible for their difficulties and challenges to an external attribution whereby the illness

was an explanation for the difficulties and challenges. However, Young et al. also maintained that this relief was short-lived and followed by feelings of turmoil and confusion as the patients looked back to their past experiences in light of their diagnosis and a new knowledge of themselves. Young et al. further discussed that some respondents also excogitated about how their lives would have been (same or different) with an earlier diagnosis. These group of respondents believed that their life and experiences would have been better and more successful. The next stage of the adjustment process began with a realization of the long-term implications of their illnesses. This realization came with several anxieties as respondents contemplated how having a “[possible] disease for life” can negatively affect their life (p. 497). The final of the stage adjustment processes occurred when respondents accepted that the illnesses regardless its magnitude is a part of their life and who they are for that material time.

In another study by Becna, Suryanaarayanan and Ganapathy (1999), they concluded that the initial reaction to the diagnosis was negative in the majority of respondents; admitting to fear of death, worry, anxiety and shock. Less than half of the respondents were hopeful of cure. Less than a quarter of the patients had mixed reactions, both negative and positive and a few expressed suicidal tendencies and denial. The initial reaction to diagnosis of patients was also studied in relation to compliance of treatment and among the majority who expressed anxiety, such as fear, worry and depression, more than half could not complete treatment. As far as the initial reactions to learning the diagnosis are concerned, those who were hopeful of cure had a better treatment completion than those who experienced anxiety following their medical regimen.

Bandura (1997) observed that diagnostic procedures can psychologically influence patient's beliefs about efficacy. Bandura argued that positive signs and responses are rarely

noticeable when an individual's efficacy has already been formed under conditions where negative signs were predominant.

2.2.3 Efficacy and Expectation in Coping in the Sick Role Behaviour

In a quantitative study conducted by Rueda and Perez (2006), they concluded that perceived health competence (PHC) is an important coping resource for essential hypertension patients, which contributes to deteriorating depressive moods for both men and women. PHC in their study was defined as “the competence belief concerning one's health” (p. 130). By extension, the belief about personal abilities with regards to a specific (health) problem –self-efficacy, and the belief that these personal abilities can be performed for a given behaviour to influence an outcome –efficacy expectation, combine to effect a perceived health competence. In the merger of HBM and TPB discussed previously, this is identical to what was explained to mean perceived behavioural control which is also a control-related factor associated with positive outcomes.

Adherence to medical routine and self-management have been linked to be promoted by an internal control belief in hypertension patients (Rueda & Perez, 2006). Patients who believed to have hypertension under control also reported better adjustment to the illness. Coping strategies aimed at problem solving or where there is an intention to confront the realities of a threat (approach strategies) with a personal appreciation of feelings and reactions and attempts to deal with these feelings reduced depressive related problems in essential hypertension patients unlike emotion-focused coping (avoidance strategies) strategies which contributed negatively (Rutter & Rutter, 2002). Rueda and Perez (2006) contended that due to contrary findings about emotion-focused and problem-focused coping, these strategies may suggest that they are not inherently adaptive. Hypertension patients who

believed to have PHC in coping reported higher levels of well-being, reported feeling happier about their life and relied on adequate social support network (Ibid).

2.2.4 Health Seeking in the African context

In a study by Awusabo-Asare & Anarfi (1997) in Ghana, they contended that some people believe that for certain diseases Western medicine can neither provide an explanation or a cure. For this reason, people consult the local herbal medical practitioners about such illness whose origins are attributed to the supernatural. These beliefs are grounded in the fact that many African communities adhere to the belief that the aetiology of some illness may be ascribed to forces of angered ancestral spirits, evil spirits or the machination of witchcraft (Gessler, Msuya, Nkunya, Schar, Heinrich & Tanner, 1995). Gessler et al. contended that in such situation people believe that the illness was caused by human induced forces and therefore requires the consultation of local healers and not Western medicine.

A study by WHO (2001) in Navrongo located in Northern part of Ghana indicated that children suffering from malaria leading to convulsions received treatment at the traditional healers and not in the hospital or other health facilities. Most of the severely ill patients consulted traditional healers before they went on to the health facilities. Over 80% of respondents in a survey responded that if a member of the family suffered from convulsions, the traditional healers were their first point of call. This is because convulsion is perceived to be caused by human induced forces among the local folks. Haram (1991) concluded in a study that health seeking in Botswana is not a question of biomedicine or Tswana medicine (practitioners from the local medical sphere) for the indigenes. Respondents (patients) in the study argued that there are various medical systems, each with its particular sphere of potency and validity. Chen, Kleinman and Ware (1994) contended that the central reason behind multiple uses of health services in times of illness is that patients feel uncertain as to

what type of therapy is required to cure a particular kind of illness. Therefore the perceived cause of an illness determined the choice between receiving treatment from a local herbal healer or a biomedical professional. Within the context of African cultural beliefs Våga (2004) argued that in general terms people seek biomedical professional health when they believe an illness is caused naturally without any machination of human induced forces. On the contrary, when an illness is perceived to be a consequent of human induced forces such as witchcraft and malicious machination then people turn to local herbal healers.

Several factors influence the seeking of health by an individual whose health is lost. A group of family kin, peers or specialist modulate the sick person throughout the episode of illness and if necessary can take responsibility for modification in the reach for restoring health (Janzen, 1978). Chen et al (1994) argued that as a result of easy accessibility to local herbal healers, people tend to use it more often than the biomedical facility. Further, local healers often charge considerably less than the biomedical professional facilities. The 2009 Austrian Centre for Country of Origin and Asylum Research and Documentation (ACCORD) report noted that as much as the traditional medicines serve to augment the health care delivery service, they also present a number of predicaments to the government's effort to providing appropriate health care delivery services. The greatest of these challenges come from those who mix traditional medicine with orthodox medicine (herbal treatment and religious engagements such as prayers and divinations) since they eventually end up maltreating and abusing their patients who are in search of spiritual healing.

In 1999 the government of Ghana merged all traditional healthcare associations into the Ghana Federation of Traditional Medicine Practitioners Associations (GHAFTRAM) to enhance capability building and the sharing of information. The Traditional Medicine Practice Act 595 was formulated by traditional healers and passed in Parliament in 2000 which mandated the establishment of a council for traditional healthcare practice. The council

was mandated to regulate and to set standards for the practice of traditional healthcare, to register and license traditional healers in the country, and to regulate the preparation and sales of herbal medicines and products (WHO, 2001). The Traditional Medicine Practice Council (TMPC) included a list of herbal drugs in the essential drug list used in the prescription and dispensing of drugs under the National Health Insurance Scheme (NHIS) in hospitals and clinics (WHO, 2001; MoH, 2004).

2.2.5 Religion and Coping

In a recent study in Ghana, Osafo, Knizek, Akotia and Hjelmeland (2011) concluded that Ghanaians are religiously committed to core and normative religious beliefs in which their religious practices are perceived as a preservation of life. Osafo et al. (2011) discussed that prayers could create and foster a relationship between a person and a divine entity (God) which enables a person to perceive that some “help could come from God during crisis” (Ibid, p. 7). Also prayer serves as a means for deferring problems to God and looking for a solution which afforded respondents an opportunity to divert self-focused attention since respondents conceptualized an active Deity who takes control of the problem when the problem is deferred to such a Deity (Ibid).

Koenig (2002) in a study with an 83-year-old woman who had multiple medical problems such as chronic progressive pain and weakness, despite numerous interventions, found out that the woman’s faith offered her the most help for coping with her illness. Koenig concluded that the woman’s faith served to make her optimistic, cooperated with her treatment and stayed socially active.

In another study, Koenig, George, Larson, Hays, Cohen & Blazer (1998) found out that religious involvement is associated with lower blood pressure and less hypertension. Mueller, Plevak & Rummans (2001), argued that religiously involved persons embrace health

promoting behaviours, eschew risky behaviours and have strong support networks. Their conclusions were that religious involvement are associated with better health outcomes, including greater longevity, effective coping skills and health-related quality of life, less anxiety, less depression and less suicidal ideations. Addressing the spiritual needs of the patient enhances recovery from illness (Ibid) because religious persons have a more reason to living and getting better (Koenig, 2004) thus in taking on behaviours directed in purpose of getting well, they are better placed than non-religious persons.

Levin (2010) in his study argued that findings which were consistent with a protective effect of religiousness especially in older adults seemed to be salient. That is, there was considerable evidence to conclude that one's religious life has something to say about one's health coping process –which includes the “being” and “doing” aspects of religion (p. 108). Where, the “being” refers to the identification of one as a religious person and the “doing” refers to one's engagement in religious activities. However, he concedes that studies of religion using epidemiological, social or behavioural methods cannot tell us anything about the possibility of a supernatural influence on health or the human body or mind.

2.3 Operational Definition of Terms

Essential Hypertension Patient:

In this study a patient who was medically confirmed by a physician as such.

Middle Aged Patients:

The study focused on patients (men and women) who were between the ages of 45-60 years.

Chapter Three

METHODOLOGY

3.1 Research Design

This study used a Qualitative Research Methodology to enable the full exploration of hypertension patients' lived experiences in their life worlds (Perett, 2007). To achieve this I explored and examined the central themes of interest with regards to the research objective to provide a deeper understanding (Kvale, 1996) in health and illness (Orb, Eisenhauer & Wyananden, 2000). In using explorative research with fewer sample size to unravel the socially and linguistically constructed world of humans, qualitative research methodology was more apposite than quantitative research methodology (Basset, 2004).

The qualitative methodology is flexible and allows modifying, reconstructing and adjusting to what is learned in the progression of the study. This gave the chance to acquire nuances of information regarding the respondents' experiences, attitude and thoughts (Kvale, 1983, 2006) by the respondents taking into account the influence of cultural, social and other familiar factors. The processes of qualitative methods offer a focused and a deeper analysis of data (Janowski & Webster, 1991). This study was informed by the relativist position which argues for the non-existence of anything as pure experiences (Willig, 2008). The different versions of experiences in different socio-cultural milieus are a result of the ways in which different cultural and discursive resources are socially constructed.

3.1.1 Interpretative Phenomenological Analysis (IPA)

The purpose of IPA is to emphasize a detailed report of the interplay of factors in a homogenous sample (Smith & Osborn, 2003). The focus of IPA is a meticulous exploration and acquisitions of detailed analysis of elements of the subjective reflected personal lived

experiences of respondents to establish central themes that the respondents make sense of as opposed to producing objective lived experiences (Ibid), which emphasizes on the role of cognition (Mulveen & Hepworth, 2006).

Data collection in the IPA approach is purposively centred on homogeneous sampling and employs fewer sample size to facilitate a detailed interpretive account of the data gathered (Smith & Osborn, 2008). Consequently, the “breadth of data [was] sacrificed for [the] depth” of data (Ibid, p. 56). IPA uses flexible interview schedule and structure (semi/un-structured interviews) which is followed by word-to-word or verbatim transcription of data. In the analysis IPA approach considers a first case and identifies central themes, summarizes associations and connections which are documented as emerging theme titles. These emerged themes are clustered into super-ordinate themes made up of subordinate themes. This ends up with creating a table of master themes. When this is completed in the first case other subsequent cases are then considered respectively by a cyclical method where new themes from subsequent cases are cross checked with the master themes to confirm their representativeness by going over the transcripts and rethinking on several phases of the analysis. IPA attempts to understand “what it is like”, from the point of view of the respondents and to report their side. In IPA the respondents are “trying to make sense of their world” and the “researcher is trying to make sense of the participants trying to make sense of their world” which is referred to as double hermeneutics (Smith & Osborn, 2003, p. 51). As such, the researcher is implicated in the research process and assumes an insider perspective where s/he produces a report by means of standing in the shoes of the respondents.

3.2 Procedure (The Study Site)

Ghana was chosen as the site for the study, specifically Korle Bu Polyclinic (KBP), a subdivision of the Korle Bu Teaching Hospital (KBTH) both located in the capital city,

Accra. Ghana was chosen because hypertension was considered non-existence or rare in most African societies, but has emerged as a challenging force to reckon with particularly in sub-Saharan Africa (van der Sandel, Milligan, & Nyan et al, 2000; Agyemang, 2006). Recent scholarly investigations points evidence to imply that blood pressure levels and hypertension rates in Ghana are among the highest in Africa which is partly due to the delay of patients in reporting to the hospitals to be checked, as well as the largest part of Ghanaians living with hypertension being unaware of the condition (Cappucio et al, 2004; Addo et al, 2006).

Polit and Hungler (1999) argued that the choice of a study site should be consistent and relevant to the topic under study. The researcher needs to make preliminary contact with key actors within the selected site to ensure cooperation and guarantee collaboration. To this end an introductory letter which also stated the purpose of the research and my interest in doing a voluntary service (see Appendix IV) was signed by my supervisor which was eventually delivered to the authorities at KBTH. Upon receiving the letter, the medical director at KBTH replied to me in affirmation. The medical director, Prof. Afua A. J. Hesse then sent me another introductory letter (see Appendix V) to be sent to KBP for the voluntary service and the study. At KBP this was approved by the head of the Polyclinic department.

3.2.1 Voluntary Service

In a bid to build familiarity and a common understanding of the health care framework I volunteered on a service at the KBP spanning the period of 8th June to 8th July (see confirmation letter at Appendix VI). This was shortly after my research protocol was evaluated and approved by the Medical Directorate of KBTH. The voluntary service also afforded me the opportunity to cushion the sense of comfort for prospective respondents and to eventually create a comfortable atmosphere for the interview session with the respondents. During the service I was undertaken through the basics of confronting patients. The acting

head of the department at the time often discussed some of the Polyclinic's approved ethics in conducting research as well as in handling patients or respondents. This was done orally because there was no hard copy of the ethical guidelines in his office.

3.2.2 Sample and Selection

Six (6) essential hypertension patients were selected as the sample size for the study. I interviewed three (3) women and three (3) men separately from each other. I maintained a gender balanced ratio in the sample size to facilitate and substantiate the appreciation of the outcome of the gender differences in the theme of the study. The time frame at my disposal and other practical issues also demanded a handy sample size of respondents who were readily accessible. IPA also requires that the researcher makes use of just enough respondents to enable a detailed interpretive account of the data gathered (Smith & Osborne, 2008).

Respondents were purposely selected after I sought permission from the head of KBP to assist in the recruitment. Participation required one to be between the ages of 45 to 60 years. My self-addressed stamped envelopes with information letter and informed consent were handed out to prospective respondents by the head of the KBP. Respondents were supposed to reply by post mail but only one did so. The rest hand delivered their response to the office of the head of KBP, contrary to expectations that they were going to send them by post mail. I was under the supervision of Dr. Gerhard Ofori-Amankwah who assumed office as the acting head of the department and also arranged for me to meet with the respondents and the interview time and venue were scheduled.

3.2.3 The Qualitative Interview

The qualitative interview affords respondents an opportunity to limn their subjective lived experiences comprehensively (Kvale, 1986, 2006). I used individual semi-structured

interview as the method of data collection. This enabled each respondent to describe what s/he experiences, thinks, feels, and reacts as regards the research question and interview guide. The essence of the qualitative interview was to gather as much as possible many nuanced descriptions of the participants' private and public life-world by focusing on the theme of the study (Kvale, 1983, 2006). The individual semi-structured interview method offered a flexible medium of communicating freely about the topics of interest in the study between the respondents and me. On a face-to-face interview format respondents were encouraged to speak candidly.

3.2.4 The Interview Setting

Normally, qualitative studies are conducted in settings involving respondents in their everyday environments to facilitate the acquisition of uninterrupted descriptions of the phenomenon of interest (Kvale, 1983; Orb, Eisenhauer & Wynaden, 2000). It is important to be aware of the specific context in which the interviews are done since this can potentially influence the data (Elwood & Martin, 2000). Respondents in this study chose to have their interviews in my office located in the Polyclinic. I quickly arranged to refund all expenses covering respondents' transportation to and from the Polyclinic where my office was located. Doing the interviews in the Polyclinic which is a familiar environment, it was hoped that the respondents will be more relaxed and feel a greater sense of security. My office was much of a personal setting; it was a confinement only for the respondent and me; ensuring a greater sense of trust between the two of us (Sanders, 2006; Elwood & Martin, 2000).

The venue for the interviews was advantageous since it would have facilitated access to the counselling and treatment centre had a respondent broken down resulting from emotional challenges, even though this possibility was not ensured before dispatching the consent and information letters. The greatest task for me was to ensure that the office was devoid of

disturbances such as noise and unauthorised entry of visiting patients who might have mistaken my office for a consultation room.

3.2.5 Materials

The main materials I used to source information from the respondents were an interview guide and a tape recorder. Field notes were used to take other observations and information which were of interest to the research serving as supplementary and complementary information to the recorded interviews (Emerson, Fretz & Shaw, 1995).

I constructed the interview guide in a funnel shape format; beginning from exploring the broader concept of diagnosis, health and illness, it narrowed down to focus on sick role behaviour, health motivation and finally to identity and influence (see Appendix I). The interview guide explored respondent's thoughts, feelings and experiences (Silverman, 2006; Smith & Osborne, 2003). The interview guide, rather than contain precise and specific questions focused on certain themes with reference to the research question (Patton, 2002; Kvale, 1983). I purposely constructed the interview guide to make it gender neutral to comply with the quality demands of qualitative research and avoid bias from myself. The interview guide sought to explore the different contexts and action radii for coping with hypertension with regards to men and women and their sick role behaviour.

3.2.6 Language Used for Interviews and Translations

For the relativist paradigm of investigation the cultural and discursive resources of the people of a context of investigation is central in constructing and understanding meaning and experiences, thus the choice of language spoken and understood by the researcher and the respondents is important for consideration in this paradigm of investigation. The multi-ethnic composition of Ghana makes her a multi-lingual society. Albeit the ethnic disparity, several ethnic groups are found in every part of Ghana. English is the official written and spoken

language of the people of Ghana. However, Ga is the language of the indigenes of Accra with the Akan language (Twi) also widely spoken by immigrants from other parts of the country who are in Accra. Usually immigrants in Accra learn both or one of these languages.

Two respondents, a man and a woman could only speak Ga and Hausa³ respectively. This meant that I needed a translator and could not directly communicate with the respondents. Obviously, this also meant that a considerable amount of data was missed directly in concrete interview sessions, and indirectly in the translation process which could also affect the transcription and the analysis. Working with the translator made it easier to agree or disagree on the meaning behind the respondents' statements and other non-verbal expressions which were contained in the field notes. At the time of translating the translator sometimes said "*by this I think that s/he means...*" These statements from the translator could verify my own thoughts, contradict my assumptions or add something new to what I might have not reflected upon. The translators were carefully selected based on their proficiency in the respective aspect not only for language but also for a wider knowledge of indigenous culture and social practices.

3.2.7 Observation during the Interviews

Other relevant information was collected by means of observing and writing down in a notebook. These field notes contained non-verbal expressions of respondent's facial expressions, eye expressions, physical movements, reflections and observations of me during the interview sessions. This maybe an important tool in any research based on the data collected from the interview. In this study the field notes also included how some problems were curbed to ensure a successful outcome.

³ Ga and Hausa: Both are among the local dialects spoken in Ghana.

For instance in one of the interview sessions a respondent prompted that the recording was too much. I quickly explained to the respondent that I only needed the recording to enable transcription and assured her that I shall strictly adhere to the regulations in the consent form and delete the recording and also destroy the transcription upon submission of the study report. In the course of the interview some respondents exhibited indications that the concepts used in the interview guide were incomprehensible. I employed familiar synonyms in place of some of the concepts which were identified to be incomprehensible. A concept “medical regimen” for instance was substituted for a common understanding of “prescriptions” and “medical schedules” was substituted for “check-ups”. Another observation was the impression two respondents had about me as a medical officer. I took time to explicitly outline my role as a student researcher.

3.2.8 Safety Measures during the Interviews

Respondents for the present study were convalescents who in one way or the other are recuperating from essential hypertension. Therefore it was important not to pressurize or coerce respondents during the interview for disclosure of sensitive information. As much as possible I endeavoured to enhance the rapport between each respondent and me by discussing my academic background before each interview. This not only served to ease the tension which might have built up between us but also re-echoed the position that I am only a student researcher and not a medical officer.

On the last but one interview the respondent arrived for the schedule and complained of fatigue as a result of traffic jam. I explained to Dr. Gerhard Ofori-Amankwah why I have to delay the interview schedule. Dr. Ofori-Amankwah took keen interest in ensuring that respondents were not in any way manhandled and always cautioned me against the use of force and subtle techniques to siphon information which may be contrary to the desires of the

respondents. During the interviews I also ensured that I kept the time span of the interview within what was stated in the consent form. I earlier estimated a time span of not less than an hour; most of the sessions lasted about 30 minutes with just one a little beyond 40 minutes.

3.3 Transcription and Data Analysis

I did the first transcription some hours after the first interview. Those interviews which I did with a translator were transcribed with the assistance of the translator and I marked them in italics to distinguish first-hand information from what had been translated afterwards. I used the word-to-word transcription to ensure verbatim transcription of the recorded interviews, with all frequent repetitions, pauses, emphasis in intonation, emotional laughter and sighs that accompanied the responses. This facilitated easy and authentic interpretations.

The data analysis involved a systematic categorizing and summary of the descriptions, and providing a lucid organizing framework that epitomized and explained patterns of the social world that respondents limned (Gubrium & Holstein, 2004). I used IPA for the data analysis. This is because the present study sought to uncover an in-depth understanding of the subjective lived experiences of the respondents. Further, in the analysis I explored and examined in detail how respondents made sense of experiences of sick role behaviour, reaction to diagnosis, source(s) of and reasons for health motivation and the influence on respondents' life and social behaviour.

I identified themes that cut across women's responses and men's responses after grouping subordinate themes in a matrix. Afterwards, I constructed a table and summarized associated central themes which gave rise to the master themes. These themes were not transparently available, they were "obtained through a sustained engagement with [the transcribed] text and a process of interpretation" (Smith & Osborn, 2003. p. 65). The analysis

underscored the importance of focusing on the content and complexity of the meanings of respondents' lived experiences rather than measuring the frequency of the meanings.

3.4 Ethical Considerations

Ethical clearance was sought from the Regional Committees for Medical and Health Research Ethics (REK) in Norway (see appendix II) and from the Directorate of Medical Affairs of the Korle Bu Teaching Hospital in Ghana (see appendix III) which runs as an autonomous institute. Ely (1991) avouched that striving to be faithful to another's viewpoint, maintaining confidentiality and trustworthy are ethical. Ethical considerations in researches are woven throughout every step of the methodology and cannot be confined to a single chapter.

3.4.1 Informed Consent and Information Letter

In doing a research, gaining informed consent from respondents is one of the most important aspects of the entire research process (Goodwin, 2006; Green & Thorogood, 2004). This does not only include obtaining respondents' signature on paper but also affording respondents enough time and space to wholly understand what is involved in the participation of the research and to make a reasonable decision. In obtaining consent respondents should be able to make rational decision whether to participate or not, it should be an independent decision and respondents must not be persuaded, coerced or induced to partake in a research (Ibid). Information letters and informed consent were dispatched early enough to give respondents ample time for consideration (for informed consent see Appendix VII, for information letter see appendix VIII).

The acquisition of consent may sometimes become fastidious; respondents who feel vulnerable or inferior in one way or the other might feel obliged to partake. In the present study respondents might have felt obliged to partake because of my association with KBP,

and give something back as a way of showing gratitude to the services of KBP. I prevented this by stating clearly in the information letter and the informed consent the dissociation between KBP and me (as a student researcher). I also informed respondents in the consent letter to accept participation on volition. Before each interview I orally gave information about the research to reiterate the information in the informed consents and information letters.

3.4.2 Confidentiality and Anonymity

As a researcher I am expected to uphold the professional ethics and principles regarding confidentiality and anonymity of respondents. This means that information gathered during research should not be traced to respondents or be accessible to others outside of the research (Goodwin, 2006; Green & Thorogood, 2004). Therefore I assured respondents that information will be used for the said purpose only and in quotations where necessary without direct reference to the identity of the respondents. This encouraged the respondents to be more conscious and opened up to disclose sufficient information regarding the research objective. In the data collection stage I ignored names and residence locations of respondents which assured respondents a sense of anonymity. Moreover, I assured respondents that in transcribing the interview, alphabets will be used as identification and no name will be tied to any quotation, since that can lead to association on who is behind which statement.

3.4.3 General Safety Measures

Huberman and Miles (1994) argue that in doing a research there is always the issue or risk. The interview guide was translated into Ga and Hausa since 2 respondents could only speak Ga and Hausa. Upon interrogation, I was informed by the families of the two respondents that a son and a sister respectively read and explained the information letter and the consent forms to the two respondents. Respondents were given the opportunity to have a

conversation with the acting head of the department of the KBP to serve as a means of relieving any sense of emotional insecurity after the interviews.

I also assured respondents that the interview will be terminated abruptly without any hesitation and respondents referred to the treatment and counselling department, should any respondent exhibit potentials for emotional breakdown or any discomfort. It was always important not to pressurize respondents to disclose sensitive information since respondents were convalescent and that would have elevated complications such as emotional breakdown.

To better understand the nature of handling patients, I volunteered on a service to have a common understanding of the health care framework. This could in a way have influenced respondents to think of me as a professional health worker. But my role as a student researcher was explicitly outlined to the respondents and with reflexive accounts I eluded personal influences on the data (see 5.2.1 for reflexivity). The location for the interviews became a good measure to advance confidence as a result of respondents' familiarity with the setting.

Chapter Four

FINDINGS AND DISCUSSIONS

Major themes which emerged from careful and detailed analysis of the data are presented with relevant literature to discuss. The major themes for which the results and discussion shall revolve around are:

- Contextualisation and Definition of Illness
- Reaction to Diagnosis and Diagnostic Procedure
- Activities toward Recovery
- Dealing with the condition as a Patient of Essential Hypertension

Each master theme shall be presented with subordinate themes; intertwined with discussions from earlier literature reviewed where necessary and relevant. Contrast findings which underline the theme of “Gender Differences” as captured in the aims of the study shall be discussed throughout the chapter. Not only shall differences in the findings be elaborated but also similarities shall be elaborated to present a comprehensive discussion of the chapter.

4.1 Contextualisation and Definition of Illness

This theme underscored the knowledge respondents expressed and demonstrated regarding their perceived experiences and understanding of illness. The theme *Contextualisation and Definition of Illness* which emerged from the analysis is important for consideration because according to Boruchovitch and Mednick (2002) individuals’ ideas, understanding, demonstration and expression of illness have an impact on their health attitude and behaviour which has merited increasing investigations into individuals’ health and illness behaviour. An improper or impaired functioning and also a deviation from normal functioning are characteristics of illness conceptions (Ibid). Boruchovitch and Mednick

(2002) averred that agreement on what constitute improper functioning or deviation from normality to enable a single definition for illness may be as difficult as a definition for health.

4.1.1 Gender Comparisons in the Contextualisation and Definition of Illness

According to Jegede (2002) the understandings and conceptions of health and illness is culturally influenced in all settings, particularly in African settings. Jegede argued that women considered health to be associated with wellness such that women defined and described health with positive statements such as eating well, sleeping well, not thin and urinating well. On the other hand, illness was considered as not being well and mostly “a description of one of the specific symptoms noted in the negative statements about health” (Jegede, 2002, p.327). Generally women and men considered illness significantly in terms of a deviation from normal health and wellness. In this present study, illness was significantly defined and conceptualised in terms of physiological functioning amidst the apparent influence of culture. Conceivably, both men and women respondents described illness significantly by alluding to malfunctions or impairments in one’s physiological components. However, few contrasts existed for remarks.

Men respondents alluded to the absence of strength, requiring assistance to function and exhaustion of internal organs as illness. For instance a 58 year old man had this to say to the question “What does illness mean to you?”

“Oh !...that one is like when you cannot do anything and need people to help you...you also see that your bodily organs are exhausted...I think it is just like the absence of some energy in you...eh...yes like that...” (Respondent B, Man, 58 years).

In the above quote the respondent pointed to requiring assistance and exhaustion of bodily organs in response to the question. This seemed to imply that illness is impairment in

normal physiological functioning where the body organs are exhausted and worn out. This impairment follows to the loss of one's capacity to function, such as to work. Consequently, as a result of the loss of the capacity to work then one would require another's assistance to be able to work. In light of the sick role model, requiring assistance as a result of incapacity when one is sick is blameless. The sick role results in the suspension of individual's everyday obligations, responsibilities and rights since "...*you cannot do anything...*" which are replaced by a set of sick role specific rights and responsibilities, thus, needing people to help you. Requiring assistance to work and exhaustion of bodily organs which characterised the conceptualisation of illness was inconsistent with the findings by Jegede (2002).

A further interpretation of men's attribution to deficit in strength could have originated from the consequences of the socio-cultural institutional frameworks which delineate the role of men in a Ghanaian setting; where men often engage in manual work for a living. This therefore often put men in an area concerned with the expression and demonstration of strength and vitality to work and to gain further promotion in employment. This explanation is supported by Courtenay (2003) who argued that men's allusions to strength and power are afforded by transactional and institutional structures (such as the stereotyped jobs for men – fishing, hunting etc.) which elicit their health belief and behaviour relative to strength. Some companies and organizations are so enormous in their operations that, sometimes it is a stereotyped belief that men are the better candidates to head such companies and organizations. The same question was posed to another man and this was his response.

"Ooh...my understanding is...you will not be of your own... you see something in your body and also stomach and other things. Mm...like when you are not strong and people help you to do so many things..." (Respondent A, Man, 55 years).

In the above quote, the notion of requiring assistance to work or function and a malfunction in physiological components such as stomach upset or the likes is mentioned.

For Respondent A, a nauseous state further conceptualizes illness. What was common for the two respondents are, according to Respondent B “...that one is like when you cannot do anything and need people to help you...” and Respondent A “...like when you are not strong and people help you to do so many things...” They both speak of the absence of strength, power and energy. However, these are two men; one unemployed and one employed in a formal sector yet they both alluded to same reasoning of requiring strength as conceptualising illness. This seemed to imply that the allusion to strength may not have stemmed from the type of job one does in the larger stereotyped jobs of men. These findings are partly in line with some of the findings by Jegede (2002), concerning the notion of absence or a deficit in strength as constituting illness.

For women respondents, albeit the differences and similarities to responses from men which will be elaborated later, responses indicated that women’s conceptualisation of illness was pinned to physiological functioning and socio-environmental explorations. Women’s indication of illness such as “something that has come to stay with you”, “some are curable and others are incurable” and “something that can disable you”, demonstrated the extent to which women respondents alluded to impairment in one’s physiological functioning. When the question “What does illness mean to you?” was posed, this is what a woman said in response.

“You see illness is bad and can harm you, so me I don’t like it at all, but sometimes you can’t do anything, it will just come...you can’t do anything. Mm...When they say someone is ill or when I hear of an unpleasant issue concerning sickness my heart beats faster than normal...”(Respondent D, Woman, 46 years).

As indicated in the above quote, Respondent D pointed to the fact that illness renders one incapable to function, (one becomes a victim of forces beyond his or her control) a notion

which was observed in the interpretations of response from men respondents. For this woman, she emphasized on the dangers of illness such as the possibility of a harm which could even be more detrimental for her personal life since she suffered from hypertension and news of illness made her palpitate. She acknowledged the unpleasantness of illness which is consistent with an undesirable state and an accompanying responsibility to want to get well as discussed earlier in the sick role behaviour. For the sick role one has to accept that the state of illness is undesirable and a responsibility to want to get well legitimizes one's innocence and endorses that one is not malingering.

Interpretatively, once you are incapacitated by an incipient illness you are unable to explore your environment and to move around as seen in your everyday life. In another instance the same question was posed to another woman and this is what she said in response.

“Illness is like some can disable you and some can also not be cured...some too are curable...all those ones are different from each other...” (Respondent E, woman, 55 years).

In the above quote, this woman also confirmed the harmful consequences of illness which can disable a person. She seemed to imply that those illnesses that cannot be cured are disabling and more dangerous. She acknowledged the different magnitudes of different illness and maintained that her illness is not disabling in another response even though she concurred to the notion of harm accompanying illness. Generally, in Africa women are considered a weaker group as compared to men. Therefore it is also culturally unlikely to be criticised as a women who feels weaker than a man. This notion of *weaker-ness* could have influenced women respondents to associate illness with weakness. As Courtenay (2003) argued, unlike men who will conceal their weakness in demonstrating illness, women do the contrary. This cultural stereotyping seemed to have reinforced the association of weakness to illness conceptualisation as admitted by women who further expressed and demonstrated

weakness in describing and defining illness and by associating it with harm and danger –an expression of fear.

The difference in conceptualising illness between men and women respondents could readily be noted; men alluded to the absence of power and strength, and requiring assistance to be able to function or work as illness while women did not significantly allude to strength and power. The allusion of illness to lack of strength and the inability to function physiologically by men respondents could be said to have stemmed from the divergent avenues which men and women encounter in their respective gender roles. The culturally accepted norm in Africa that men are superior in strength than women manifested in the conceptualisation of illness which also seemed to have reinforced the admission of weakness by women in light of describing and defining illness. It is important to recall that the expression and demonstration of strength and power by men is so because it reinforces men's role of masculinity. Men do so to preserve and protect their masculine role as argued by Courtenay (2003).

The negative connotations ascribed to conceptualising illness by both men and women respondents go to confirm the cultural influence in how men and women understand and experienced illness as discussed in the study by Jegede (2002), which was done in Nigeria. The findings in the present study about contextualisation and definition of illness suggested that illness as an impairment of physiological functioning and a loss of strength, power and social exploration demanded some corrective measure(s). Emke (2002) argued that, following from the undesirable state of illness one is obligated to seek technically competent help. For both men and women respondents, like the elucidations in the sick role model illness disrupt normal personal, bodily and social explorations. Further, like the sick role model women unlike men admitted that nothing can be done about ones subjection to illness and therefore

the sick cannot be blamed but instead has a right to assistance and may be obliged to seek help, - a technically competent help.

4.1.2 Gender Comparisons in the Contextualisation and Definition of Hypertension

For a study of health and illness whose respondents were essential hypertension patients, it was imperative to ascertain the understanding and experiences ascribed to essential hypertension by these respondents. Women respondents seemed to be much informed about the conceptualisation of what hypertension entails. The responses from women also indicated the features or characteristics of hypertension and not an objective definition of a scientific acceptance. Paraphrase responses such as essential hypertension is brought “...*in your body by something you don't know...*”, “...*doing something that will increase your pressure...*” demonstrate the level to which women respondents could proffer a fairly befitting knowledge of what hypertension entailed in their subjective world view. Courtenay (2000c) argues that women are more knowledgeable in health and illness matters than men. In the present findings women respondents demonstrated a good knowledge of essential hypertension; hence the present findings are consistent with the findings by Courtenay (2000c). For instance when a question about the meaning of essential hypertension was posed, this was the response of a woman who was a nurse by profession.

“Ooh that one.....is like you can't know what brings this hypertension into your body....you can just get it because of something worrying you.....sometimes if you already have diabetes you can also have essential hypertension...” (Respondent F, Woman, 51 years).

In the quote above, this woman seemed to be much informed about essential hypertension, probably because she was a nurse. She was able to point out that essential hypertension results from a blood pressure of an unknown cause. She further enumerated the

risk factors of essential hypertension such as if one has diabetes one stands a higher risk for contracting essential hypertension. Another risk factor mentioned was anxiety, which is, if one is perturbed by events in life it may become risky for such a person and catching essential hypertension may thus not be far from that person. The same question was posed to another woman and this was her response.

“My understanding includes not eating much salt, pepper, foods of the like as told me by the Doctor at the hospital since that will increase your pressure. You know that those foods can worry you...” (Respondent D, Woman, 46 years).

As indicated in the above quote this woman's response represented what risk factors there were in one's daily life as a patient of essential hypertension. She acknowledged the physician as being the source of her knowledge and that seemed to be very influential in her response by emphasising the consequences of going contrary to what the physician has directed. Her response as compared to the nurse is slightly different, in that, the nurse's response was more clinical than this present woman. However, it wasn't like this woman has no knowledge of essential hypertension since she understood the risk factors and the fact that blood pressure is of essence in conceptualising hypertension. Perhaps, respondent D's response is more of an informal understanding which reflects her experiences in her subjective life than the formal or clinical conceptualisation given by Respondent F who was a nurse.

Women's fair understanding of what hypertension entails did not go without the admission that hypertension could be chronic and a reference to the physician as an absolute authority. In their views hypertension has come to stay and therefore there is the need for corrective measures. This not only seemed to have exposed women respondents to be able to handle their condition once they had an admission for corrective measures but also it seemed to have enhanced women's better adjustment in coping. Since women admitted to the need

for corrective measures it is true to argue that women were better placed to deal with their condition as would be discussed later. For instance on issues relating to corrective measures this is what the nurse had to say.

“I think it is something that has come to stay with me...something that has come to stay with me... and the only thing that I have to do...have to do is eh...know how to go about my life, and everything I do...” (Respondent F, Woman, 51 years).

In the above quote it could be noted that this woman has admitted that she is sick with essential hypertension, and even though she seemed to have accepted that it may be chronic yet she believed that adjusting to corrective measures was important for her survival. Thus, knowing how to go about her life and everything she does is important for her since that would not escalate her condition.

Men respondents on the other hand indicated some of the accompanying diseases that come with hypertension such as fatigue and dizziness when the question about the meaning of essential hypertension was posed. Predominant among the indications of such diseases in the responses of men were “...palpitations, weakness and sleep disturbances...” For instance this is what a man said in response to the question “What does essential hypertension mean to you?”

“This sickness can get you to be tired very fast and you will be weak too sometimes even when you sleep it can disturb you and you can't sleep well...” (Respondent C, Man, 60 years).

This quote above seemed to be influenced by much of the accompanying diseases that come with being an essential hypertension patient such as fatigue and insomnia. By these indications this man was more concerned about what essential hypertension can do to you

rather than what it is. In another instance the same question was posed and this was what another man said in response.

“My understanding is ...eh beating of the...organs and...eh the blood and I feel something is pushing me in my heart” (Respondent A, Man, 55 years)

The allusion to physiological mechanisms in the conceptualisation of illness seemed apparent in the response by this man. In the above quote this man pointed to the fact that blood pressure of an unusual nature constituted hypertension. He further went on to indicate that it is related to an organ of the body, -heart. This man could also clearly relate the essence of blood pressure and the heart in conceptualising essential hypertension.

Like women, men demonstrated the clinical understanding of essential hypertension which bothers on blood pressure. But unlike women, men's' conceptualisation of essential hypertension was largely pinned on other diseases that follow from catching essential hypertension while women described experiences of the features of hypertension and the unknown cause of essential hypertension.

Coutenay (2000c) discussed that men underuse health care facilities and as a result men are less knowledgeable in health and illness matters than women. This was partly consistent with the findings from this present study. Women could conceptualise and define essential hypertension with regards to the unknown nature of it as well as the high levels of blood pressure. Men could only largely talk of the accompanying diseases that come with essential hypertension and to also relate it with the heart.

4.2 Reaction to Diagnosis and Diagnostic Procedure

At the point of learning about one's diagnosis, findings from this present study suggested that respondents demonstrated several emotional and cognitive searches for meanings or reactions. These reactions varied for women and men, with women expressing unperturbed emotional reactions and readily admitting to positive cognitive adjustments

while men expressed shock and worry over learning about their diagnosis. It is important to observe that findings from this study indicated that reaction to learning of one's diagnosis can take several forms of reactions which influences how one conceives of and interpret his or her status relative to the diagnosed illness. Among the forms of the reactions were:

- Recognising the diagnosis but dismissing symptomatology –where an individual recognised that the medical diagnostic procedure is valid, however, that individual dismissed acceptance of being ill (“*I don't think I am sick*”).
- Recognising diagnosis and admitting symptomatology –where an individual recognised that the diagnostic procedure is valid and also admitted to being ill (“*yes, I am sick*”).
- Not recognising diagnosis and not admitting symptomatology –where an individual outrightly rejected the validity of the diagnostic procedure as well as rejected to being ill (“*no, no I'm not sick*”).

These cognitive concept formations illustrated the resolutions that individuals settled for after being diagnosed of an illness, in this case, of essential hypertension.

4.2.1 Gender Comparisons in the Reactions to Diagnosis and Diagnostic Procedure

Learning about the diagnosis instigated a wide range of varied reactions which influenced how women interpreted their status differently from how men interpreted their status. Women upon learning about their diagnosis reacted less negative; women's unperturbed reactions were indicated from such responses as “*...it was not a big deal...*”, “*...I don't feel any bad...*”, “*...it was OK...*” Women were not troubled upon learning about the diagnosis and indicated minimal demonstrations of negativity with diagnosis of essential hypertension. In the forms of cognitive search for meaning in an attempt for concept formation women expressed favourable responses which seemed to have sustained them

through their cognitive adjustments for acceptance and recognition of the diagnosis. Women readily recognised the diagnosis and admitted symptomatology. When the question, “Could you describe how you felt when you were first diagnosed of essential hypertension?” was posed this is what one woman had to say.

“Ooh...I don't feel any bad, even I know my mother has and my father too has so I know it is hereditary so I don't feel too much bad about it. Even this one is normal nowadays; you see hypertension...is like most people have it...oh! (Respondent F, Woman, 51 years). (She smiled throughout what she said and didn't seem to be bothered)

In the above quote this woman seemed to imply that because of her previous knowledge about her parents' condition of essential hypertension she was not worried upon learning about hers too. She also seemed to rely on the fact that as a nurse she is aware that most people have the condition which, perhaps, was a common phenomenon and should therefore not be a cause for alarm. As a nurse, knowing of the possibility of controlling her condition might have also reinforced her calm reaction upon learning about her diagnosis. This is because she might have been aware that her type of hypertension was not one that could be said to be a terminal illness and explained that *“Even this one is normal nowadays...”* This one, meaning the type of hypertension she was diagnosed with. For another woman who was asked the same question this is what she had to say.

“...it was not a big deal, for me...after all...me I was not too strong so it was hiding inside me and worrying me...”(Respondent E, Woman, 55 years)

As indicated in the above quote this woman's thoughts are consistent with Respondent F. They both seemed to indicate that being diagnosed of essential hypertension is not a problem which should make one feel troubled because *“...it was not a big deal...”* as

indicated by Respondent E. This woman however, seemed to imply that her previous ill strength must have originated the essential hypertension. This seemed to mean that since she was already suffering some form of ill health, then being diagnosed with essential hypertension was not anything new to her. What is particularly interesting in the two cases is the history of the illness. In the first case of Respondent F, there was a family history of hypertension which seemed to be the influence for Respondent F's calm reaction upon learning about her diagnosis. In the second case, Respondent E seemed to have a history of some ill health (which was not named) and therefore being diagnosed with essential hypertension was not troubling to her.

The absence of negative reactions from women upon learning about their diagnosis in this present study was inconsistent with the findings of Becna et al. (1999) who reported that an initial reaction to learning of a diagnosis was associated with negative emotions such as fear of death, worry anxiety and shock. However, the present findings are partly similar to the findings of Young et al. (2007) who reported that an initial reaction to learning about diagnosis was somewhat relieving because respondents now knew answers to their long quest for ascertaining what could be worrying them. In these present findings women were not exactly relieved but seemed untroubled when they were informed about the outcome of their diagnosis. This absence of negative reactions is what perhaps influenced women to seem to have a better control of their status and condition, as shall be discussed later. It should be recalled that Bandura (1997) argued that under conditions of mild and unperturbed outcomes of diagnostic procedure patients are psychologically influenced to demonstrate positive signs of efficacy throughout their sick role behaviour.

The absence of negative emotional reactions from women in the present findings upon learning about their diagnosis of essential hypertension may have a link with how women perceived of the diagnostic procedure. Based on the findings in this study the reactions to

learning about a diagnosis are influenced by the perceptions of the diagnostic procedure. One aspect of the diagnostic procedure is the physician who did the diagnosis and confirmed the outcome of the diagnosis. Women seemed to have expressed believe and acceptance in the competence of the physician such that women could only remain in the confinements of the competence of the physician and desisted from any possible dismissal to the confirmation of the outcome of the diagnosis by the physician. For instance when the question “What do you think of the diagnosis and how do you believe it and the physician?” was posed this is what one woman said.

“...For me I think it is good diagnosis, the Doctor is good and I was not bothered much even people say the hypertension is not good...” (Respondent D, Woman, 46 years).

In the above quote this woman directly linked the physician to the diagnosis as well as to the nature of her illness. In the quote it could be noted that this woman seemed to imply that since the physician was good then the diagnosis was good too. According to her, the goodness of the physician or the validity of the diagnostic procedure constituted a good diagnosis. So that in her view once you have a good physician then your diagnosis cannot be bad or invalid. Further, once you have a good physician it is likely to influence your attitude towards the nature of your ailment. This is because according to her *“even [if] people say that hypertension is not good... [you don't have to be] bothered... [since your physician] is good”* This illustrated the extent to which the physician played an important role in ones reaction to learning about a diagnosis. Conceivably, the stereotyped gender role could have played a part in influencing women to subject to the outcome of the diagnosis. This is because the physician in question was a male physician and the respondent, a woman. To emphasise the fact that the stereotyped gender role could have elicited women's subjection to

the diagnosis and the absolute acceptance of the competency of the physician by women.

The same question was posed and this is what another woman, a nurse, had to say.

“...the physician is just doing his work...and he said it was hypertension...me I know it was BP worrying me...you know it is his work” (Respondent F, Woman, 51 years)

As indicated in the above quote this woman, a nurse, knew she was suffering from BP, as hypertension, is sometimes literally referred to. Her knowledge about BP could have been as a result of her profession or as it were the family history which she had earlier indicated. Nonetheless, she seemed to imply that without the endorsement of the physician she may not really conclude to be suffering a BP. So she said *“...you know it is his work...”* referring to the authority of the physician. She disregarded how authoritative her own knowledge about essential hypertension could be and referred to that of the physician by saying that *“...the physician is just doing his work...[because] it is his work”* This seemed to imply that the physician wielded an absolute competence which could not have been challenged or could be incorrect. It is important to observe that the readily recognition of the diagnosis and admitting to having the illness by women might not have been a relaxed recognition, acceptance and admission. This is because physicians are reported by Courtenay (2000) to exercise power and control over women and even women medical officers who are in lesser positions of power such as nurses. It is also important to mention that the present study did not find such exercise of power by the physician over the women respondents.

Responses from men on the other hand demonstrated that men exhibited shock and surprise upon learning about their diagnosis. In the present findings the expression of shock and surprise could be identified from such responses as *“I was surprised...”*, *“I was not expecting it...”*, and *“I’m not vulnerable because I’m active...”* Shock and denial according to the National Institute of Health (USA) report in 2011 are among the initial reactions exhibited by some individuals upon learning about their diagnosis. In this study when the

question “Could you describe how you felt when you were diagnosed of hypertension?” was posed, this is what a man said in response.

“I was very... I think... should I term it very surprised, because I was not thinking I will develop this sickness so I was very surprised...” (Respondent A, Man, 55 years).

(Shook his head to depict some kind of regret for catching the illness)

In the above quote this man pointed to the fact that he was surprise upon learning about the diagnosis. He seemed to be surprised because he did not have the thoughts of possibly catching the illness. He seemed to imply by his body language and facial expression that he is disappointed with himself for the condition and perhaps blamed himself for catching the hypertension. This finding is consistent with the findings in the report of the National Institute of Health. The initial reaction of shock and denial was also demonstrated in another instance when a question was posed to Respondent B. This was his response.

“I felt...then the feeling was...you know...it was a bit surprising but it was OK too even though it was shocking to know...” (Respondent B, Man, 58 years).

As indicated in the above quote, this man seemed to have an initial mixed reaction. Upon learning about his diagnosis he seemed to imply that he was not perturbed and felt calm. However, he pointed out the shock and surprise reaction, which seemed to be emphasised in his response by saying “...it was a bit surprising... [and] ...it was shocking to know...” Emotionally he seemed to have implied some sort of denial of the shock and surprise when after saying “...it was a bit surprising...” he quickly added that “...it was OK too...”

The presence of shock and surprise which men indicated in their reaction in these present findings are also consistent with the findings from Becna et al. (1999) who reported such initial reactions as denial and shock upon learning about a diagnosis. In compliance to

medical regimen Becna et al. argued that respondents who expressed shock and denial could not complete compliance and had a relatively low compliance to treatment compared with respondents who were not surprised upon learning about their diagnosis. What seemed to have instigated the expression of shock, surprise and denial in men could be interpreted in terms of what men thought of their masculinity and the encounter with the physician who was a male too. It should be recalled that Charmaz (1995) argued that men conceal and sometimes deny their emotional weakness and pain to illness in the presence of their male counterparts because of their stereotyped masculine role which also influences men to perceive themselves less susceptible to risk of illness (Gustafson, 1998; DeJoy, 1992).

In the cognitive search for meaning, men by their reaction expressed that they recognised diagnosis. Men likewise women also indicated their readily acceptance of the authority and competence of the physician and also admitted that the outcome of the diagnostic procedure was valid. For instance when the question “What do you think of the diagnosis and how did you believe the physician?” was posed, this is what one man said.

“The Doctor....he diagnosed me and he confirmed that I have it so I believed it...” *“But they are the experts...so if an expert tells you something you have to believe it...”* (Respondent A, Man, 55 years).

In the above quote this man pointed out that since the physician has confirmed the diagnosis then it couldn't be incorrect. His recognition of diagnosis was pinned on the authority of the physician. He seemed to imply that his perception of the physician was premised on the expertise and integrity of the physician. He buttressed that by indicating that the physician cannot be challenged, likewise the earlier indication by women because according to him “... [*the physicians*] *are the experts...*” This seems to add to the understanding that the physician wielded an absolute competence which couldn't have been

challenged or which could be incorrect. The seemingly absolute competence and the uncompromising authority of the physician could further be explained in relation to another man who was posed with the same question about what he thought of the diagnosis and how he believed the physician. This is what he had to say.

“...it was true, I believed it after all...you know the Doctors study so many years and so they can tell you your problems...”(Respondent C, Man, 60 years)

The quote above readily tells of the important role the physician played in the admission of the validity of the diagnostic procedure. This man pointed out that the diagnosis couldn't be false because the physician apparently by the number of years in school suggested that the physician knows it all. Further, his response seemed to be in line with the reasoning of Respondent A, that the physician is infallible in diagnosis as a result of his authority and competence.

It could be noted that men recognised the authority of the physician and accepted the validity of the diagnostic procedure. Regardless the encounter between same gender role types, men in this present study subjected to the outcome of the diagnostic procedure by the physician. What is important to look at is the status of the physician which seemed to have influenced men into submission. The responses from men could be interpreted in terms of who the physician was and what the physician did. This is not necessarily about the masculine gender of the physician but the reputation and integrity attached to the physician which can be identified in the responses by men, such as *“...But they are the experts...so if an expert tells you something you have to believe it...”* (Respondent A).

Courtenay (2000) maintained that social practices required for demonstrating masculinity are associated with different health beliefs which can influence men to demonstrate a wide range of reactions upon learning about their diagnosis. In this case, when

a man encounters a male physician, it is likely that the man may not expose physical or emotional weaknesses and admission to the diagnosis may be rejected by the man. This finding by Courtenay (2000) was partly inconsistent with the present findings because in this present study men submitted to the diagnosis which seemed to be a result of the influence of the authority, reputation and integrity of the physician. What was consistent with the findings by Courtenay (2000) was the emotional and physical reaction by men upon learning about their diagnosis when men in this present study reacted in ways acceptable to their masculine gender role such as denial and shock.

Generally the findings from this present study suggested that both women and men respondents recognised the validity of the diagnosis by admitting to the authority of the physician which eventually seemed to influence the validity of the diagnostic procedure. This was possibly because of the reputation attached to the profession of a physician in the Ghanaian society where the physician is held in high esteem and perceived to be a noble worker whose integrity about his profession cannot be questioned.

What seemed contrary for women and men respondents were physical and emotional reactions upon learning about their diagnosis. Women demonstrated less negative and unruffled reactions upon learning about their diagnosis. Men on the other hand demonstrated negative reactions upon learning about their diagnosis. The shock, mixed reaction and amazement expressions by men seemed to have been influenced by their stereotyped masculine role in a society where men are viewed as superior to women. This was to support the fact that men behaved in ways acceptable to their masculine gender role. However, unlike Courtenay (2000) argued, the masculine gender role of the physician did not seem to have an effect on men's reaction to and recognition of the diagnosis. Instead the reputation, integrity and authority of the physician seemed to influence men to recognise the diagnosis and the validity of the diagnostic procedure.

4.2.2 Gender Comparisons in the Interpretation of Status

This sub-theme basically outlines what both women and men after learning about their diagnosis conceded to be defining their health status. Findings in this study revealed that one may not admit symptomatology and regard himself or herself as having a particular illness even after recognising diagnosis.

For women, upon learning about their diagnosis, women did not demonstrate substantial attempts other than admission to symptomatology which also seemed to indicate gaining a sense of control over the illness. For instance when a question was posed concerning how respondents interpreted their status in relation to being diagnosed of hypertension, this is what one woman said.

“I think this illness is general so if I have it, it is ok, see...even younger people have it so if me your mother has it...should it be my problem?”(Respondent D, Woman, 46 years)

The woman in the above quote pointed to the fact that being a patient of essential hypertension is not an issue of alarming concern. She pointed out that it is a general and even younger people have it. She seemed to imply that once you grow older you're blameless for catching essential hypertension. For her, admitting symptomatology was “...ok...” more so because she thought that at her age she is more vulnerable to it. Another woman went on to admit explicitly that she is indeed sick to indicate the readily admission of symptomatology. This is what she said to that effect.

“How I see myself now is not like I used to see in the past...there's been some difference... I know that I am sick, so when I am given the date I make sure I don't miss check-up for medicine...” (Respondent E, Woman, 55 years).

In the above quote this woman compared her status before and after diagnosis. She indicated that she was not the same person as she used to be and that the incipient illness has

caused a difference in how she saw herself. She seemed to imply that now she is indeed sick as compared to the past days. Here she explicitly stated that she was sick and therefore she made sure she was compliant to the medical schedules. She further seemed to mean that the promptness in relation to the medical schedules is borne out of the fact that she is sick.

From the above interpretations of Respondent D and E, it could be noted that women indicated their readily admission to symptomatology. It seemed that women did not need more time to regroup to confront the illness because as it was discussed earlier women were not bothered and perturbed about the diagnosis hence the readily acceptance of symptomatology. Women admitted that they were sick and indicated a change in their life as a result of the illness and did not seem bothered about it, a similar instance which was discussed earlier in their reaction to the diagnosis.

It can be observed that women like Becna et al (1999) argued were better placed in dealing and coping with their condition and illness than men. Becna et al. argued in their study that as far as learning of a diagnosis is concerned respondents who demonstrated unperturbed emotional reactions and are able to construct favourable cognitive meanings are hopeful of effective coping and also comply with their medical regimen. This also include respondents who are not troubled in admitting symptomatology and are able to admit in favourable terms that they are indeed sick. This is because when that happens then like in the case of Respondent E, the respondent is motivated to comply with the medical schedules.

Men on the other hand dismissed symptomatology. It is important to state that only one of the respondents (man) did not recognise the diagnosis and also dismissed the symptomatology (all at the same time – *no, no, I'm not sick* concept formation). It is also important to observe that the recognition of the diagnostic procedure, the competence and authority of the physician and the dismissal of symptomatology influenced how men

interpreted their status. This is because men accepted the validity and the competence of the physician yet they expressed surprise and shock over the outcome of the diagnosis and eventually rejected to be sick (*I don't think I am sick* concept formation). For instance when a question was posed about how respondents interpreted their status in relation to being diagnosed of hypertension this is what one man said.

“Myself...it is not like I am vulnerable to sickness...but anybody too can get it so for me I don't think anything bad of myself, I am not like sick you know...”(Respondent C, Man, 60 years).

In the above quote this man did not entirely admit symptomatology since he did not have any bad thoughts of himself. He seemed to imply by “*...not think anything bad of myself...*” that he did not have any serious symptomatology which could subject him to be sick. This is because since he thought that he was not vulnerable to sickness, which might have been because of infrequent experiences with illness and also not seeing any dangerous or serious symptoms of hypertension, then he couldn't be sick. He further went on to resolve the mixed understanding by generalising hypertension so that it was not a problem even if indeed he was sick. In a separate instance, another man had this to say in response.

“...they think it is worrying me much, my friends at work especially, but my wife knows it all...I am not... Oh of course.....I don't often get seriously sick...me, I'm not a sick person” (Respondent A, Man, 55 years).

Even more readily, this man pointed to the fact that for him he did not think he was sick but it was the people around him except his wife who thought that he was sick. He seemed to imply that since he is not a sick person and since he did not have any personal worries or like in the case of Respondent C, infrequent sickness, then he couldn't be sick. He seemed to rely on the fact that he is often active and healthy and therefore he couldn't be sick. The failure of

men to have readily admitted symptomatology seemed to have been borne out of the admission of men that they were “...invulnerable...” and “...active...” Further, it seemed that because they were not frequently sick or did not frequently experience symptomatology then they couldn't be sick. However, this also seemed to have afforded men to engage in a cognitive search for adjustment and perhaps also to have emotionally and cognitively regrouped to confront the illness.

What was difficult to divulge was how one could have confronted an illness when one had dismissed the symptomatology and rejected to be sick. Nonetheless, in a society like Ghana, where the status of a physician is deemed with such a high reputation and whose integrity in his profession cannot be questioned, it seemed rather that, even though men rejected symptomatology the status of the physician and the physician's confirmation of the outcome of the diagnosis influenced men to engage in activities and services which are reserved for individuals who actually are sick and deserve such services. So that one could argue that (in the views of men) even though they rejected to be sick yet their perception of the physician's competence and authority forced them into a sick role behaviour.

Conclusively, for men what dominated the interpretation of their status was “*I don't think I'm sick*”. Unlike women who interpreted their status as “*Yes, I am sick*” As discussed earlier the “*I don't think I'm sick*” concept formation seemed to have been the consequent of men's reaction to learning about their diagnosis and other factors such as the influence of their masculine gender role, expression of power, infrequent experiences of illness, absence of serious or alarming symptoms and acceptable gender behaviours. On the other hand women's “*Yes, I am sick*” was also found to have been influenced by their unruffled reactions to learning about their diagnosis, the reputation attached to the physician (which seemed to have been the major influence for men into the sick role behaviour), and other factors such as their association of weakness with illness conceptualisation.

4.3 Activities toward Recovery

This theme elaborates on which activities the respondents reported to be taking in anticipation of recovery. In this section, constraints hampering on the progress of these activities shall be discussed as well. In light of the sick role model, the sick should appreciate that the state of being ill is undesirable and therefore should want to try to get well (Emke, 2002). It is in view of this precedent that the present study sought to report, if there is or not, any activities that respondents were taking to want to get well.

4.3.1 Gender Comparison in Health Motivation

The important aspect of the Theory of Planned Behaviour (TPB) which merited its place in this study was the emphasis it placed on personal motivation towards behavioural control. Motivation to want to do something to stay healthy or to be healthy is critical in the sick role behaviour of any individual given that in the presence of symptomatology an individual's positive health motivation may account for his or her optimal outcome of the sick role behaviour as reviewed earlier. Findings in the present study suggested that both women and men are in this regard somewhat motivated relatively different.

Women seemed to have been motivated as a result of experiences with a positive progression of their sick role behaviour and their health restoration process. Further women demonstrated some sort of motivation which was fuelled by intrinsic elements and finally one that could be seen as a result of their involvement in religious activities. In view of these explanations, it seemed that the women had a greater perceived behavioural control in their condition which served as an impetus to incite their motivation to want to be healthy. For instance when the question about health motivation was posed, this is what one woman said in response.

“...you see, because at first when I recognised that I am hypertensive in fact I became a little dull but right now after the CVA is down, I’m now happy...Because I have seen some people who had CVA but luckily for me, unless I tell you that I had this condition... before you can know... so I am ok” (Respondent F, Woman, 51 years).

This woman in the above quote pointed to the fact that her motivation to regain her health was based on how successful she had become in her sick role behaviour. What she seemed to imply was that when she first learnt of her condition she was saddened by it but because of her progress in the sick role behaviour she felt even more motivated to want to be fully healthy. This present finding goes to disconfirm that of Champion and Skinner (2008) and as theorized in the HBM, that an individual must necessarily feel threatened by an illness to be motivated to act. Neither was perceived re-susceptibility nor perceived threat of the sickness an enough impetus to incite women to want to stay or do something to be healthy. The sources of motivation for women seemed to have been positively motivated where the motivation was borne out of a positive inclination towards some sort of favourable outcomes of their sick role behaviour. The same question was posed to another woman concerning health motivation and this is what she also said in response.

“I just have to be well... I just want to be free from this...Oh I have to be well and stay healthy too...then you can enjoy life for long...I just want to be well again...Ooh most of the time I wish that I will be free from this illness...” (Respondent E, Woman, 55 years).

The above quote indicated the extent to which this woman had some sort of a personal motivation rather than seeing the threat of the illness or re-susceptibility as a factor for motivation. Her motivation to be healthy was fuelled by her innate desires; intrinsically informed that she believed she just had to be well. This seemed to have been implied in the

fact that she could have a prolonged life. She seemed to have a positive inclination towards her health motivation without any negative factors serving as the basis for her to be healthy. Her desire to stay longer and be free from illnesses seemed to be more positively inclined than negative. This is also in contrast to the findings by Champion and Skinner (2008) and also as theorized in HBM. In this positive health motivation of women what seemed to have also been very influential was their desire for longevity. It is important to state that women's desire for longevity did not mean that they feared to have a short life. This is because none of the responses from women was made to suggest so and throughout the interview not an indirect or subtle implication regarding the fear of short life was mentioned. For instance when the question about health motivation and whether the longer days on earth was a sole reason for motivation, this is what another woman said in response.

“Ah, yes! Who doesn't want to? I want to get a better medicine that will increase my days on earth..... No...no...I like it that way, to stay longer on earth....this man why, will you not be happy if your mother lives longer?...”(Respondent D, Woman, 40 years).

In the above quote this woman clearly indicated the extent to which longevity is vital for her health motivation. She questioned whether anyone could reject longevity as a motivation which emphasis the reasoning of Respondent E, as earlier discussed. This woman seemed to imply that longevity was enough impetus for her to stay healthy. This finding is consistent with the claim of this present study that the threat or re-susceptibility of an illness may not only be the factors which serve to motivate patients to regain a full healthy status. For women the threat of the sickness and re-susceptibility were not an impetus for them in their condition to have been a necessary motivating factor to act. The progression of their condition, an innate desire to be well which was fuelled by intrinsic elements and a desire for

longevity rather seemed to have been the salient impetus which fostered women's positive health motivation.

Men demonstrated a somewhat contrary source of their health motivation to that of the women. For men neither the perceived threat of the sickness, progression of the condition (as in the case of women), nor perceived re-susceptibility, served to incite their health motivation. Men associated strength to work, and a perceived benefit to be their sources and reasons for health motivation respectively. The health motivation for men seemed to be their ability to provide for their family and significant others in their continued healthy state. Because men are viewed as the head of the family, this status comes with a responsibility to ensure that the family's needs and wants are catered for. For men, the absence of health will mean the absence of their ability to be able to provide such needs and wants to the family. This seemed to be the source for which men derived their health motivation. The benefits which the family of men (such as children, wife etc.) could derive were what seemed to be the reason for men's health motivation. For instance when a question about health motivation was posed, this is what one man said in response.

"I get motivation from so many things like my children...you have to stay alive and take care of them very well because if right now I don't take the drugs and maybe the sickness becomes very serious then my children will be in trouble too...because I can't work...that one is very often and important for me I have to be well...to stay and work..." (Respondent C, Man, 60 years)

In the above quote this man indicated that his ability to be able to provide for his children served to be the source of his health motivation. So that if he is not healthy then he wouldn't be able to provide for his family and that would mean a trouble for his children. He also emphasised how that was important as a source of motivation for him. This seemed to imply that the benefit that the family would derive when one is healthy served to be the

reason for men's health motivation. This aspect of the perceived benefit to the family is consistent with the perceived benefit claims by Champion and Skinner (2008). This and other similar responses demonstrated the extent to which the ability to provide for one's family and significant others are important for men to be healthy. Further, their ability to maintain their strength or gain strength and to be able to work (e.g. to feed the family) was a vital source for which men derived their health motivation.

Conclusively, not too distinct from the experiences of women, men also demonstrated the extent to which longevity served to be a reason for their health motivation. Women attributed longevity to be their reason for health motivation and the progression in their sick role and an innate desire to be healthy as their source of health motivation. Strength to work and feed the family and the need to stay longer were what seemed to be the reasons for men's health motivation. In a society where the onus lies on men to almost be the sole provider for the family, it makes sense to explain that this could be the interpretation to the reason for which men alluded to their ability to provide sustenance for the family as a reason for their health motivation. This is because; in the absence of health one would not be able to provide subsistence for the family and may be perceived by the society as not man enough. Therefore men seemed to be motivated to want to be healthy or maintain health to be able to prevent the societal criticism and castigations that accompany ones inability to provide for his family.

4.3.2 Gender Comparison in the Sick Role Behaviour

In this present study, both women and men respondents indicated the support they received from family and significant others as a result of their assumption of the sick role behaviour. This goes to confirm that, the sick person cannot be expected to get well on his/her own and therefore has the right to assistance (Emke, 2002; Varul, 2010). What this means is that the respondents were not blamed to be responsible for their illness and therefore received care and sustenance from their significant others as elucidated in the sick role

model. For instance when a question was posed about whether or not the family was supportive in health matters; this is what one man said in response.

“... they see me to be ill...it is not my fault... just ill that’s all...and because it is a family house they make sure they help me” (Respondent B, Man, 58 years).

In the above quote this man pointed to the fact that he couldn’t be blamed for his condition. He seemed to mean that the family helped him in all he does since the family members acknowledged that he was not strong but sick. The absence of blame on him seemed to be a good indication for his emotional progress which he indicated in mild terms in relation to his sickness, thus –“...just ill that’s all...” This also seemed to mean that he downplayed, if any, the seriousness of the illness. The same question was posed and this is what another man said in response.

“Like, if I am in need of... let me say money and other things to buy drugs my brothers assist me to buy them...they respect me a lot and I don’t think this hypertension will make them not to respect me even some of my friends keep telling me I should take the drugs and it will go” (Respondent A, Man, 55 years).

In the above quote this man indicated that he also received assistance from his family and significant others. Here it could be seen that aside the care and assistance this man received, his family wouldn’t blame him and censure him as responsible for his state of illness. The family still respected and offered the necessary and needed support. This confirms the assumption of the sick role behaviour regarding the relationship between the individual and his family, if the individual is not malingering. For women, a question was posed whether or not the family was supportive in health matters and this is what one woman said in response.

“Ooh... for that...truly they help, when someone is not well at least people visit and help also...sometimes the little money they have they can give you some...you normally don't have to expect much because of the situation...”(Respondent E, Woman, 55 years)

This woman also indicated the fact that the family provided assistance and care. She seemed to imply that even though the family's help and assistance was provided one should not make that a sole source of support. This is because the situation in terms of financial gains was poor and therefore family members may not be able to provide everything. She seemed to imply that irrespective the fact that family members may not provide much financial help, they provide other means of support such as visits which could strengthen her social support network. This also goes to confirm the assumption in the sick role that the family provides for the sick in terms of assistance because the sick couldn't be blamed for his illness.

The provision of assistance which is consistent to the claims in the sick role model could be likened to the argument that the sick is a victim of forces beyond his or her control and should have the right to assistance and care. That is also to say, illness according to these responses may be beyond the control of the sick and should also not be blamed on the sick as was originally argued by Parsons (1978). However, the sick does not seem to need an absolute assistance. In this regard the argument has to be, the more severe the sickness the more one has to receive help and not only that the more severe the sickness the more one is expected to be exempted from normal personal and social roles.

Aside the support and sustenance women respondents generally indicated to have received; women respondents indicated that they were undertaking activities by themselves apart from the medical regimen prescribed by the physician to get well. Women did not seem

to rely solely on the medications to get well. This is because women seemed to have an approach strategy in dealing with their condition. Women were also active agents in the therapeutic process. This finding goes to disconfirm the assumption by the sick role model that because the patient entrust fiduciary responsibilities to the physician, the patient becomes a passive agent in the therapeutic process. For instance when a question was posed about what respondents were doing to get better (aside the medical regimen) this is what one woman said in response.

“You see...this illness is with me... but I am not lazing about with it... I make sure I do some little little things to get active... I don't just rest and rest and rest... I walk to most places and visit friends too” (Participant E, Woman, 55 years)

In the quote above, this woman pointed to the fact that she is not passive in the activities of getting well. She indicated how she refused to excessively rest but take on activities to be able to get well. She seemed to imply that even though she is sick she did not remain a passive agent by lazing about instead she walked (as a form of exercise) to places as a means of getting active. The same question was posed to another woman and this is what she said in response.

“First I did not know I had the illness, but now that I was told I ensure I comply with the medications and regulate my choice of food to suit what the Doctor said...look...eh...if you don't do what the Doctor says you know what can happen”(Participant D, Woman, 46 years).

In the quote above this woman indicated how she was also an active agent in the therapeutic process. For her, she seemed to imply that her active participation in the therapeutic process by regulating her choice of food was elicited by her condition. This present finding also contradicts what is postulated in the sick role behaviour that the sick person is a passive agent in the therapeutic process.

Men on the other hand demonstrated that they could only comply with the medication and not go beyond it. Men seemed to justify this with the economic burden on them. Men seemed to be in a situation which could not afford them the opportunity to do anything apart from taking the medications. Men seemed to place their economic activities at par with their health or maybe higher to their health and therefore could not forfeit their economic activities for their health facilitating activities. For instance when a question was posed about what respondents were doing to get better (aside the medical regimen) this is what one man said in response.

“My work is very early in the morning...you know the customers come early it is just like Abossey Okai⁴ ...Kokompe⁵ and Abossey Okai are the same...so I don't get time to exercise regularly but sometimes on weekends I do some walk and other things... That is what the Doctors will always say...but sometimes you the individual also have to make adjustment to suit your survival...you don't expect me to leave my job and go about exercising every time...” (Respondent C, Man, 60 years)

In the quote above this man indicated that his job prevented him from other activities which otherwise could facilitate his sick role behaviour. This is because as a man who is burdened with caring for the family the priority is normally your ability to work sufficiently to be able to meet the demands of the family. He seemed to imply that he is aware of the things he has to do to facilitate his recovery process, nonetheless, that is a choice and it lies with the individual to choose what is best for him. So that for instance, having to exercise is good but he also need to get to work to be able to meet his customers. It seemed that how men interpreted their status could have influenced their minimal attention to their sick role behaviour. Men's inability to prioritize activities which are health enhancing to facilitate

⁴ Abossey Okai: A suburb of Accra where there is mainly merchandise of car parts, both used and new parts.

⁵ Kokompe: Also a suburb of Accra involved in the same business like Abossey Okai.

recovery could stem from the dismissal of their status as being ill. Men had dismissed interpreting their status as being sick and rejected to be regarded as sick. This seemed to have influenced men to be sluggish in their attempts at doing more apart from medication to get well. It also seemed that there is not a want for men to be well. All these could have been influenced by the fact that men did not think that they were sick because they were “*active*”, “*invulnerable*” and “*not always in the hospital*” as represented in their earlier responses. It is important to observe that physician’s status in the Ghanaian society seemed to have been the influence why men complied with the clinical schedule, though sluggishly.

By enhancing their health status and facilitating their recovery process women played an active role in the therapeutic process by going beyond medication and actively approaching their medical regimen. In view of this, this present findings suggested that the responsibility of restoring health and teleonomic capacity is not solely on the therapeutic agency but also on the patient. Unlike women, men seemed to rely solely on the available medication and could conceivably be passive agents in the process of restoring health. But that is, because men seemed to have less concern about their illness status since they dismissed their symptomatology and interpreted their status as not sick –*I don’t think I am sick* concept formation.

4.3.3 Gender Comparison in Constraints in the Sick Role Behaviour

Findings in this present study suggested that both women and men were faced with some sort of constraints by the sick role behaviour. In the assumption of the sick role, illness becomes an institutionalized role and not a mere state of the person (Parson, 1978; Varul, 2010). This role results in the suspension of the sick person’s everyday obligations and responsibilities which are then replaced by “a set of sick role specific rights and responsibilities” (Varul, 2010, p.77). These set of sick role responsibilities and rights which are legitimized by the physician comes with a cost. The sick person according to Varul

(2010) relinquishes his/her personal autonomy because of the prescriptions and the medical regimen by the physician and the conferment of the sick role specific rights and responsibilities on the sick person. For instance when a question was posed about how respondents saw themselves after their diagnosis and assumption of the sick role behaviour this is what one woman said in response.

“Before I was diagnosed.... in fact... I lived well... I used to go out...partying...but right now....at times I do forget about some of the activities and stay in the house. It has changed me a lot... it has changed me a lot....I don't bother myself going to anywhere just like that...you see....like the party....I used to go out for engagements and outdoor ceremonies and even funerals....but now I am not much concerned about going out to all these events...”(Respondent F, Woman, 51 years)

In the quote above this woman indicated how the assumption of sick role has caused a change in her life. She seemed to mean that she has refrained from her social explorations such as going out to parties and other ceremonies because of her condition. She seemed to imply that she has become selective in her social explorations with much concern. This constraint she indicated was absent prior to assuming the sick role. This is because she indicated how she “...lived well...” before she was diagnosed of hypertension. It could also mean that she was eating too much and obviously she regulated her food intake by avoiding temptations in social explorations. In the same vein another woman remarked on how she was affected by assuming the sick role. When the question was posed this is what she said in response.

“Well now, when I eat certain kinds of food we all know I will be ill, so when we cook we put no salt, no pepper to ensure that my BP is OK, also they make sure I don't eat late, by 4pm I should have eaten” (Respondent D, Woman, 46 years)

In this quote also just like in the case of Respondent F, this woman indicated how she has been constrained as a result of the sick role. She indicated that she has rejected to eat certain meals which could destabilize her blood pressure. This constraint seemed to have extended to the other family members as well. This is because normally in Ghana, people live in family houses where there is more than just a nuclear family. She seemed to imply that having to assume the sick role behaviour had caused her to have her meals at an earlier time which meant that the other members of the family must also eat earlier than they might have preferred. Women demonstrated more constraints with regards to relinquishing their personal autonomy as a result of assuming the sick role. The losses included decrease in partying and social events, interruptions in social explorations, cessation of preferred meals and dictating the family menu. These findings are consistent with the claims by Varul (2010) as discussed earlier.

In another instance women indicated their inability to have access to some other prescriptions which in their view were expensive to purchase. This finding goes to confirm the findings by Hausmann-Muel et al. (2003) who concluded that in sub-Saharan African women's limited access to health care facilities and services is a consequent of the lack of economic independence of women. It also confirms the findings by Cappuccio et al. (2004) who contended that in the case of female patients, their limitation to compliance and accessing health care services is as a result of their dependence on their husband for financial support and upkeep, even though this present study did not find a connection between the limitation relative to dependence on husbands as argued by Cappuccio et al. (2004). However, what this present study found was that the burden of financial constraints does not only affect women but also men (which was the only constraint men indicated). In view of the foregoing, financial constraints posed as a threat to both women and men in receiving health care. High expenditure on medication was indicated as a single constraint knocking on both women and

men. This finding is consistent with the findings by Buabeng et al. (2005) who concluded that the lack of compliance to medication by hypertension patients in Ghana is as a result of high cost of medication. The present findings go to compliment the fact that high cost of medication poses a threat to compliance with medical regimen for essential hypertension patients.

The reason why women seemed to have more constraints in the sick role behaviour than men could have stemmed from the fact that after all, women assumed the sick role more than men, while men even dismissed their status as being sick and could therefore had not much incentive to assume the sick role with its accompanying constraints.

4.3.4 Gender Comparison in Medical Pluralism

Findings from this present study indicated some form of multiple usages of medications by men unlike women. It is important to observe that in Ghana, the Traditional Medicine Practice Council (TMPC) approves of a number of herbal drugs as a relevant contribution to the group of essential drug list used in the prescription and dispensing of drugs under the National Health Insurance Scheme (NHIS) in hospitals and clinics (Ministry of Health, 2004). The use of multiple medications basically means the different approaches to medication, such as receiving diagnosis and treatment designed in a single society (Janzen, 1978). The use of herbal drugs as a compliment to the formal health sector or the Western approach to medication is enshrined in the regulation of the MoH of Ghana supervised by the TMPC. However, ACCORD (2009) report argued that notwithstanding the fact that the traditional medicines augment the formal health care delivery it also presents a considerable amount of predicaments in the entire health sector of Ghana.

In this present study, only men indicated the use of traditional medicine as a compliment to the Western medication. Contrary to the findings by Awusabo-Asare et al.

(1997), the complimentary use of herbal drugs by men in the present study was not premised on the view that Western medicines could not provide sufficient explanation or cure for their illness. The present findings are consistent with the findings by Chen et al (1994), thus the use of herbal drugs by men in this present findings seemed to be a result of uncertainty surrounding which type of medical approach is sufficient to provide absolute restoration of health. For instance when a question was posed about what strategies were adopted to help deal the condition as an essential hypertension patient, one man said this in response.

“...but at times they say this thing[essential hypertension] comes from other sickness so I have been taking this neem tree⁶ and other herbs...Yes, some neem tree and others...I think they can also help me...”(Respondent A, Man, 55 years).

In the above quote this man added the use of *neem tree* to the strategies he adopted to deal with his condition. He seemed to mean that the use of *neem tree* is as a result of uncertainties surrounding what he had heard regarding essential hypertension. He seemed to imply that since he was not sure where the sickness was coming from then he could use the herbal medicine as a supplement to the Western ones given him by the physician. This uncertainty regarding which type of medical approach is sufficient demonstrated the extent to which this present finding is consistent with Chen et al. (1994) but contrary to Awusabo-Asare et al. (1997). In some communities in Ghana it is the general belief that herbal drugs can be taken even on daily basis to boost ones immune system. This generalised belief is sometimes incorporated into radio and television adverts by companies which produce and sell these herbal drugs.

Further, the use of herbal drugs as a supplement to the Western medication by men seemed to have been influenced by the high cost of Western medication and the availability

⁶ Neem Tree: A type of the various herbal plants used for producing herbal medicines. The pinnate leaves have a very bitter taste and a garlic-like smell.

of herbal drugs. In considering activities towards recovery, both women and men are constrained by economic hardships which militate against their capacity to afford Western drugs. Men used both Western and traditional medicines as complimenting each other since the traditional medicine were readily available and less expensive to access. For instance this is what one man said in response to indicate how accessible herbal drugs were.

“...there is one younger brother who is a herbalist...ahaa!...you know Yafo Yafo⁷... my brother worked at Yafo Yafo for some time...”(Respondent C, Man, 60 years)

This man's access to herbal drugs seemed to have been as a result of his younger brother who worked as a herbalist and could therefore provide him with the drugs. He seemed to imply that there was some sort of convenience in accessing the herbal drugs from his younger brother.

Conclusively, the use of herbal drugs which was indicated by men seemed to be as a result of uncertainty surrounding which of the medical approach could provide absolute restoration of health, high cost of Western medication and the readily availability of herbal drugs. Women respondents also faced constraints in terms of limited financial gains but did not indicate any use of herbal drugs to compliment the Western medication. Contrarily as reported by ACCORD (2009), this study did not find any predicaments presented by the complimentary use of herbal drugs to the Western medication on the individual.

4.4 Dealing with the Condition as a Patient of Essential Hypertension

This theme elaborates on which coping strategy, the locus of control and the outcome expectation for both women and men. Further, findings regarding how both women and men perceived of their self-efficacy relative to the coping strategy adopted by either group shall be

⁷ Yafo Yafo: A Traditional medical practitioner company which manufactures most herbal drugs, Yafo Herbal Centre (Drugs).

discussed. The ability to control one's stress in the sick role behaviour requires that the sick who is taking on activities directed in purpose for the restoration of his/her health is motivated in that direction with the same magnitude of motivation relative to the purpose of restoration. This means that to be able to achieve effective coping, there is the need for the sick to have a perceived behavioural control which will result in mastery, control and resolution (Miller, 2000). However, to be able to achieve this, one appraises a stressful stimulus and then adopts a coping strategy which will favour him/her in controlling the stress to recover reversible impaired functions or to compensate for any irreversible loss.

4.4.1 Gender Comparison in Coping or Control Strategy

Findings from this present study indicated different coping strategies for women and men which seemed to have been influenced by the appraisal associated with the stress. Women respondents demonstrated approach coping processes which seemed to be a result of the adopted problem-focused coping strategy of women involving planning, information seeking and problem solving skills. Women intimated that they were particular about their condition and therefore paid much attention to the condition and as a result complied with the medical regimen and remained absolutely subjective to the medical regimen, as discussed earlier. For instance when a question was posed about control strategy, this is what one woman said (in addition) as response to the question.

“...well, all is that I need to be well... so I am particular about my medical routine not to miss the drugs [medical schedules] ...” (Respondent E, Woman, 55 years).

This respondent seemed to imply that to be able to be well again then one has to be attentive to the medical regimen and schedule to avert missing out in the schedules. This finding is consistent with the findings by Charmaz (1995), Sutkin & Good (1987) that women are more attentive to their health demands. This also goes to buttress the point that women perceive themselves as more susceptible to illness and therefore are more attentive to their

health and illness needs (Gustafson, 1998; DeJoy, 1992). Amongst other strategies which women indicated include singling out and fighting the condition other than the trivial issues that accompanied the condition. To deal with the accompanied issues, women brushed away those trivialities to be able to pay much attention to their condition to consider what could be done to reduce their stress. For instance this is what one woman said in response to a question about her control and coping strategy.

“...the thing is I don't keep something that will bother me too much, ... I don't think of something that will bother me too much, I just brush any nonsense things away and then go on with my life, because if you think too much it will worry your hypertension...”(Respondent F, Woman, 51 years)

This woman indicated how she dealt with her condition and controlled it from escalating by reducing her stress level. She seemed to imply that singling out her condition and being attentive to the condition was more important than thinking about other issues. This problem-focused strategy which seemed to be the type women adopted to cope could be a result of how women perceived their condition. As indicated earlier women perceived their condition as one that required attention right from their reaction to the diagnosis and the diagnostic procedure. Findings from this present study indicated that women appraised their condition with much attention and also much concern where women enumerated a lot more benefits of being able to deal with their conditions than being unable to do so. According to Lazarus and Lazarus (2006) this type of appraisal results in an effective coping and it is also favourable for the patients concerned. This goes to confirm that where there is relatively much perceived benefits than perceived costs; the patient will focus attention on what can be done to alter the condition favourably and thus, employ a direct confrontation to the condition (Miller, 2000).

Unlike women, men in this study indicated that they seemed to have a form of appraisal which did not perceive their condition as one that needed much attention and concern. Men demonstrated that there was not a need for assessment on coping strategy since they did not perceive of any complications in their condition. For instance when a question was posed about control strategy, this is what one man said in response.

“My condition is not bad...as I said I am not vulnerable to sickness or like I am sick prone...it is just that I have this now...I don't have any problem with this sickness...”(Respondent C, Man, 60 years).

This man indicated that he did not have any problem with his condition, even though the physician has diagnosed him with hypertension. He seemed to mean that once he did not have any complications then he couldn't be sick. However, the possibility of a flawed diagnosis could be unchallenged. Since this man did not perceive himself to be sick prone (demonstration of masculinity in health and illness) then he could also not be vulnerable to illness. There seemed to be some lack of appraisal since men did not have enough indications to admit being sick, which meant they were not facing any stressful stimulus. The seemingly unconcerned demonstration by men is in line with the findings by Charmaz (1995), Sutkin & Good (1987) that men are less attentive to their health demands. This also goes to buttress the point that men perceive themselves as more insusceptible to illness than women and therefore men are more inattentive to their health and illness needs (Gustafson, 1998; DeJoy, 1992).

Nonetheless, it seemed that men had a bit of concern regarding their control strategy which could be said to have been influenced by the reputation and integrity of the physician and not because of the illness. For instance when a question was posed about the control strategy, this is what one man said in response.

“Ooh my condition is stable and so at times if I report sick my people (colleagues at work) say no but you’re not sick, how do you feel sick when you’re standing there like that...” (Respondent A, Man, 55 years).

This man was concerned about his ill health and therefore reported sick to work as directed by the physician. This man seemed to imply that his colleagues at work do not believe that he is sick probably because he does not show any symptoms of illness. For this particular respondent (Respondent A), in reacting to the diagnosis he was very surprised, because he was not thinking he will develop this sickness. He further remarked that he believed the outcome of the diagnosis because of the Doctor’s confirmation. He attributed his believe to the fact that the physician is an expert and so if an expert tells you something you have to believe it. This man also explicitly stated that he was not a sick person. Hence, the only reason he was concerned about his health and reported sick to work (even though his colleagues sometimes do not accept it) was because the physician had directed him to do so. This and similar subtle concerns by men could only be described as a form of avoidance coping strategy because it did not involve the conscious confrontation with the stressful stimuli (Miller, 2000). This also could not suffice to be interpreted as emotion-focused coping. Emotion-focused coping is when a person makes no effort to change the stressful condition because s/he concludes that nothing can be done about the condition (Lazarus & Lazarus, 2006). The findings from this present study about men indicated that the dismissal of their status interpretation as sick influenced men to also not have specific coping strategy or coping process which could be distinctly described as emotion-focused even though there seemed to be some evasion of conscious confrontation from their condition. The absence of complications in their condition seemed to have influenced men to think that perhaps there was no need to do something directly about their condition to cope and control it. Nonetheless, it could also mean that men seemed to be dealing with their condition in a

favourable way (and for instance did not see the need to do something beyond taking the medications).

Generally in dealing with their conditions as patients of essential hypertension, women seemed to have a favourable appraisal which resulted in an approach process and a problem-focused coping strategy which was characterised by fighting the condition, seeking information and singling out the condition by ignoring trivialities. Men on the other hand seemed to have no distinct form of coping strategy except what could be described as avoidance coping processes which was characterised by evasion of conscious confrontation with their condition. This evasion of conscious confrontation with the condition seemed to have been influenced by the dismissal of being regarded as sick and the lack of complications in their conditions as indicated by men.

With the increased involvement in religious activities by Ghanaians, it was apparent in these present findings that prayer was used by both groups as a control strategy and a tool for coping. This finding is consistent with the findings by Osafo, Knizek, Akotia and Hjelmeland (2011), who contended that prayer serves to provide an enduring hope for patients by reassuring them that the stressful condition is not the end after all. For instance when a question was posed about how respondents were coping, some of the significant attributions that were made relative to religious involvement serving as a means of control strategy and a tool for coping included:

“...I know God will help me... I know God....God is watching over me and if I have faith in Him, He can do all things...”(Respondent D, Woman, 46 years)

This woman indicated that since she knew God and trusted in Him, God could watch over her (take care of her). She seemed to imply that God wields an absolute power and by

faith one can be redeemed from stressful events by God's power. In response to the same question, this is what one man said.

"...ah, I have no choice but to wait upon God...to help me find a proper medication and to ease myself of the illness and to protect me..." (Respondent B, Man, 58 years)

This man also seemed to entrust a wealth of hope to God. He indicated that God could help him find an alternative medication for his treatment which meant that waiting upon God was some form of a control strategy. For both women and men this was apparent in their responses. Where faith and prayers served as a protective or buffer model of coping as used by Osafo et al. (2011) with stress, what this present study found could be describe as deferred coping. This is because respondents seemed to have deferred their condition to God and conceptualized God to be someone whom you can entrust your stressful conditions to, for Him to take care for you whiles you watch on for favourable outcomes.

4.4.2 Gender Comparison in Locus of Control and Perceived Health Competence

This sub-theme resulted from findings on the extent to which respondents believed they were capable of coping with their condition and whether or not respondents believed they were capable of performing the needed behaviours relative to controlling their condition. According to Rueda and Perez (2006) perceived health competence – the combined effect of self-efficacy and efficacy expectation – are vital resources for coping which also reduce depressive moods that accompany hypertension and other sicknesses.

Findings from this present study indicated that women seemed to be attentive to their condition and strongly believed to cope and perform the relevant behaviours to control their condition. Women demonstrated perceived behavioural control and by extension perceived health competence to be able to deal with their condition. For instance when a question was

posed about the extent to which respondents believed their attempts to controlling and coping were adequate or not, this is what a woman said in response.

“...now, I see good things in this (condition) so I believe very soon it can go but sometimes too they will say that it can't go again; but me I know it will go...”

(Respondent D, Woman, 46 years).

This woman indicated that she believed what she was doing to contribute to restoring her health was adequate and that she would be well again. She seemed to mean that regardless what people sometimes said to her about the possibility that her condition may be terminal she did not believe so. She seemed to imply a sense of perceived behavioural control because she believed she could cope and that her efforts were adequate. Not only did women demonstrate that they deferred their condition to God for coping but also they demonstrated that they viewed themselves competent enough to be able to perform other behaviours which can help them restore their health. Women also demonstrated a favourable believe about their personal abilities to be able to control and cope. This personal believe about women's ability to cope and control their condition (self-efficacy) together with the believe that they can influence positive outcomes of their condition (efficacy expectation) forms PHC and is consistent with the findings by Rueda and Perez (2006). This is also consistent with the findings by Glanz and Schwartz (2008) who argued that when a stressor is appraised as controllable and a person has favourable beliefs about self-efficacy and efficacy expectation, “[s/he] is more likely to use [approach] effective coping strategies” (p. 218). This by extension means that when a person has a favourable PHC, the person is more likely to use approach coping strategies which is a reflection of problem-focused coping. These elucidations make explicit why women had demonstrated an approach or problem focused coping strategy. The strong sense of competence and believe about the ability to cope and perform the relevant behaviours by women seemed to be a result of the influence of

favourable outcomes expressed by women relative to what they had achieved so far in their sick role behaviour which also served as one of their source of health motivation. That is also to say, women demonstrated, as part of their positive health motivation, the favourable progression of their condition. Women's positive health motivation could have conceivably resulted from the fact that women expressed satisfaction with their progression in the sick role behaviour and believed that they were competent to succeed in coping and controlling their condition. For instance when a health motivation question was posed in relation to PHC, this is what a woman said in response.

“...but personally I am able to take care of my condition so it is not anything bad for me...Yea, which is why I still do that...Yes, I have been able to recover from the CVA.....I was fortunate that it was just starting and then I saw it.....so I spent a lot of money to get myself healed....for this hypertension, I believe it will go very soon...”

(Respondent F, Woman, 51 years)

In the above quote it could be noted that this woman had a lot of believe about the fact that she would get well soon. She seemed to indicate that she was not going to relent on doing whatever she was doing in response to restoring her health. She seemed to imply that her motivation for doing whatever she was doing was because she had a favourable progression which made her recover from an earlier condition (CVA). For that reason, she kept doing what she was doing. This finding is consistent with the personal believe about women's ability to cope and control their condition and influence positive outcomes of their condition which together forms PHC as argued by Rueda and Perez (2006). This is also consistent with the findings by Glanz and Schwartz (2008) who argued that a controllable appraisal of a stressor enables a person to have favourable beliefs about self-efficacy and efficacy expectation and therefore adopts an approach coping strategy. Accordingly, Rueda and Perez (2006) concluded that patients who believed to have their condition (hypertension)

under control also reported better adjustment to the illness and also promoted an internal control. Women demonstrated that they were competent to succeed with the required behaviour or that they were able to access whatever dispositional resources in demand to help them restore their health. This further seemed to influence women to be optimistic about their condition because they believed they can cope and therefore be able to restore their health.

Men on the other hand also indicated that they believed what they were doing to restore health was sufficient. In doing so, men demonstrated somewhat externality regarding the belief about their ability to cope and control their condition. Men seemed to have attributed the extent to which they believed they could succeed to the physician and the medication. Further analysis indicated that men demonstrated somewhat lagging competence to be able to succeed in the sick role behaviour. For instance when a question was posed about the extent to which respondents believed their attempts to controlling and coping were adequate or not, this is what a man said in response.

“For that...me, I think the medicines are good.... I think that if you are serious about it then you will be able to control your condition well...if you know this sickness is not good then you will follow the medical regimen regularly...”(Respondent B, Man, 58 years)

In the quote above this man indicated that once you adhere to the medical schedules with seriousness and you also comply with the medical regimen then you can control your condition. He seemed to imply that the ability to control your condition is based on the potency of the medications. Here more like the question whether a given course of action will lead to a certain outcome which is similar to perceived benefit in HBM seemed to underlie what constituted men's inclination towards efficacy expectation. In this form of expression of competence regarding health and illness Bandura (1997) and Clark et al. (1988) indicated

somewhat low levels of response efficacy. This present finding is consistent with the findings by Furnham and Kirkcaldy (1997) who argued that given their locus of control men are more externalized than internalized in terms of controlling their condition in the sick role behaviour. Courtenay (2000c) associated this explication in this present finding and the findings by Furnham and Kirkcaldy (1997) to the underuse of health facilities and services by men. Regardless the fact that men believed their activities were sufficient to succeed they demonstrated to be externalised unlike women. This could be said to have been as a result of the absence of complications or problems associated with the incipient illness which otherwise could have influenced men to be much attentive to the condition. Therefore the perceived behavioural competence associated with men was lower to that of women. Hence, by extension the subtle PHC by men as analysed in their responses.

4.4.3 Gender Comparison in Religion and Faith providing Hope

This sub-theme elaborates on what lies ahead for the future or the future expectations of patients relative to restoring health. Patients were asked to describe what the future holds for them and what they perceived to be the future outcome and whether or not they were hopeful of a possible restoration. Koenig (2002) asserted that faith and religion provided optimism for the future, served as an incentive for cooperation with medical regimen and treatment and enhanced a woman's social interactions.

Findings from this present study indicated that women derived a favourable amount of hope from their faith in their religious orientations and practices. Women demonstrated optimism about the future and believed that their faiths in their religious practice would enable them restore their health status. This seemed to have been influenced by the deferred coping strategy which characterised an aspect of their coping and control strategy discussed earlier. Women in their responses indicated that God has control over the future and over all things under the sun and therefore when one relies and trust in God, s/he can be saved no

matter what happens in the future. For instance when a question was posed about what respondents thought of their condition and the future, this is what a woman said in response.

“Well everything is in the hands of God... God does everything or am I lying?... but yourself you know what you want but God has the power....so it is in the hands of God...the future is unknown and so you just have to leave everything for God to take care of you...” (Respondent E, Woman, 55 years).

In the quote above this woman indicated that even though one may want something to be done in his or her condition regarding favourable outcomes, it is only God who has the absolute power to make that happen. She seemed to mean that her faith in God provided a future of positive outcomes though unknown to her but known to God. This present finding is consistent with the findings by Koenig (2002) who concluded that faith provided optimism for the future through a person's believes in God. He further indicated that by this optimism a person is able to derive an incentive for cooperation with the medical regimen and schedule and to maximise his or her social support network. Women further seemed to derive compassion from their faith in God and prayers and believed that this was adequate for their survival in the future regardless the uncertainty the future may hold for them. That is also to say their involvement in their religious practices seemed to have provided them with some form of favourable future expectation. In response to the same question asked earlier, about respondent's condition and what they thought of the future, this is what another woman said in response.

“Mm....I know God will help me and I know God...Not exactly so, God is watching over me and if I have faith in Him, He can do all things...I have faith that I will be fine...”(Respondent D, Woman, 46 years)

This woman seemed to believe that since God can do all things then she can be fine in the future. She was emphatic about her optimism in respect of here future expectation

because she had faith in God. Women seemed to be more optimistic about the future in their sick role behaviour and believed they can survive the future. This was influenced by their reliance on God, prayers and religious faith which served to provide them with hope and assurance that their faith is sufficient to face the challenges that the future may hold for them in their condition. This is consistent with the explanation by Koenig (2004) that religious faith and involvement are associated with better health outcomes such as greater longevity, less depression and anxiety and effective coping skills. Thus, in taking on behaviours which are directed in purpose for recovery of health and functionality religiously involved people stand a greater advantage to do well (Ibid).

On the other hand men believed less strongly that they had control over their future health or that personal actions contribute to healthful outcomes (Furnham & Kirkcaldy, 1997; Wilson & Elinson, 1981). Men indicated somewhat a similar perception of the future and their chances of survival to that of the women. However, men seemed to have a future of possible loss where they demonstrated that regardless their optimism about the future, it is possible that they may not survive the future.

“You know if this thing continues disturbing me it will end my life so I have to continue to take the drugs and the advice...the future is alright...I know very soon I will be fine and work well... (Respondent A, Man, 55 years)

This man seemed to be even more realistic about the possible loss of future when he started by admitting that if the illness continues it may end his life. However, he also seemed to mean that regardless the possible loss of future, it was alright anyways. This was seemed to be premised on the fact that he takes his medication and adhere to advices. He further implied a sense of optimism when he indicated that he would work well again because he believed he would be fine soon. This finding was not exactly consistent with the findings by Furnham and Kirkcaldy (1997), who concluded that men’s weak believe about their future expectation also

influenced men to have somewhat pessimistic expectations about the future in terms of controlling their condition. Men seemed to acknowledge that it was possible to lose the future regardless the faith in God and their religious practices, given that the future is unknown. Notwithstanding the possible loss of future which men demonstrated, they also seemed to have some form of compassion in life and a survival for the future which is premised on their faith in God and religious practices. It probably looked like this because men dismissed their status as sick and demonstrated a sluggish approach to coping which went on to influence their perception of the future. What it seemed was that because men disregarded any active concerns about their condition they seemed not to have a formidable hope to face the future. Men demonstrated that they could survive the future but it was possible that they may lose the future. This optimism about the future coupled with the possible loss of future seemed to be bothered on the feeble coping strategy by men in this study. The future expectation demonstrated by men was conceivably less than what was demonstrated by women. Faith in God and religious practice providing hope for the future cut across both groups with a somewhat minimal admission by men than women who demonstrated much admission in that regard.

Generally, women seemed to be very optimistic about the future and they demonstrated that they were capable of surviving the future. Most of these admissions seemed to have been influenced by their involvement in religious practice and their faith in God and prayers. Men indicated that they were capable of surviving the future but also admitted that they may lose the future. Additionally it also seemed that men's admission about their optimism for the future was influence by their involvement in religious practices and their faith in God and prayers. This was explained by Levin (2010) that there is a considerable evidence to conclude that peoples involvement in and identification with religious faith and practices seems to suggest optimism about their coping process and their efficacy expectations.

Chapter Five

GENERAL DISCUSSIONS AND CONCLUSIONS

5.1 Overview of Findings

Some of the recent studies on the theme of sick role behaviour include Varul (2010) and Emke (2002). In addition to these previous studies this present study investigated sick role behaviour in relation to hypertension patients in Ghana where previous studies (see Amoah, 2003; Cappucio et al., 2004; Addo et al., 2006; Agyemang, 2006; Bosu, 2010) were reviewed for the benefit of this present study. This study sought to investigate hypertension patient's emotional and physical reaction to diagnosis. It also sought to investigate the approach adopted to cope and deal with the condition as a patient of hypertension in the sick role. The health motivation of hypertension patients and their sick role behaviour were also investigated.

The findings from this present study indicated that men's conceptualization of illness involved the absence of strength, requiring assistance to function in daily activities and exhaustion of internal bodily organs. Men's allusion to power, vitality and strength seemed to be a result of socio-cultural transactional and institutional structures such as stereotyped jobs for men and their gender roles (Courtenay, 2003). However, this present finding was partly inconsistent with the findings by Jegede (2002) who argued that illness was conceived as not being well and mostly negative statements about health. Findings in this study also indicate that women's conceptualisation of illness involved mainly impairment in physiological functioning and feelings of weakness or nausea. This present finding also indicated that people's conceptualisation of illness is culturally influenced. In light of the sick role model, findings were consistent with the assumption that the sick is a victim of forces beyond his/her capabilities. Findings further indicated that illness as impairment in physiological functioning, deficit in strength or power and the loss of social explorations required

corrective measures. This was consistent with the sick role model assumption that following from the undesirable state of illness the sick is obligated to seek technically competent help.

Upon learning about their diagnosis women respondents reacted less negative and were unperturbed by the outcome of the diagnosis. The unruffled physical reactions from women seemed to be a result of women's admission that the outcome of the diagnosis was not a problem. Men respondents on the other hand reacted negative upon learning about their diagnosis which involved shock, denial and surprise. Despite men's reaction, men and women respondents recognised the validity of the diagnostic procedure. Men's reaction could be that men sometimes conceal and deny their emotional weakness in the presence of their male counterparts (a male physician, in this study) (Becna et al., 1999; Charmaza, 1995) because of their stereotyped masculine gender role (Courtenay, 2000), which also influence men to perceive themselves as less susceptible to illness (Gustafson, 1998; DeJoy, 1992). However, men's refusal to accept the outcome of the diagnosis could have afforded them some time to regroup and gather enough strength to confront the illness. In view of sick role behaviour Becna et al. (1999) argued that respondents who expressed shock and denial could not complete compliance and also had a lower compliance with medical schedules and regimen than respondents who were not surprised upon learning about their diagnosis. Further findings indicated three forms of cognitive concept formations in relation to how individuals interpreted their status. These were:

- I don't think I am sick
- Yes, I am sick
- No, no...I am not sick

After readily recognising the validity of the diagnosis which seemed to have also been influenced by the reputation and authority of the physician women respondents admitted symptomatology. Recognising the validity of the diagnosis and admitting symptomatology

constituted *Yes, I am sick*. Women's *Yes, I am sick* concept formation seemed to have favoured them in gaining a sense of control over their illness. This is because respondents who demonstrated unperturbed emotional reactions at diagnosis are able to construct favourable cognitive meanings in their sickness which also enhances their compliance to medication (Becna et al., 1999). In this study, women's *Yes, I am sick* status interpretation seemed to have been a result of their unruffled emotional reactions to the diagnosis, the reputation and integrity attached to the physician and other factors such as association of illness conceptualisation with weaknesses.

Men respondents on the other hand mainly interpreted their status as *I don't think I am sick* with only one interpreting his as *No, no...I am not sick*. The *I don't think I am sick* status interpretation was a result of recognising the validity of the diagnosis but dismissing symptomatology. This involved two parts, where, one –men recognised the validity of the diagnosis because they believed the physician was an expert whose integrity, competence and authority could not be challenged and two –men dismissed their symptomatology because they believed they were strong, invulnerable to sickness, active, infrequently experienced symptoms and not always in the hospital. The second part seemed to be a result of expression of masculinity associated with health and illness behaviours (Courtenay, 2000). However, the expressions by men respondents could constitute iatrogenic conditions where activities by the physician or their exposure to the health care facility might have induced their condition.

In health motivation, findings from this present study indicated that emphasis on personal motivation towards behavioural control is important in the sick role behaviour. Women respondents seemed to be positively motivated as a result of progressive sick role behaviour. Longevity was an important reason why women wanted to be healthy. Women's sources of their health motivation included their improved condition and an innate motivation to be healthy and well again. This was contrary to the assumption that an individual's health

motivation stems from feeling threatened by an illness in the HBM (Champion and Skinner, 2008). Neither was perceived re-susceptibility nor perceived threat of the illness an impetus to incite women to want to do something to be well again. Men's ability to work seemed to be the only reason for their motivation towards doing something to stay healthy. However, to be able to provide sustenance for the family seemed to be the source of men's health motivation. This seemed to be a result of a perceived benefit that is derived by the family of men (such as wife, children etc.) which was also very influential in instigating men's health motivation. In this study it was further indicated that women respondents were active agents in the therapeutic process of restoring their health by actively engaging in activities such as exercising and being attentive to their medical schedules and regimen. This finding was inconsistent with the assumption in the sick role model that because patients entrust fiduciary responsibilities of their health to the physician, the patient becomes a passive agent in the therapeutic process. However, men respondents did not seem to be actively involved in the therapeutic process which they justified to be a result of their inflexible economic demands such as going to work early, etc. Men were more concerned about their economic activities than health facilitating activities to be able to meet the demands of the family than. This also seemed to be a result of men's dismissal of symptomatology and interpreting their status as *I don't think I am sick*. In this regard, men could be said to be passive agents in the therapeutic process.

Women respondents seemed to be more constrained than men respondents in taking on activities towards recovery such that women reported interruptions in their social explorations, reduction in attendance to social events, cessation of preferred meals and dictating the family menu. In view of the sick role model, these findings are consistent with the assumption that there is a loss of personal autonomy in which the patient's everyday obligations and responsibilities are suspended and replaced by a set of sick role specific

rights. This means that the patient has the right to receive help, if not malingering (Parson, 1978; Varul, 2010).

Financial constraint as a result of high medical expenditure was one factor that both men and women respondents reported. This finding was consistent with the findings by (Hausmann-Muel et al. 2003; Cappuccio et al. 2004; Buabeng et al. 2005). As a result of the financial constraints (and availability) men respondents indicated multiple drug use. The use of multiple drugs by men also seemed to be a result of uncertainty surrounding which medical approach provided absolute restoration of health.

In dealing with their condition this present study found that both men and women respondents had different contexts and action radii for coping and therefore adopted different approaches. Women's appraisal of their stress (their condition) seemed to have afforded them an effective coping strategy which involved a problem-focus coping characterised by singling out their condition and fighting it, seeking information about their condition and ignoring trivialities. The approach strategy which women respondents seemed to have adopted could be a result of their reaction to the diagnosis and the interpretation of their status. Since women admitted to be sick, they also seemed to be more attentive to their condition to be able to deal with the condition and also to know what can be done to reduce their stress. It was also because women are more attentive to their health demands (Charmaz, 1995; Sutkin & Good, 1987) because they perceive themselves as more susceptible to illness (Gustafson, 1998; DeJoy, 1992).

This goes to buttress the notion that where there is relatively much perceived benefits than perceived costs; the patient will focus attention on what can be done to alter the condition favourably and thus be confrontational to the condition (Miller, 2000). Men respondents demonstrated an avoidance approach in dealing with their condition, hence the evasion of conscious confrontation with their condition. This seemed to be a result of how

men reacted to the diagnosis and dismissed their status as being sick. Men's sluggish concern towards dealing with their condition also seemed to be a result of economic demands. In Ghanaian societies where the man is mainly the sole provider for the family, men were therefore more concerned about being able to provide sustenance for their family than to engage in health matters. Both men and women respondents fell on their religious faith to deal with their condition in a deferred coping strategy by assuming God to be someone whom you can defer your stressful conditions to take care for you.

Present findings in this study indicated that since women had an approach strategy and a problem-focused coping they believed that they were competent to perform the relevant behaviours to cope and control their condition. Women's perceived health competence seemed to be a result of their belief that they perceived their efforts to be adequate to control their condition. The personal belief about women's ability to positively influence the outcome of their efforts seemed to be a result of their health motivation and their efficacy expectations, which were consistent with findings by Glanz and Schwartz (2008); Rueda and Perez (2006). Men respondents also believed in the adequacy of their efforts to restore their health. However, men respondents demonstrated external locus of control which was consistent with the findings by Furnham and Kirkcaldy (1997). In view of the sick role model, Bandura (1997) argued that under conditions of mild and less negative reactions to the diagnosis, patients are psychologically influenced to demonstrate positive signs of efficacy throughout their sick role behaviour.

The findings in this study also indicated that women respondents were more optimistic about their condition and the future. Women perceived that they could survive the future because they believed they were competent to do so irrespective of difficulties in their condition. This future optimism seemed to have also been a result of their religious faith and practices. This finding was consistent with the findings by Levin (2010) who explained that

people's identification with and involvement in religious activities could provide them optimism about their coping process and their efficacy expectations. Men also demonstrated such optimism about the future which was also partly premised on their religious involvement. However, men respondents seemed to be partially optimistic about their future; they remarked that they could survive the future and they could also be unable to survive it. In view of the sick role behaviour, Koenig (2004) explained that religious involvements are associated with better health outcomes; hence in taking on behaviours which are directed in purpose for recovery of health, religiously involved people are better placed.

5.2 Trustworthiness of the Study

Lincoln and Guba (2000) argued that qualitative studies should be evaluated in a way other than quantitative studies by providing an alternative to reliability and validity which are used in quantitative researches. Trustworthiness, the alternative, is however criticized for its underlying assumption of unadulterated and infrangible truth about social reality. Lincoln and Guba explained that the focus should be on different perspectives of the social world and encourage discussions between these perspectives instead of the search for one singular truth. Patton (2002) has argued that trustworthiness is more appropriate for qualitative researches which seek to unravel the social world of respondents and how they experience, think, describe and understand the physical world. Therefore, trustworthiness was adopted for this study which is within the purview of social construction of knowledge. Trustworthiness has four criteria which are: Credibility, Transferability, Dependability and Confirmability, which enable the discussion of strengths and limitations of the study as well.

Credibility according to Bryman (2008) refers to conducting the research in a proper practice and methodology. Consequently, in this study methodological and research questions were explicitly outlined and their relevance at each stage of the study was evaluated. Ethical considerations were at no point downplayed at any stage of the study. The effective handling

of data without compromise was another prioritized aspect of the study to ensure that I adhered to the principles of anonymity and confidentiality of respondents. The question of whether the respondents gave truthful information was crucial to my findings. Respondents may just say what the researcher wants to hear or portray information according to their motives and interests as a result of culture of gratitude (Clarke, 1999). In this study the interviews were localized and the respondents were recruited at source by the head of the department of the Polyclinic and therefore the respondents could feel comfortable to discuss all aspects of the topics of interest. However, during the interview sessions some of the respondents referred to me as “...my son” which could have garbled my role as a student researcher. Nonetheless, I probed further when there was the need and resisted the son role. Transcribing two interviews with a translator demanded a lot of time since the translator was not always available after the interviews.

The second aspect of credibility, which was a bit challenging for me, was to have availed the findings to members of the social world that have been studied in order to confirm their responses. This was not possible due to practical reasons because I returned to Trondheim after collecting the data until the final submission of the study.

However, triangulation has been used to enhance the second aspect of credibility which sometimes becomes difficult to achieve (Patton, 2002). Therefore I applied a form of triangulated technique where the data from the male respondents were cross-checked with that of the female respondents to verify whether the essence of the original information I intended to seek were actually sought. This technique was necessary to assist me in searching for confirmatory and disconfirmatory evidences, where applicable in health researches (Miller & Crabtree, 2000) and to search for regularities in the data. In this subtype of data triangulation called person triangulation, data is collected from more than one level of

persons, which could be individuals or groups (Denzin, 1970) to ensure completeness of findings or to confirm the findings.

Transferability implies giving a thick description of the data to other researchers in the field and the possibility to transfer it to other settings (Bryman, 2008). This however, should not be confused with generalization since the findings should remain in the confinements of the specific context of the social world being studied. The findings from this research are context specific and the conclusions are bound by time and space. Nonetheless, it will hopefully provide an insight and sufficient knowledge for health promotion and education in other fields. Hypertension patients across Ghana could benefit from the findings in this study which was done in Accra.

Dependability may run parallel to reliability in quantitative studies. Reliability suggests the sameness of result when a study is replicated. This however, may be difficult to achieve in qualitative studies since the social world is dynamic, evolving and impossible to bring to a standstill. Therefore as a criterion for trustworthiness of a study, dependability implies keeping absolute track of the entire phases of the research process and the data collection (Bryman, 2008). In this study every stage has been described, discussed and debated where necessary, beginning from project description presentation and defence in the second semester of the first year with my supervisor and colleagues on the course who served as scrutinizers. This has ensured the dependability of the study and its findings.

Finally, confirmability suggests the avoidance of interference by the researcher's personal viewpoints, beliefs, characteristics, background and values in the research process (Bryman, 2008). Absolute objectivity may be unrealistic in qualitative researches; hence with confirmability the researcher should have acted in good faith throughout the research process to ensure the avoidance of personal and inherent attributions into the study process. One way

of reflecting on how one might have influenced the research is through reflexivity (Patton, 2002; Bryman, 2008). Reflexivity was therefore a crucial aspect of this study.

5.2.1 Reflexivity

It is important that the researcher is able to reflect upon how his/her characteristics and background might influence the research process. Practicing reflexivity helps to minimize experiences of power problems, because it makes it important for awareness of how knowledge is created (Hammarstrom & Alex, 2007) even though Hammarstrom and Alex conceded it has received some critique as subjective and non-scientific from Harding in 1986.

A reflexive account on how one's persona affect and influence different contexts and social settings affords the researcher an opportunity to take possible biases into account throughout the research (Patton, 2002). Also addressing the pre-knowledge and assumptions of the researcher is vital to achieve the flexibility and openness required for qualitative research. In this study it was easier for me to relate with the respondents because I had undertaken a voluntary service and built familiarity with the respondents and to have a common understanding of the health work frame. The challenge with the voluntary service however was that, the respondents could have conceived of me as a professional medical officer. To prevent this challenge, the interviews were done after the voluntary services had elapse its due time over a week. In the interviews I wore mufti clothes to delineate the distinction between the time of voluntary service and the interview session.

5.3 Recommendations for Future Studies

In the future other studies should consider the sick role behaviour of younger people in Ghana who are also essential hypertension patients. Future research may investigate the influence of the physician on a patient's sick role behaviour or the influence of religion on

patient's sick role behaviour. Ghana like any other developing country faces innumerable predicaments in health facilities, logistics and resources. Future investigations should target how to make the necessary recommendations regarding health promotion programs which will target the resources a person has and try to strengthen them in asymptomatic stage instead of or parallel to reducing risk factors for diseases.

5.4 Implications for Intervention

The goal of this study was to unearth the subjective life world and lived experiences of the essential hypertension patient in taking on behaviours directed in purpose to restore teleonomic capacity to provide the relevant assistance. To be able to achieve this health psychologists and professionals are encouraged to always precede the goal of persuading patient to modify their behaviours with understanding the patient's illness and health behaviours. Rosenstock (2005) argued that "efforts to modify behaviours will ultimately be more successful if they grow out of an understanding of causal processes" (p. 1).

This study has findings which suggest that the cost of health delivery is a constraint on both women and men; therefore it is important that health professionals encourage the practice of preventive health behaviours to people (i.e. efforts focusing on preventing/reducing incidence or onset of a disease). This is because preventive health behaviour generally follows from a belief that such behaviours will benefit health outcomes (Ibid). In light of essential hypertension where unhealthy and sedentary lifestyles are the greatest risk factors encouraging preventive health behaviour and modification of lifestyle (such as moderation of food intake, increased fresh fruits and vegetables) is undoubtedly critical for all people. Also in a country where many individuals are struggling for a favourable financial standing it is prudent to encourage the habit of preventive health behaviours which are usually more resource and cost effective than treatment.

Physicians are encouraged to be attentive to their engagement with patients since they can potentially influence the outcome of their patient's health and illness behaviours. To an extent physicians can collaborate with health psychologists in the treatment process of patients. Health professionals should also encourage the education of people on subtle symptoms which may not manifest even though one may actually be suffering from an ailment.

Koenig (2004) argued that given the advancements of religious influences on health and illness behaviours physicians "can no longer ignore the spiritual aspect of health care" (p. 1199). In light of the foregoing, it is suggested that a whole-person medicine where the patient's religious beliefs are considered in addition to who the person is should be the way forward. However, this should only be appropriate for persons who do not have conflicting religious faith with the practice of whole-person medicine (Koenig, 2002). For instance, Koenig suggested that when a patient or family is praying for a miracle in medically futile circumstances, the physician should respect that belief and join in a supportive dialogue with the patient or family on the subject. Osafo et al. (2011) also indicated that since people listen to religious leaders in Ghana, this could provide religious leaders the chance to encourage the congregation to practice healthy behaviours and also to boost their hope in God to enhance their coping process and control strategy, since this is culturally relevant.

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APPENDICES

Appendix I

Interview Guide (semi-structured)

How old are you?

What do you do for a living?

How many are you in your family?

prompt: Any children ? Any influential external relations such as aunt, uncle etc

How do you see the relationship in your family?

prompt: supportive or unsupportive in health matters and why ?

For how long have you had the illness?

Diagnosis

Could you describe how you felt when you were diagnosed of hypertension?

prompt: What do you think of the diagnosis, how do you believe the diagnosis, the physician?

Could you tell me what you think about yourself being diagnosed of hypertension?

prompt: What do you think of essential hypertension and yourself?

What is your understanding of your condition of being hypertensive?

Prompt: what do you think of your condition?

Health and Illness

What does the term illness mean to you? How would you define it?

Do you see yourself as being ill?

prompt: always, sometimes, would you say you were an ill person

Could you tell me what you think about being able to control your condition?

prompt: how do you have control over your condition?

Sick-role behavior and Health motivation

What are you doing to get better?

prompt: apart from the medical regimen?

How are you dealing with your condition?

prompt: Do you have particular strategies for helping you? ways of coping, practical, mental.

Do you think your efforts are adequate to get better?

prompts: if yes, what makes you think so, if no: what makes you think so ?

Could you tell me if it interferes with your daily activities?

prompt: if yes, how do you reconcile that with your daily activities?

What motivates you to do something to get well?

prompt: How often do you have this motivation? What do you think of doing this?

Could you tell me what you think about your condition and the future?

Identity and influence

Could you tell me how you would describe yourself as a person?

prompt: what sort of a person are you, happy, moody, nervy

Has having hypertension made a difference to how you see yourself?

prompt: if so how do you see yourself now as different from before you were diagnosed of hypertension. How would you say you have changed?

What about the way other people see you?

prompt: your family members, friend, and has it changed?

Could you tell me how that influences you?

Thank you for your time and effort in answering the questions. Maybe you have thought of something that I have left out. Is there anything else that you would like to tell me about your experiences?

THANK YOU VERY MUCH FOR TAKING THE TIME TO TALK TO ME.

Appendix II

Letter of Ethical Clearance from REK, Norway (copied from my inbox)

<http://us.mg2.mail.yahoo.com/neo/launch?.rand=1cfft25>

Subject: Sv: Tilbakemelding til REK
From: post@helseforskning.etikkom.no (post@helseforskning.etikkom.no)
To: Birthe.Loa.Knizek@SVT.NTNU.NO; anyan4usall@yahoo.com;
Cc: jan.dyrstad@SVT.NTNU.NO; rek-4@medisin.ntnu.no;
Date: Tuesday, June 28, 2011 9:16 AM

Vår ref. nr.: 2011/968

Prosjekttittel: "Gender Differences in Sick-role Behavior of Essential Hypertension Patients and the Implications for Intervention"

Prosjektleder: Birthe Loa Knizek

Birthe Loa Knizek and Frederick Anyan,

The Regional Committee for Medical and Health Research Ethics, Central Norway, evaluated the project in its meeting on May 28, 2011. The project was accepted with some comments. The response to our comments and the revised information letter was approved June 28, 2011.

The project can now be completed as planned.

Best regards

Sven Erik Gisvold
Professor
Leader of the Committee

Anneli Pellerud
Secretary of the Committee
post@helseforskning.etikkom.no
T: 73597509

**Regional komité for medisinsk og helsefaglig
forskningsetikk REK midt-Norge (REK midt)**
<http://www.helseforskning.etikkom.no>



Appendix III

Letter of Permission in response to my Ethical Clearance from KBTH Medical

Directorate, Ghana

In case of reply the number
And the date of this
Letter should be quoted

My Ref. No.....

Your Ref. No.....



KORLE BU TEACHING HOSP.
P. O. BOX 77
KORLE BU, ACCRA

Tel: 233-21- 673033-6
Fax: 233-21- 667759
Email: korlebu@ghana.com
Web Site: www.korlebu.com

8th June 2011

MR ANYAN FREDERICK
ACCRA

**RE: INTRODUCTION OF MR FREDERICK ANYAN FOR A 30-DAY
VOLUNTARY SERVICE AND FIELD DATA COLLECTION IN KORLE BU
POLYCLINIC**

With reference to your letter dated 27th April, 2011 on the above subject, I write to inform you that, permission has been granted you to do your research in this Hospital.

You are required to pay an administrative charge of One Hundred Ghana Cedis (GH¢100.00).


Thank you.



PROF AFUA A J HESSE
DIRECTOR OF MEDICAL AFFAIRS
FOR: CHIEF ADMINISTRATOR

Appendix IV


Introductory Letter from my supervisor, Birthe Loa Knizek (Prof., PhD)




NTNU
Faculty of Social Sciences and Technology Management
Department of Psychology

1 of 2
Date 27.04.2011 Our reference
Your letter dated Your reference

The Korlebu Teaching Hospital
The Director
Accra
Ghana



0209193326



Introduction of Mr. Frederick Anyan for a-30-day Voluntary Service and Field Data Collection in the Korle-Bu Polyclinic, Accra Ghana

This letter serves to introduce Mr. Anyan Frederick; a student of MPhil in Human Development, at the Norwegian University of Science and Technology (NTNU), Trondheim, Norway.

As part of the course each student is required to carry out an independent research project under the supervision of a senior staff. Frederick Anyan has chosen to carry out his study on:

Gender Differences in Sick-role Behavior of Essential Hypertension Patients and the Implications for Intervention: A Comparative study of Middle Aged Patients at Korle-Bu Polyclinic, Accra-Ghana

In the bid to build familiarity and strong rapport with potential informants, it is an advantage he acquaints himself with a common understanding of the health work frame through voluntary service (spanning 30th May to 30th June, 2011). As a student researcher this will enable him create a comfortable atmosphere for the interview session with participants in the study.

The study is to enable him determine how hypertension patients react to and interpret the pronouncement thereafter, and the approach they adopt to cope and deal with the condition. The

Address	Org.no. 974 767 880	Location	Phone	PhD
NO-7491 Trondheim	E-mail: psykologi@svt.ntnu.no http://www.svt.ntnu.no/psy	Bygg 12, nivå 5 NTNU Dragvoll NO-7049 Trondheim	+ 47 73 59 19 60 Fax + 47 73 59 19 20	Birthe Loa Knizek Phone: + 47

All correspondence that is part of the case being processed is to be addressed to the relevant unit at NTNU, not to individuals. Please use our reference with all inquires.

Norwegian University of Science and Technology

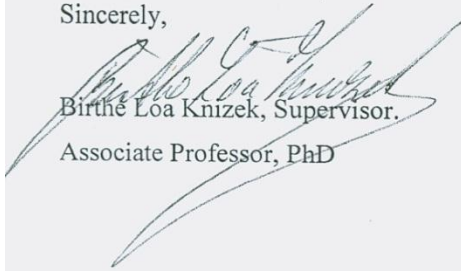
Date
27.04.2011

Our reference

study will further explore the sick role behavior of essential hypertension patients and the health motivation of the patients, or the reverse (refer to attached research protocol)

Thank you very much and I appreciate your co-operation on this.

Sincerely,



Birthe Loa Knizek, Supervisor.

Associate Professor, PhD

Approved on payment
of administrative fee
of 912100
BH
6/6/11

Appendix V

Letter of Introduction from KBTH Medical Director to KBP Head of Department

In case of reply the number
And the date of this
Letter should be quoted

My Ref. No.....

Your Ref. No.....



KORLE BU TEACHING HOSP
P.O. BOX 77
KORLE BU, ACCRA

Tel: +233 30-266-6766
Fax: +233 30-266-6766
Email: korlebu@ghana.com
Web Site: www.korlebu.com

SH June 2011

THE HEAD
DEPT. OF POLYCLINIC
KORLE BU

INTRODUCTION – MR FREDERICK ANYAN

This is to introduce to you the above-named Officer, a student of MPhil in Human Development, at the Norwegian University of Science and Technology (NTNU), Trondheim, Norway.

- He has expressed the desire to do a 30-day Voluntary Service and Field Data Collection in this Hospital, in your department.

Grateful for your cooperation.

Thank you.

PROF AFUA A J HESSE
DIRECTOR OF MEDICAL AFFAIRS

Appendix VI

Letter of Confirmation for Voluntary Service

In case of reply the number
And the date of this
Letter should be quoted

My Ref. No.

Your Ref. No.

KB/P-1420SF



KORLE BU TEACHING HOSP
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Email: Korlebu@ghana.com
Web Site: www.korlebu.com

afua
August 2011

BIRTHE LOA KNIZEK
NORWEGIAN UNIVERSITY OF SCIENCE & TECHNOLOGY
BYGG 12, NIVA 5
NTNU DRAGVOLL
NO-7049 TRONDHEIM
NORWAY

LETTER OF CONFIRMATION

Mr Frederick Anyan visited our Hospital, the Korle Bu Teaching Hospital to undertake a research project at the Polyclinic Department from 8th June to 8th July, 2011.

During this period he undertook a research among hypertensive patients with the approval of the Unit

His conduct was professional and exemplary upon the recommendation from his unit Head.

Please do not hesitate to contact this Hospital should there be any further information you require.

Thank you.

afua

PROF AFUA A J HESSE
DIRECTOR OF MEDICAL AFFAIRS

Appendix VII

Letter of Informed Consent (approved by REK, Norway)

Gender Differences in Sick-role Behavior of Essential Hypertension Patients and the Implications for Intervention

A Comparative study of Middle Aged Patients at Korle-Bu Polyclinic, Accra-Ghana

Anyan Frederick, MPhil. Human Development

Norwegian University of Science and Technology (NTNU)

Department of Psychology

General Information about Research

The objective of the study is to determine how essential hypertension patients react to and perceive of the diagnosis and interpret the pronouncement thereafter, and the approach they adopt to cope and deal with the condition. The study will further explore and report the sick-role behavior of convalescent hypertension patients and the health motivation of the patients.

Participants will be selected by Purposive Sampling. Participants will be selected after permission is sought from the Director of the Korle-Bu Polyclinic Hypertension Out Patient Departemnt (OPD) to assist in the recriutment. Self-addressed stamped envelopes with information letter and informed consent will be given to the Director to send to identified prospective participants, recommending only participants willing to participate to reply. Participation will be based on voluntary admission to do single/individual interview which will request participants to stay for not less than an hour, but can decide to withdraw at any point in time. Participants would be requested to answer only questions from the interviewer

and relevant to the research. Where participants feel uncomfortable about a question he or she can decline to answer. There will be no attempt in the study to ridicule participants' status as a hypertension patient.

Possible Benefits to Individuals and Society

This research aims to produce knowledge which will enhance and facilitate an effective guide to health education, and promotion programs particularly directed to reducing the pervasiveness of hypertension. The study will also capture knowledge necessary to ease the pressure on health workers having to struggle to comprehend the "life-world of the hypertension patients" and to know the appropriate approach to apply in dealing with patients of hypertension. Further, the study aims to enhance a healthy and sustaining society amidst the presence of optimal social, emotional and cognitive functioning. This is because the knowledge produced from this study will aim to facilitate the design of appropriate intervention strategies which will seek to reduce the impact and progression of symptomatic disease like hypertension, which benefit will extend to the general population of hypertension patients. Therefore, participants' contribution to achieving these goals are very much needed and will be much appreciated.

Possible Risks and Discomforts

Discussing the health and illness of people may be uncomfortable on the part of the participants and they may have emotional breakdown. Therefore, the researcher will offer an option for the participants to have a conversation with the Director of the Korle-Bu Hypertension Out Patient Department after the interview if necessary. To further cushion the sense of comfort the researcher has intended to do a voluntary service at the Hypertension Out Patient Department of the Korle-Bu Polyclinic to have a common understanding of the health care frame and eventually create a comfortable atmosphere for the interview.

Confidentiality

The researcher will ensure that the information given by the participants will be used for research purposes only and will be kept confidential to the best of his ability as regards the principle of anonymity. Participants will not have their name mentioned or stated in any reports. The Supervisor of this research will from time to time have access to the analysis of the interview.

Appreciation

At the end of the interview sessions participants will be given small symbolic gift as token of gratitude.

Voluntary Participation and Right to Leave the Research

As a participant you are informed that you may withdraw from participation at any time without prejudice or penalty.

Termination of Participation by the Researcher

Where participants exhibit potentials for discomfort and complications in their condition as hypertension patients regarding the study the appropriate referrals to the treatment or counselling service of the Korle-Bu Polyclinic Hypertension OPD will be effected without any hesitation and the participants participation will be terminated abruptly.

Your rights as a Participant

This research has been reviewed and approved by the Institutional Review Board of Noguchi Memorial Institute for Medical Research (NMIMR-IRB). If you have any questions about your rights as a research participant you can contact the IRB Office between the hours of 8am-5pm through the landline 0302916438 or email addresses:

nirb@noguchi.mimcom.org or HBaidoo@noguchi.mimcom.org . You may also contact the chairman, Rev. Dr. Ayete-Nyampong through mobile number 0208152360 when necessary.

Contacts for Additional Information

Pertinent questions regarding the research should be directed to the IRB office as stated on this form or to the researcher, by mail: anyan4usall@yahoo.com or by phone: 0047-738-87721, 0023-20-9193326. You can also contact the supervisor for this study, Prof. Birthe Loa Knizek via electronic mail: birthe.loa.knizek@svt.ntnu.no

VOLUNTEER AGREEMENT

The above document describing the benefits, risks and procedures for the research title **(Gender Differences in Sick-role Behavior of Essential Hypertension Patients and the Implications for Intervention: A Comparative study of Middle Aged Patients in Korle-Bu Polyclinic, Accra-Ghana)** has been read and explained to me. I have been given an opportunity to have any questions about the research answered to my satisfaction. I agree to participate as a volunteer.

Date

Signature or mark of volunteer

If volunteers cannot read the form themselves, a witness must sign here:

I was present while the benefits, risks and procedures were read to the volunteer. All questions were answered and the volunteer has agreed to take part in the research.

Date

Signature of Witness

I certify that the nature and purpose, the potential benefits, and possible risks associated with participating in this research have been explained to the above individual.

Date

Signature of Person Who Obtain Consent

Appendix VIII

Information Letter (approved by REK, Norway)

Request for participation in a research project

Gender Differences in Sick-role Behaviour of Essential Hypertension Patients and the Implications for Intervention: A Comparative study of Middle Aged Patients in Korle-Bu Polyclinic, Accra-Ghana

Background and purpose

This is a request for you to participate in a research study that intends to study how essential hypertension patients react to and perceive the diagnosis and interpret the pronouncement thereafter and the approach they adopt to cope and deal with the condition. The study will further explore and report the sick-role behavior of convalescent hypertension patients and the health motivation of the patients. This research aims to produce knowledge which will contribute to and facilitate a guide to health education, and promotion programs particularly directed to reducing the pervasiveness of hypertension. You have been selected because you have first-hand knowledge about the phenomenon of sick-role behaviour of hypertension patients. This research is a part of the Master Programme in Human Development at the Department of Psychology of the Norwegian University of Science and Technology (NTNU), Trondheim, Norway.

What does the study entail?

You would be requested to do an interview with the researcher. Where you feel uncomfortable about a question you can decline to answer. I will take notes in the course of the interview; I will use a tape recorder to record the interview session. There will be no consequences for you, if you do not wish to participate, if you decline to answer a question or withdraw from the research during the process.

Potential advantages and disadvantages

This research aims to produce knowledge which will contribute to and facilitate a guide to health education and promotion programs particularly directed to reducing the pervasiveness of hypertension. The study will also capture knowledge necessary to ease the pressure on health workers having to struggle to comprehend the “life-world of the hypertension patients” and to know the appropriate approach to apply in dealing with patients of hypertension.

As a participant it is possible there will be some discomfort about discussing your health and its influence onto your life to the researcher. Another disadvantage is that the researcher will not recommend to you what to do about your illness as he is a student and not a health professional.

What will happen to the information about you?

Your identity as a participant will be kept confidential, only my supervisor and I will have access to the interview. We are both bound by the promise of professional secrecy and the principle of anonymity to do so. The data that are registered about you will only be used in accordance with the purpose of the study as described above. All the data will be processed without name, ID number or other directly recognisable type of information. A code number links you to your data and samples through a list of names. It will not be possible to identify you in the results of the study when these are published

Voluntary participation

Participation in the study is voluntary. You can withdraw your consent to participate in the study at any time and without stating any particular reason. This will not have any consequences for your further treatment. If you wish to participate, sign the declaration of consent on the final page. If you agree to participate at this time, you may later on withdraw your consent without your treatment being affected in any way. If you later on wish to

withdraw your consent or have questions concerning the study, you may contact the researcher, by mail: anyan4usall@yahoo.com or by phone: 0047-738-87721, 0023-20-9193326.

Chapter A – Further elaboration of what the study entails

- **Criteria for participation**

Once you have been diagnosed of essential hypertension you are eligible to participate. Self-addressed stamped envelopes with information letter will be given to the Director of the Korle-Bu Hypertension Out Patient Department to send to identified prospective participants. You are requested to only respond to this information letter if you admit give consent to participate in the research.

- **Background information about the study**

Sometimes people may question the diagnosis of their illness to ascertain the validity of the diagnosis with regards to their health and illness. When people are diagnosed of hypertension and accept the diagnosis by the established medical care system, they take on behaviours purposely in compliance with the medical system. These behaviours are purposely directed towards reducing the impact and progression of the illness. But this will only be achieved if the patient is willing and able to take the medications and modify his or her lifestyle as needed. This is what the study wants to discuss with you as a participant and to know your views about these claims. The study seeks to understand how hypertension patients react to the diagnosis and interpret the pronouncement thereafter, and the approach they adopt to cope and deal with the condition and their health motivation.

- **Alternative procedures or treatment the patient receives if he or she chooses not to participate in the study**

There will be no consequences for you, if you do not wish to participate, if you decline to answer a question or withdraw from the research during the process. Where you choose to end the participation because of potentials for discomfort and complications regarding the interview you will be referred to the treatment and counselling service of the Korle-Bu Polyclinic Hypertension Out Patient Department for counselling, and if necessary, treatment.

- **Schedule – what happens and when does it happen?**

You will decide when and where to do the interview, so that it does not interfere with your working hours or other activities. If at any point in time you wish to modify something you have said or wish to withdraw the information you have shared in the interview, you are free to do so. However, you are advised to do so on or before the date of publication of this research which is approximately July, 2012

- **Potential advantages**

This research aims to produce knowledge which will contribute to and facilitate a guide to health education, and promotion programs particularly directed to reducing the pervasiveness of hypertension. The study will also capture knowledge necessary to ease the pressure on health workers having to struggle to comprehend the “life-world of the hypertension patients” and to know the appropriate approach to apply in dealing with patients of hypertension.

- **Potential discomforts or disadvantages**

The researcher does not have any professional competence in treatment of hypertension therefore participants cannot expect to have any recommendations from the researcher. As a participant it is possible there will be some discomfort about discussing your health and illness life to the researcher.

- **Compensation**

If you incurred any travel expenses the researcher will pay for that.

Consent for participation in the study

The above document describing the benefits, risks and procedures for the research title **(Gender Differences in Sick-role Behavior of Essential Hypertension Patients and the Implications for Intervention: A Comparative study of Middle Aged Patients in Korle-Bu Polyclinic, Accra-Ghana)** has been read and explained to me. I have been given an opportunity to have any questions about the research answered to my satisfaction. I agree to participate as a volunteer.

Date

Signature or mark of volunteer

If volunteers cannot read the form themselves, a witness must sign here:

I was present while the benefits, risks and procedures were read to the volunteer. All questions were answered and the volunteer has agreed to take part in the research.

Date

Signature of Witness

I certify that the nature and purpose, the potential benefits, and possible risks associated with participating in this research have been explained to the above individual.

Date

Signature of Person Who Obtain Consent