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## CHAPTER 1

### PHASE ONE: PROBLEM ANALYSIS AND PROJECT PLANNING

#### *Orientation to the Research Project*

##### 1.1 INTRODUCTION

The Global Report on the Acquired Immune Deficiency Syndrome (AIDS) and the Human Immune Deficiency Virus (HIV) describe the AIDS/HIV epidemic as a crisis and the greatest challenge the world is facing (2004:13). AIDS has remained complex and incurable, and has devastated individuals, communities and countries (UNAIDS 2005:5).

The rate of new HIV infections continues to climb every year with an estimated 4.9 million people having been infected in 2004 (UNAIDS 2005:7). HIV prevalence in Swaziland has steadily increased. The prevalence among Antenatal Care (ANC) clients, as measured by sentinel surveillance, increased from 3.9% in 1992 to 42.6% in 2004 (MOHSW 2004:3). This has led King Mswati III to declare HIV/AIDS as a disaster (MOHSW 2004:8).

Swaziland is currently grappling to respond to the increasing numbers of AIDS cases, opportunistic infections including debilitating diseases, premature deaths, orphans and destitution among the elderly (MOHSW 2004: 6). Because the Ministry of Health and Social Welfare (MOHSW) is concerned with the AIDS epidemic, one of the priority themes to guide the national response to HIV/AIDS is Response Management. This theme includes:

- > Care, support, treatment and counselling
- > Epidemiology, research and surveys
- > Positive living and nutrition and
- > Sexually transmitted infection treatment

This research is an endeavour to respond to some of the identified areas of concern.

National responses to HIV/AIDS endeavours are based on the Ministry of Health and Social Welfare's policy mission which "seeks to improve the health and social welfare status of the people

of Swaziland by providing preventive, promotive, curative and rehabilitative services that are of high quality, relevant, accessible, affordable, equitable and socially acceptable (MOHSW 2004:7)".

The Government of Swaziland established Voluntary Counselling and Testing (VCT) Services to improve the response of the health and social welfare service system to societal needs. Services provided in VCT centres include voluntary counselling for pre-and post HIV testing, treatment of opportunistic infections and distribution of antiretroviral drugs (ARVs).

Voluntary Counselling and Testing is the process by which a person undergoes counselling, enabling him or her to cope with stress and to make an informed choice about HIV testing and future behaviour (MOHSW 2002:2). Confidentiality of counselling sessions, test results and voluntary choice to test are emphasized. Voluntary Counselling and Testing has been shown in many countries to be an effective intervention strategy that promotes positive and protective behaviour changes among those counselled and tested for HIV.

Voluntary Counselling and Testing is a cornerstone for early access to prevention as well as to care and support services. According to the Centres for Disease Control (CDC 2003) the need for VCT is increasingly compelling as HIV infection rates continue to rise and countries recognize the need for their population to know their serostatus as important prevention and intervention tools. Those people who learn they are seronegative can be empowered to remain disease free. For those HIV infected development of less costly interventions to reduce HIV associated infections take on a new importance. In addition other medical supportive services can help those living with the disease to live longer, healthier lives and prevent transmission to others.

AIDS is a very emotive disease, which has brought challenges for society and the practice of nursing. At VCT centres, nurses are challenged with new skills such as counselling (which is different from health education), testing and administration of new and complex drugs. Working at VCT services exposes one to various types of suffering which may be stressful. Kennedy (2005:380) states that prolonged job stress has negative effects on the quality of work life for nurses and clients.

In Swaziland, counselling and HIV testing are new procedures for nurses that have emerged due to HIV/AIDS. Nurses have to adapt and be innovative since their actions will impact on outcomes (Castledine 2004:546). The new role enactment of nurse counsellors needs to be defined clearly as it will measure the quality of activities performed at VCT centres. These nurses are expected to *"apply, modify, and utilize the dynamics, resources and variables in the specified context of HIV/AIDS (Squires 2004:272)"*. However, as new skills are developed for these new roles, these nurses need support and empowering systems that will enhance growth and prevent stress and burn out. Stewart (1993:15) contends that, with social support, the level of functioning for nurses is enhanced. Hence an empowerment programme for nurses working in VCT services is important.

In the next section, the researcher presents the background and motivation that led to the study of nurses working in VCT Centres. VCT services are described, and how VCT can be utilized as an effective tool in reducing the spread of HIV. This chapter also includes the statement of the problem, research questions, research objectives and significance of the study.

## **1.2 BACKGROUND AND MOTIVATION**

Voluntary counselling and HIV testing have become an increasingly important area of HIV prevention and care in Swaziland. VCT services are recognized as a major strategy in responding to HIV/AIDS as it is estimated that a large number of HIV positive people do not know their serostatus (Whiteside, Hickey, Ngcobo & Tomlinson 2003:6). Thus provision of VCT services have been scaled up through decentralization and involvement of the private sector and community organizations (MOHSW 2005:6).

When VCT services were introduced, most were integrated into the general running of hospitals and health centres (TASC 2003:2). Some nurses were deployed from their work stations to provide VCT services after they were exposed to a one week course on counselling skills. When the rolling out of antiretroviral drugs began, the number of clients in VCT centres increased. This led to increased workload and frustrations for the nurses.

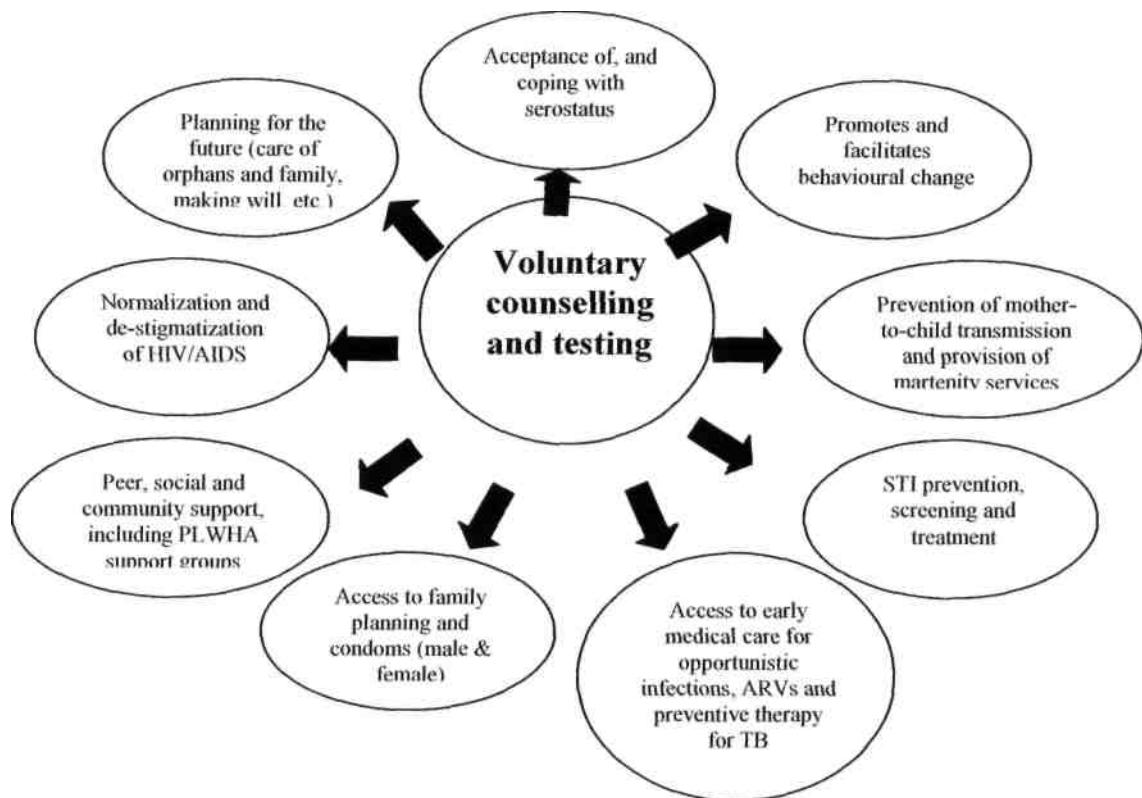
Services provided at VCT centres include early detection of the virus which enables referral for clinical care and psychological support (UNAIDS 1998:10). Early access to VCT directs to early

access to HIV treatment which increases the effectiveness. At VCT centres clients receive services which often lead to behaviour change. Results of a study in Uganda report that a reduction of infection rate of 35% was observed in a group which was assigned to VCT services as compared to 13% reduction in a group that was provided with basic health education (UNAIDS 2002:122).

Investment in HIV prevention averts untold human suffering. The services at VCT centres provide information that enhances risk reduction through skills building. Skills building strengthen HIV/AIDS prevention behaviour such as condom usage and reduced numbers of sex partners (Galloway 2001:28). With early treatment of opportunistic infections in VCT centres, there are possibilities of extending and improving the lives of those people living with HIV/AIDS (PLWHA). Summers, Spielberg, Collins and Coates (2000:128) concur by stating that VCT services can be seen to provide potential life saving care.

Summers et al (2000:129) further report that different tests performed at VCT centres can facilitate immediate reports on serostatus, early partner notifications and when combined with cross sectional studies yield estimate HIV incidences (2000:130). Improved technology such as rapid testing for HIV has also enhanced VCT efficiency. Rapid testing has proven to be of assistance in cases of rape, occupational exposure, and other high risk groups where immediate use of antiretroviral treatment can prevent HIV infection (Pronyk, Kim, Makhubele, Hargreaves, Mohlala & Hausler 2002:859). It is unfortunate that the HIV epidemic continues to shift. While most of the attention was focused on prevention in the early years, more attention is now needed for care and social support for people living with HIV/AIDS and their families (MOHSW 2005:9)

Voluntary Counselling and Testing services often become entry points for other services for clients' benefit as illustrated in Figure 1 below, proposed by UNAIDS (2002:123)



**Figure 1**

***Voluntary counselling and testing as an entry point for HIV prevention and care***

Source: UNAIDS 2002:123

Figure 1 highlights the many entry points for HIV prevention and care. These include care and support for people living with HIV/AIDS (PLWHA) when opportunistic infections occur or when other care is needed. Mother to child transmission of HIV can be prevented when pregnant mothers are identified and appropriate interventions are taken. Antiretroviral therapy (ART) is now available in many countries since the 3 by 5 mission of the World Health Organization (WHO) was initiated. These drugs are useless if an individual does not know his or her serostatus. Ongoing counselling is essential when clients take ART, as support is needed for adherence to treatment regimen and coping with adverse effects (MOHSW 2004:9).

Health care utilization and health-seeking behaviour are influenced by clients' experiences, their expectations and the environment. Often the quality of care at VCT services encourages or

discourages such utilization. Client satisfaction with services should be the major goal of health care programmes. There are various factors that may influence satisfaction. Sukati (1995:11) states that according to Ware and Associates, client satisfaction includes the following:

- > Art of care; which is the behavioural aspect from nurses
- > Technical care; the use of technology and the know-how, such as rapid testing
- > Physical environment; the logistics which include privacy
- > Availability; services always there when needed
- > Accessibility; services within reach by all
- > Finances; low charges or none at all
- > Continuity of care; clients do not have to move from one area to another for different services
- > Outcome an efficacy; these are outputs of services to the associated cost of producing those services

Some nurses in Swaziland have been trained as pre-and post HIV test counsellors to work in VCT services. The training period on counselling skills ranges between one to three weeks followed by one week VCT centre management (TASC 2003:2). The country has developed training guidelines which are used as standards; however, counsellors are not properly selected, evaluated and supervised. Nurses work at VCT centres not because of interest and commitment, but through selection by employers. This may lead to poor services, stress and "burnout" especially because social support and de-briefing services are often not available (Van Dyk & Van Dyk 2003:5). VCT services need human resources that are adequate in terms of quality and quantity, consistent in management, training and remuneration. The above described background led to the following statement of the research problem.

### **1.3 STATEMENT OF THE PROBLEM**

In most VCT centres in Swaziland, services are provided by nurses whose training in counselling skills is minimal. It is estimated that in Swaziland there are over 20, 000 AIDS clients without adequate care and support at all levels due to inadequate numbers of nurses (MOHSW 2003:5). Sullivan and Decker (2005:231) assert that managers should provide appropriate numbers of

nursing staff for the delivery of effective and efficient care. Staffing should be based on the ratio of health workers to client population (Booyens 1998:37).

Voluntary Counselling and HIV testing are key components of prevention and care programmes. Wider access to VCT enhanced by competent nurses may lead to openness about HIV/AIDS that may lead to the reduction in prevalence. Though much research has been done on HIV/AIDS, in Swaziland, there is paucity of research on how the introduction of VCT services have impacted on nurses nor has there been documentation of what nurses working in VCT perceive as their needs, or challenges for effective delivery of VCT services and quality care to clients. This problem led to the following research questions:

#### **1.4 RESEARCH QUESTIONS**

- What is it like to work in VCT services?
- What is it like to receive VCT services?
- What could be done to enhance quality care for clients and create job satisfaction for nurses' work in VCT services in Swaziland?

#### **1.5 PURPOSE OF THE STUDY**

De Vos (2002:107) states that a goal or purpose indicates the 'dream' whereas objectives indicate steps for the actualization of the dream. The purpose of this study is to explore the meaning of working in and receiving VCT services in Swaziland. The information obtained would be utilized to develop a empowerment programme for the nurses working in VCT services in Swaziland. The following steps guided the actualization of the purpose.

#### **1.6 RESEARCH OBJECTIVES**

The research objectives of this study are as follows:

- > To explore and describe the experiences of nurses working in VCT services in Swaziland and clients receiving them (Phase 1-3).



- > To develop an empowerment programme for nurses working in VCT (Phase 4).
- > To describe an empowerment programme for nurses working in VCT (Phase 5).
- > To formulate guidelines to operationalise an empowerment programme for nurses working in VCT services in Swaziland (Phase 6).

## **1.7 SIGNIFICANCE OF THE STUDY**

The success of VCT services depends on the ability to deliver care that improves the health status of the majority of people in a manner that takes into consideration the social environment, values and beliefs. In pre-and post HIV test counselling, clients are provided with information to minimize risk behaviours. With motivation, clients can willingly utilize VCT services where new behavioural skills are learnt and reinforced (Galloway 2001:29). Where counselling is done right by competent nurses, behaviour change can be achieved and with regular and periodic updating of counsellors, counselling can be effective ([www.procare...2004:2](#)). The development of an empowerment programme is crucial in enhancing quality health care services that would lead to a reduction of HIV prevalence in Swaziland.

## **1.8 THE PARADIGMATIC PERSPECTIVE OF THE RESEARCH**

The word paradigm was rescued by Thomas Kuhn (1970) from obscurity when he applied it to science in his book, *The Structure of Scientific Revolution*. Since then it has been utilized in different ways to formulate reality and point at direction for research (Brink 1990:28). A paradigm is defined by Denzin and Lincoln (1994:107) as a world view or basic beliefs that may point at a variety of relationships for an individual and his "world". Parse (1987:2) concurs that a paradigm assists scientists to explicate particular phenomena as it enhances development and growth.

A discipline such as nursing has beliefs and philosophies on the nature of phenomena. As a discipline grows, there is a sense of shared values and achievements which will provide a set of directions or a model for research (Hacking 1983:11). Mouton (2002:15) concurs with Hacking (1983) when stating that once a particular paradigm is identified, it will dictate the research agenda, assumptions, problems and constitute acceptable solutions. The paradigm is used as a vehicle to systematize the gathering, interpretation and application of knowledge (Mouton & Marais

1991:203). Paradigms include theory applications and comprise models that represent coherent traditions of scientific research.

Philosophical beliefs are bases for research and such beliefs lead to identification of a theoretical framework for a particular study (Henning, Van Rensburg & Smit 2004:16). These authors identify possible theoretical paradigms as the positivist, interpretivist and critical.

Meta-scientific reflections on social inquiry came up with positivism and anti-positivism (phenomenological) as schools of thought (Hacking 1983:169).

The ontological position of a positivist about the nature of reality is against metaphysics, against causes and against explanations (Hacking 1983:169). Henning et al (2004:17) concur that the positivist believes that truth is found by proving it through empirical means. On the other hand the phenomenological position aims at gaining deeper understanding of the nature or meaning of everyday experiences (Van Manen 1990:9). Phenomenologists believe that each person has his own reality; therefore there is no single reality (Burns & Grove 2001:30).

### **1.8.1 The paradigmatic approach for this research**

This research is situated in a phenomenologist research paradigm that has emphasis on experience and interpretation (Denzin & Lincoln 1994:204). The paradigm considers the complexity of the phenomenon "lived experiences of nurses working in VCT services". The researcher believes that the human science approach that emphasizes the humanness is suitable in studying this phenomenon as it attempts to gain meaning of everyday lived experiences (Van Manen 1990:13).

Nurses are scientists and their holistic orientation to health care is ideal to a health strengthening environment and positive behaviour norms. In undertaking this study, the researcher's assumptions are based on the Intervention Research developed by Rothman and Thomas (1994:28). These authors contend that research should be applicable to everyday use (1994: xxv).

They continue to state that research must;

- > extend knowledge of human behaviour relating to human service intervention
- > be the means by which the findings may be linked to, and utilized in practical application
- > be directed towards developing innovative interventions (1994:3)

The qualitative research approach is used in exploring and describing everyday experiences of the nurses', and clients' 'world' (Van Manen 1990:9). The data from the qualitative approach is utilized to form the bases for the development of an empowerment programme for nurses working in VCT services. Qualitative research involves studying phenomena within natural settings (Denzin & Lincoln 1994:2) and aims at depth, allowing participants to express themselves in their own words (Henning et al 2004:3). Following are the researcher's assumptions for this study.

## **1.8.2 Assumptions**

Assumptions are basic principles or statements that are taken for granted to be true without proof or scientific testing (Burns & Grove 2001:720). In research these are embedded in the philosophical base of the framework of the study design. Assumptions may be based on accepted knowledge or personal beliefs and values (Powers & Knapp 1995:10). These influence the development and implementation of the research process. Botes (1995:6) suggests a selection of certain assumptions from the paradigm for interaction with the research field. In this research the researcher made explicit her meta-theoretical (ontological), theoretical (epistemological) and methodological assumptions in the following manner;

### **1.8.2.1 *Meta-theoretical (ontological) assumptions***

These are the researcher's beliefs, conceptions and commitments that should be clearly stated. These may not be theoretically grounded, but must be reconcilable with theoretical assumptions (Mouton 2002:174). In this study, the following ontological assumptions are made by the researcher:

## **Man/Person**

The researcher believes that man is an open spiritual being, freely choosing meaning in situations (Van Manen 1990:13). Man functions in an integrated biopsychosocial manner within the environment (Parse in George 1995:337). Parse in Pearson, Vaughan and Fitzgerald (2005:207) emphasize that *"man is an indivisible, responsible being, forever changing and growing as a result of interaction with the universe. Interaction with others and the universe is a rhythmical pattern of closeness and distance, revealing and concealing, enabling and limiting"*. In this study man is a nurse who is a universally caring being able to provide care in different ways according to needs, settings and cultures (Leininger 1997). Man also refers to the HIV positive person who receives services at VCT centres.

### ■ **Environment/Psychosocial**

This includes the external and internal factors and conditions that affect life and development of the human being (Neuman in George 1995:286). Du Toit and Van Staden (2005:69) state that much of human existence is made up of social interaction and this always takes place in some or other social environment or context. These authors are supported by Leininger (1995:254-257) when she states that environment can be defined within a cultural context as a situation, event or experience. Stewart (1993:161) contends that nursing actions take place within an environment - person interaction as these actions are "created, developed, modified and constrained within a given environmental context". In this study, the environment can be identified as the VCT centres in Swaziland where interactions between nurses and clients occur. This environment can impact on the lives of both nurses and clients.

### ■ **Nursing**

Nursing is seen within a humanistic context. It is a nurturing response of one individual to another in time of need that aims towards the development of well-being (Paterson & Zderad 1976:18). Nursing is concerned with the individual's unique being and striving towards becoming. It focuses on the whole, looking beyond the categorization of the parts (Paterson & Zderad 1976:18). Chinn and Kramer (1995:41-42) emphasize that nursing's primary focus is on interpersonal interaction

between individuals. Nurses' response to personal needs is an expression of the art of nursing. Nursing at VCT centres should be an interpersonal interaction that is defined by both the nurse and client as nursing is viewed as enabling and empowering.

The nurse is an interpersonal guide who acts in true presence and energetic authority, responsibility and consequences of decision to the client (Parse 1987:137). The role of the nurse is that of facilitating as sometimes clients direct the interaction and other times the nurse initiates the process (Chinn & Kramer 1995:41).

## **Health**

Health is a state of balance between the person and environment in which the balance is held at the level which allows the person to function physiologically, psychologically and socially at his optimum level (Basford, Slevin & Arets 1995:460). Our relationship with the world is disturbed when we are ill and when our bodies are healthy and strong we meet the world unafraid and functional (Dahlberg, Drew & Nystrom 2001:53). The level of functioning of nurses in VCT centres somehow defines their state of balance, and the strengthening of social networks and empowerment for these nurses can be seen as a health promotion strategy (World Health Organization 1994)

### **1.8.2.2 Theoretical (epistemological) assumptions**

Theoretical assumptions reflect the researcher's view about what is considered as the true or valid knowledge in the theoretical framework that relates to her research subject (Botes 1995:6). Botes (1995:6) contends that theoretical assumptions are testable and yield epistemic pronouncement which can lead to a better understanding of the research problem (1995:6). The following theoretical perspectives were selected for this study.

#### **Parse's Human Becoming Model**

Parse sees an individual as "*a patterned, open being more than and different from the sum of its parts*". The model emphasizes the importance of the meaning that underlies behaviour and

provides structure that identifies and clarifies the whole person as she/he interacts with the environment (Phillips in Parse 1987:187).

In her model Parse identifies the following concepts that influence the quality of life as perceived by the person, family and community.

- > *Imaging- making real events, ideas and people*
- > *Valuing- living of cherished beliefs*
- > *Languaging- how one uses language to represent the structure of personal reality*
- > *Connecting - separating processes of distancing and relating*
- > *Powering-the inter-human encounters in the process of transforming*
- > *Transforming- the process of change*
- > *Originating- these are creating unique ways of living*
- > *Revealing - concealing- rhythmical patterns of relating with others*
- > *Enabling-limiting- infinite number of possibilities within choice (Leddy & Pepper 1998:89)*

### **Definitions of concepts**

It is important at this point to define concepts which are used or noted throughout this study. These concepts include the following:

- **VCT services**

Voluntary Counselling and Testing services include counselling for pre and post HIV testing voluntarily by trained nurse-counsellors, treatment of opportunistic infections and administration of antiretroviral treatment (UNAIDS 2002:11). Counselling is the process of helping a client to recognize and cope with stressful psychological and social problems, to develop improved interpersonal relationships and to promote personal growth (Kozier, Erb, Berman & Snyder 2004:1450).

- **Experience**

(Noun) - It is the things that have happened to you that influence the way you think and behave, or an event or activity that affects you in some way (Oxford Advanced Learner's Dictionary 2000:406). In this study it is the meaning of the day-to-day interaction of nurses and clients who come for counselling, testing and treatment. It also includes the working environment and job satisfaction.

- **Nurses**

Nurses are individuals who have undergone training according to the specification of the Swaziland Nursing Council (SNC) and can work as independent practitioners. Only nurses who have undergone counselling courses should work at VCT services.

- **Client**

A client is an individual who is a social, psychological, spiritual and physical being that interacts with the nurse and environment for promoting and restoring health (Stewart 1993:168). In this study the client is the HIV positive person who receives VCT services.

- **Day-to-day**

In this research this means the everyday life of the nurse counsellor where she interacts with clients who are at different biopsychosocial levels of health.

- **Programme**

A programme is plan of things that will be done (*Oxford Advanced Learner's Dictionary 2000:931*). The programme in this study is a plan of activities that are necessary to enable the nurse to be energized for future interaction with clients (Kozier, Erb, Berman & Snyder 2004:146). Programme development is defined by Rothman and Thomas (1994:20) as a process that is systematic, deliberate and varies greatly according to specific human needs.

- Social Support

It refers to processes of interaction in relationships and social structures that shore up coping, esteem, belonging and competence through actual or predictable exchanges of tangible or psychological resources (Gottlieb & Selby 1989 in Stewart 1993:5). In nursing, empowerment is perceived as the availability of social support, emotional support, appraisal support, and duration of relationship support are said to be inversely related to burnout (Stewart 1993:93).

- Swaziland

This is a small country in Southern Africa surrounded by the Republic of South Africa and Mozambique. Presently Swaziland has the highest HIV prevalence in the World 42.6% (MOHSW 2004:3). Intervention strategies to fight HIV include VCT services.

The methodological assumptions in this study are as follows:

#### *1.8.2.3 Methodological assumptions*

Methodological assumptions concern the researcher's view of the nature of the research process and the most appropriate methods as these direct the research design (Mouton 1996:124). As this research is exploratory and descriptive, the qualitative approach of research is used. Botes (1995:17) states that research should be functional, as the researcher will state his/her purpose and method that will make the research justifiable. Nursing care is action-focused and therefore functional as it takes place within a specific context of knowledge to solve problems and improve life.

Data in this research was collected from unstructured in-depth interviews, field notes and literature review; this study, therefore, is functional. The purpose of this study is to design an empowerment programme for nurses working in VCT services so that clients receiving these services may be provided with quality care to improve lives, and the nurses achieve job-satisfaction.

The central theoretical statement is presented below.



## 1.9 CENTRAL THEORETICAL STATEMENT

It is necessary for the researcher to formulate his or her central theoretic statement; it gives direction to the research process. The central theoretical statement of this study is as follows:

The exploration and description of day-to-day experiences of clients and nurses at VCT centres in Swaziland identified perceived or real concerns of the nurses. This information formed the basis for the development of an empowerment programme for these nurses to provide quality care and improve patients' lives.

## 1.10 RESEARCH DESIGN AND METHOD

A brief overview of the research design and method is now presented. A detailed description of the design is discussed in chapter 2.

### 1.10.1 Research Design

A research design is defined as the overall plan for data collection and data analysis (Polit & Hungler 1999:36). This study uses an exploratory descriptive design in that it seeks to answer the **what** question of the experiences of participants in VCT services. It also endeavours to respond to **how** nurses working in VCT services can provide quality care to their clients. The purpose of descriptive studies is the accurate portrayal of the characteristics of individuals, groups or situations and the frequency with which phenomena occur (Polit & Beck 2004:192). The strength of the qualitative approach lies on the holistic view, which allows understanding of process and meaning within contextual framework (Burns & Grove 2001:61). The research questions in this study are: what is it like to work in VCT services and how could these nurses be supported to provide quality services, or what type of programme do they need?

In responding to these stated questions, the Intervention Design and Development Model by Rothman and Thomas was used (De Vos 2002:396). Schilling (1997:174) in De Vos (2002:396) defines Intervention Research as *studies carried out for the purpose of conceiving, creating and testing innovative human services approaches to prevent or ameliorate problems or to maintain*

*quality of life*. Thomas and Rothman (1994:9) contend that the Intervention Design and Development Model has six phases. Following is a diagrammatic presentation of the phases and operations of the Intervention Design and Development Model as proposed by Rothmans and Thomas (1994:28). This study follows a programme development design, which is qualitative, explorative, descriptive, and contextual. See chapter two for a full description of research design.

**Table 1.2 Phases and operations of intervention research (Rothman & Thomas 1994:28)**

<b>PHASE 1</b>	<b>PHASE 2</b>	<b>PHASE 3</b>	<b>PHASE 4</b>	<b>PHASE 5</b>	<b>PHASE 6</b>
Problem analysis and project planning	Information gathering and synthesis	Design	Early development and pilot testing	Evaluation and advanced Development	Dissemination
<b>Operation 1</b>	<b>Operation 1</b>	<b>Operation 1</b>	<b>Operation 1</b>	<b>Operation 1</b>	<b>Operation 1</b>
Identifying and involving clients	Using existing information sources	Designing an observational system	Developing a prototype or preliminary intervention	Selecting an experimental design	Preparing the product for dissemination
<b>Operation 2</b>	<b>Operation 2</b>	<b>Operation 2</b>	<b>Operation 2</b>	<b>Operation 2</b>	<b>Operation 2</b>
Gaining entry and cooperation from settings	Studying natural examples	Specifying procedural elements of the intervention	Conducting a pilot test	Collecting and analyzing data	Identifying potential markets for the intervention
<b>Operation 3</b>	<b>Operation 3</b>	<b>Operation 3</b>	<b>Operation 3</b>	<b>Operation 3</b>	<b>Operation 3</b>
Identifying concerns of the population	Identifying functional elements of successful models		Applying design criteria to the preliminary intervention concept	Replicating the intervention under field conditions	Creating a demand for the intervention
<b>Operation 4</b>	<b>Operation 4</b>	<b>Operation 4</b>	<b>Operation 4</b>	<b>Operation 4</b>	<b>Operation 4</b>
Analyzing identified concerns				Refining the intervention	Encouraging appropriate adaptation
<b>Operation 5</b>	<b>Operation 5</b>	<b>Operation 5</b>	<b>Operation 5</b>	<b>Operation 5</b>	<b>Operation 5</b>
Setting goals and objectives					Providing technical support for adopters

The researcher adapted the intervention research model to suit the research methods of this study.

Following is a comparison of the adapted Model's steps and the researcher's steps.

**Table 1.1 Model's and researcher's steps**

Adapted intervention Research Model	Researcher's Steps of Programme
<b>Steps Rothman and Thomas (1994:28)</b>	<b>Development</b>
<ul style="list-style-type: none"> <li>&gt; Problem analysis and project planning</li> <li>&gt; Information gathering</li> <li>&gt; Information synthesis</li> <li>&gt; Designing and observational system</li> <li>&gt; Early development and pilot testing</li> <li>&gt; Evaluation and advanced development</li> </ul>	<ul style="list-style-type: none"> <li>&gt; Orientation to the research project</li> <li>&gt; Research design and methods</li> <li>&gt; Discussion of Research findings and Literature</li> </ul> <p>Control</p> <ul style="list-style-type: none"> <li>&gt; Development of an empowerment programme for nurses working in VCT services</li> <li>&gt; Description of an empowerment programme</li> <li>&gt; Guidelines to operationised programme</li> </ul>

### 1.10.2 The Intervention Design and Development Model as applied in this study

Programme development is defined by Rothman and Thomas (1994:20) as a process that is systematic and deliberate that provides effective interventions to problems. Programmes greatly vary according to specific needs of a population. The Intervention Design and Development Model comprises six phases and operations. Each phase has clearly defined activities, which must be carried out before completion of that phase. Rothman and Thomas (1994:9) continue to state that even though activities should be performed in a stepwise sequence there might be need of looping back to earlier phases as the researcher encounters difficulties or new information.

#### 1.10.2.1 PHASE 1 *Problem analysis and project planning*

This phase deals with the following operations or steps: identifying and involving clients, gaining entry to and cooperation from settings, identifying concerns of the population, analyzing identified problems, setting goals and objectives (De Vos 2002:398). Each operation is now discussed briefly.

#### 4- **Setting goals and objectives**

Though Rothman and Thomas (1994:28) identify setting goals and objectives as the last operation of the first phase, the researcher identifies this activity as the first operation in this research.

De Vos (2002:107) states that the terms goal, purpose and aim can be applied interchangeably. A goal or a purpose indicates the *dream or the end towards which effort or ambition is directed*. The dream in this study is the development of an empowerment programme for nurses working in VCT

services in Swaziland. Nurses at some VCT centres communicated that they feel disempowered to execute duties.

Objectives indicate steps for the actualization of the 'dream' and these are more specific as they contribute to the broad purpose (Rothman & Thomas 1994:31). The objectives of this study as indicated in 1.6. are:

- > To explore and describe the experiences of nurses working in VCT services in Swaziland and clients receiving them (Phase 1-3).
- > To develop an empowerment programme for nurses working in VCT (Phase 4).
- > To describe an empowerment programme for nurses working in VCT (Phase 5).
- > To formulate guidelines to operationalise an empowerment programme for nurses working in VCT services in Swaziland (Phase 6).

#### **i Identifying and involving clients**

Nurses who had undergone HIV counselling course and working at VCT services in all the regions of Swaziland were identified as participants in the research. Clients who receive these services were also involved as they form the "population with whom to collaborate (Fawcett et a, 1994 in De Vos 2002:398)

#### **i- Gaining entry and cooperation from setting**

Gaining entry to and cooperation from the setting was not a problem to the researcher as she is a member of a professional team of HIV/AIDS counsellors in the country; however assistance in gaining entry was necessary and gatekeepers were approached. These included the senior nurses at VCT services.

#### 4- Identifying concerns of the population

The researcher employed unstructured in-depth interviews with nurses and clients on their day-to-day experiences at the VCT centres. This was done using the qualitative approach which involved studying phenomena within their natural setting (Denzin & Lincoln 1994:2).

It is important to note that in the qualitative approach, the researcher is looking for meanings of actions and perceptions of the participants; thus a strategy that is exploratory, descriptive and contextual was utilized. In collecting data, in-depth interviews were used where participants were asked to describe their experiences at the VCT centre. Interviewing is the most common form of data collecting in phenomenology (Morse & Field 1997:115). Kvale (1996) in De Vos (2002:292) contends that qualitative interviews *attempt to understand the world from the participant's point of view to unfold the meaning of people's experiences*. The researcher continued with the in-depth interviews until data was **saturated** (Gillis & Jackson 2002:185).

#### \*1> Analysing identified problems

The identification of research problems involves focusing upon specific aspects of the nurses working in VCT services in Swaziland (Cormack 1996:337). Qualitative analysis is concerned with describing the actions and interactions of research participants in a certain context. It also includes interpreting the motivations and understandings that lie behind those actions (Terre Blanche & Durrheim 1999:234).

#### 1.10.2.2 PHASE 2 Information gathering

This phase involves the following three operations:

#### / Using existing information sources

De Vos (2002:405) contends that literature review pertaining to a particular concern being studied is imperative. Existing information relevant to topic of study should be obtained from journals, dissertation abstracts, reported practices and empirical research. Information can also be accessed from computerized databases such as EBSCO HOST, MEDLINE and COCHRANE

LIBRARY. Intervention research must contribute to the generation of new knowledge about behaviour-environment relations (Fawcett et al 1994:32 in De Vos 2002:406)

#### **4- Studying natural examples**

According to De Vos (2002:406), the best way of studying natural examples is observing the people who have actually experienced the problem and how they have attempted to address it. This was through unstructured in-depth phenomenological interviews of both nurses and clients.

In qualitative research one-to-one interviews are a common data collecting method. Moreover interviews fare well compared to the other data collecting techniques in terms of trustworthiness of the information obtained (Krefting 1991:215). An audiotape recorder was used to capture participant's experiences and to get a deeper understanding and insight into problems (Kvale 1996:81-107).

The interviews focused on experiences at the VCT centre as perceived by nurses and clients. The information obtained aided in identifying needs, and in the development of an empowerment programme for nurses at VCT centres. Interviews were done until data saturation was achieved.

#### **1.10.2.3 PHASE 3: Information Synthesis**

This phase is about synthesising the data gathered during the information gathering phase with literature found by the researcher. This phase is therefore dealt with in two inseparable activities which must be carried out by a qualitative researcher. These activities are

- Discussion of research finding and
- Literature control

See chapter three for a comprehensive discussion of research findings and literature control.

#### **1.10.2.4 PHASE 4: Designing and observational system**

In developing an empowerment programme for nurses working in VCT services in Swaziland, phase 4 of the Intervention Design and Development Model was utilized. This was operationalized in the development of an empowerment programme for nurses working in VCT services in Swaziland.

Design is a stage of purposive planned change, one of several alternative processes leading to the development of social intervention (Glaser, Abelson, & Garrison: 1983 in Rothman & Thomas 1994:164).

See chapter four for a comprehensive outline of steps followed by the researcher in the development of the programme.

#### **1.10.2.5 PHASE 5: Early development and pilot testing**

This phase is operationalised as the description of an empowerment programme for nurses working in VCT services in Swaziland. In this phase researcher follows the steps of theory description proposed by Chinn and Kramer (1995:82).

See chapter five for a comprehensive description of the programme.

#### **1.10.2.6 PHASE 6: Evaluation and Advanced Development**

This phase is about how and why a programme does or does not work. It comprises these operations: selecting and experimental design, collecting and analysing data, replicating the intervention under field conditions and refining the intervention (Rothman & Thomas 1994:37).

This phase is operationalized as formulation and description of guidelines to operationalize the programme in the practice of nurses working in CT services on Swaziland. The researcher uses the programme as the bases of this phase. The researcher also utilised the strategies for theory description and evaluation proposed by Chinn and Kramer (1995:82).

See chapter six for a comprehensive description of guidelines to operationalize the programme.

### **1.11 TRUSTWORTHINESS**

Streubert and Carpenter (1999:28) describe trustworthiness as establishing the reliability and validity of a qualitative research. Trustworthiness is when the researcher can convince the consumer that the results are worth paying attention to and worth taking account of (Lincoln & Guba 1985:290). These authors state that a study is credible when the description and interpretation of human experiences are such that other people who share the same experiences can identify with the account. The trustworthiness of this study was ensured by using the four criteria (credibility, transferability, dependability and confirmability) identified by Lincoln and Guba (1985:293) and will be discussed in detail in chapter 2 together with legal and ethical considerations.

### **1.12 OUTLINE OF THESIS**

- > **Chapter 1:** Problem Analysis and Project Planning: Orientation to the Research Project.
- > **Chapter 2:** Information Gathering: Research Design and Methods.
- > **Chapter 3:** Information Syntheses: Discussion of findings and literature control.
- > **Chapter 4:** Designing an Observational System: Development of an empowerment programmer or nurses working in VCT services in Swaziland.
- > **Chapter 5:** Early Development and Pilot Testing: Description of an empowerment programme for nurses working in VCT services
- > **Chapter 6:** Evaluation and Advanced Development: Description of Guideline to operationalize the programme.
- > **Chapter 7:** Conclusions, limitations and recommendations



### **1.13 CONCLUSION OF CHAPTER**

This chapter dealt with an overview of the study the aim of which was to develop an empowerment programme for nurses working in VCT services in Swaziland. The Intervention Design and Development Model by Rothman and Thomas (1994), which is the framework within which the study was conducted, were introduced. Relevant literature and reasons were stated to justify the need for this research. Detailed description of research methodology will now be discussed in Chapter 2.

## CHAPTER 2

### PHASE TWO: INFORMATION GATHERING

#### *Research Design and Method*

#### 2.1 INTRODUCTION

Chapter 1 provided an overview of this study which included the purpose, problem statement and research design and method. It was also mentioned that the study was conducted within the genre of Intervention Research developed by Rothman and Thomas (1994) as the Intervention Design and Development Model. Though relatively new, intervention research is often carried out for the purpose of conceiving and creating innovative human services approaches to prevent problems or to maintain quality of life (Schilling 1997:174 in De Vos 2002:396). Paradigmatic perspectives and, trustworthiness relating to the study were also discussed.

The research design and method are discussed in detail in this chapter so that the researcher clearly reveals the design and method appropriate to this research. Design and method direct the researcher's planning and implementation in a way that is most likely to achieve the intended goal. This is a step-by-step process; however, the researcher is cognisant of the fact that qualitative research is often circular (Terre Blanche & Durrheim 1999:39). These authors continue to state that in qualitative studies researchers employ an open, flexible and inductive approach as they attempt to look for new insights into phenomena.

#### 2.2 RESEARCH DESIGN

A research design is defined by Creswell (1998:2) as the whole process of conducting research, from conceptualization to narration. Cormack (1996:44) cites Grinnell and Williams (1990:138) who describe a research design as a plan used by researchers to answer research questions. According to Durrheim in Terre Blanche and Durrheim (1999:29-30) a research design is a strategic framework for action that specifies how the research should be executed in a way that answers the research questions. These authors continue to state that *in developing a research design, the researcher must make a series of decisions, along four dimensions: 1) the purpose of the research; 2) the theoretical paradigm informing the research; 3) the context or situation within*

which the research is carried out; 4) the research techniques employed to collect and analyze data (1999:33).

Latimer (2003:27) describes qualitative research as part of a debate, an attempt to capture the sense that lies within that structure and an exploration; elaborating the significance of a defined phenomenon. The choice of the research design in this study must consider the sensitivity of HIV and AIDS and the participants involved as they provide individual lived experiences with regards to what is happening in VCT centres in Swaziland. Marshall and Rossman (1999:60) concur that one of the traditions of qualitative research is focus on individual lived experiences. Understanding the portrayed picture of participants' reality was instrumental in developing an empowerment programme for the nurses working in VCT services in Swaziland through the use of the Intervention Design and Development Model proposed by Rothman and Thomas (1994:28). The design adopted by the researcher in this study is programme development, which is qualitative, explorative, descriptive and contextual. Following is a diagrammatic representation and discussion of the relevant phases of the programme development design used by the researcher in this thesis.

**Table 2.1 Phases followed by the researcher in this study**

Phase	Rothman & Thomas Steps (1994)	Researcher's Step	Chapter
Phase 1	Problem Analysis and Project Planning	Orientation to the research project	Chapter 1
Phase 2	Information Gathering	Research Design and Methods	Chapter 2
Phase 3	Information Synthesis	Discussion of Findings and Literature Control	Chapter 3
Phase 4	Designing and Observational System	Development of an Empowerment Programme	Chapter 4
Phase 5	Early Development and Pilot Testing	Description of an Empowerment Programme	Chapter 5
Phase 6	Evaluation and Advanced Development	Description of Guidelines to Operationalise the Programme	Chapter 6

### **2.2.1 Qualitative aspect of design**

This study was conducted in the qualitative approach. Qualitative research is based on a philosophic orientation that adopts a person-centred and holistic perspective (Burns & Grove 2001:27). These authors continue to say the qualitative design focuses on discovery that is a

systematic inquiry with the understanding of human beings (Burns & Grove 2001:28). Qualitative research develops an understanding with human opinions about own life, behaviour and environmental circumstances (Binoliel 1984 in Brink & Wood 1998:335). Denzin and Lincoln (1994:2) have defined qualitative research as a "bricolage; that is a pieced-together, close knit set of practices that provide solutions to a problem in a concrete situation". Parse, Coyne and Smith (1985) in Van der Wal (1999:56) concur by stating that, in qualitative studies new perceptions (gestalts) are formed as the researcher identifies characteristics and the significance of human experiences as described by the participants. The focus in the qualitative design is in understanding the whole by giving meaning to experiences such as emotions which are consistent with the nursing philosophy (Brinks & Wood 1998:246; Burns & Grove 2001:61&64). Burns and Grove (2001:75) continue to refer to this design as inductive, holistic, subjective and process oriented method used to understand, interpret and describe a phenomenon. They argue that the qualitative approach is not based on a single reality as reality varies in different people and is not static (Burns & Grove 2001:61).

In this study the qualitative design was used to generate an in depth account that presented a lively picture of participants' reality in working in VCT services in Swaziland and the reality of receiving such services. Understanding the opinions of these participants was instrumental in developing an empowerment programme for the nurses.

### **2.2.2 Exploratory aspect of design**

Exploratory studies are done to discover or learn the truth about something, break new ground, establish facts and gather data to identify patterns of interest (Mouton 2002:72; Babbie 2001:90). When a study is exploratory, it tries to uncover relationships and dimensions of a phenomenon by investigating the manner in which the phenomenon manifests itself to other related areas (Mouton & Marais 1991:43; Wilson & Talbot 1994:90). The exploratory design explores a research question about which little is currently known in order to uncover generalizations, which means that the researcher departs from a point of reference of not knowing (Grinnell & William 1993:136). Experiences as described by participants can be explored to reveal new meaning, the manner in which it is revealed and other factors relating to it (Polit & Beck 2004:20). Cohen, Kahn & Steeves (2000:2) refer to this design as a journey that is similar to a person with its individuality and

uniqueness. Exploring day to day experiences of nurses and clients at VCT centres resulted in gaining insights and meaning to the researcher and aided in the development of an empowerment programme for the nurses.

### **2.2.3 Descriptive aspect of design**

In a descriptive design the main purpose is to examine relationships among variables and provide an accurate description of a phenomenon that is being researched (Wilson 1993:11). Researchers must observe, count, delineate and classify as means to obtain facts that provide truthful description of a phenomenon (Mouton 2002:102). There is accurate portrayal of characteristics of persons; situations or groups add Polit and Hungler (1999:643). Polit and Beck (2004:20) contend that a descriptive design is suited for an in depth and probing nature that describes dimensions of a phenomenon, its importance and variations. This fact is confirmed by Babbie (2001:91) when stating that researchers in descriptive studies examine why the observed patterns exist and their implications. "Descriptive" in this study refers to the experiential meaning of lived experiences of nurses and clients in VCT centres. An accurate and authentic description of experiences was required for the development of empowerment programme, and for the formulation of guidelines for the empowerment programme for nurses working in VCT services.

### **2.2.4 Contextual design**

Burns and Grove (2001:793) describe context as *the body, the world and the concerns unique to each person within which the person can be understood*. Thus a contextual design is one where a phenomenon of interest is studied in terms of its immediate context (Mouton 2002:133). Denzin and Lincoln (1994:339) assert that a contextual design studies a phenomenon for its intrinsic and contextual significance with a focus on specific events. Contextual studies are conducted where participants are in the various life worlds, which are naturalistic settings and are uncontrolled real life situations (Franfort-Nachmias & Nachmias 1996:284; Munhall 2001:168). Streubert and Carpenter (1999:331) confirm that research done in naturalistic settings is free from manipulation. This research was conducted in some VCT centres in Swaziland where VCT services are provided. The study is contextual in the sense that VCT centres are the nurses' and clients' "world", thus the experience will not be separated from participants for articulation of context. The research methods

used in this study are dealt with in the following phases of programme development design proposed by the researcher in relation to Rothman and Thomas intervention design and development model.

## **2.3 RESEARCH METHODS**

Research methods are described by Polit and Beck (2004:5) as techniques utilized by researchers to structure a study. Methods should be written in detail to provide information and what is to be done in a research project (Cohen et al 2000:16). Mark (199) in De Vos (2002:271) echoes these authors by stating that methods are the way the researcher follows to develop rich insight about a phenomenon. The following aspects are discussed with relevance to this study:

- > Gaining entry
- > Research setting or location
- > Methods of data collection and techniques

### **2.3.1 Gaining entry and cooperation from setting**

In gaining entry and cooperation from setting, the researcher needs the assistance from key informants to introduce him or her to gatekeepers. Gasa in Terre Blanche and Durrheim (1999:265) states that entry into a particular community is a challenging task. Following are some guidelines, which Gasa has developed to assist in gaining entry and cooperation from setting:

- > The researcher must read to acquire knowledge about the targeted setting.
- > It is useful to have contacts in the area to introduce researcher to key members.
- > It is important to know about the "culture" of that particular setting.
- > Quickly establish contacts that will provide with inside information.
- > The researcher must avoid power dynamics that exist.

Swaziland is a small country, the researcher is a lecturer and a counsellor; most of the participants in the study were known to her, however entry to the working environment was not as easy as anticipated (De Vos 2002:399). After the research purpose and methodology was clarified, the

"intrusion" of the researcher was accepted, and eagerness to participate occurred. The clients had no problem with the researcher as leaders of their support groups identified with her as she is part of a multi-professional team. In ensuring **no harm to participants**, the rights of participants were protected and risk of harm minimized during interviews. The research proposal for this study was submitted to the review committee charged with protection of participants..

### **2.3.2 Ethical and Legal Considerations**

Holloway and Wheeler (1996:39) contend that ethical and legal issues have to be considered in all research methods. The researcher has a moral obligation to strictly consider the rights of the research participants. In this study the researcher ensured ethical and legal considerations through the following ethical principles.

#### **2.3.2.1 Informed consent**

Informed consent is based on the principle of respect for the participants. Obtaining it is not merely the signing of the consent form but should be voluntary and informed. An informed consent requires that there is disclosure of sufficient and appropriate information so that participants can make an informed choice to participate voluntarily in the research (Gillis & Jackson 2002:333; Terre Blanche & Durrheim 1999:66).

The informed consent for participants in this study was obtained from the MOHSW, heads of VCT centres, nurses working in the identified VCT centres and clients receiving VCT services. Participants signed a written consent form; the MOHSW and heads of VCT centres wrote letters of approval after they had seen a copy of the research proposal. The information on the consent forms included data collecting methods and how results were to be disseminated.

#### **2.3.2.2 Confidentiality and anonymity**

This concerns the protection of the participants' interests especially their identity. Confidentiality implies that the researcher can identify the participants' responses but promises not to do so publicly. Anonymity refers to when the researcher cannot identify a given response with a given

participant. Confidentiality was ensured by training the audiotape operator and then removing all names and addresses from data collecting tool. Only codes were used to identify audiocassettes. Participants were also assured that data collected would be discussed with research promoters who guided the research.

Anonymity was ensured with the use of codes thus making it difficult to attribute responses to particular participants. Interviews were secretly arranged thus protecting both participants and VCT centres. Data collected was kept in the strictest confidence; it was not made public to other people.

### **2.3.2.3 No harm to participants**

A researcher should ensure that participants should not be injured regardless of whether they volunteered or not. Often participants reveal sensitive or embarrassing information about themselves which may result in psychological trauma. The researcher ensured protection by addressing concerns prior to interviews and a conducive environment to interviews. No harm to participants was also ensured by the scrutiny of the proposal by the MOHSW.

### **2.3.2.4 Deceiving participants**

A researcher may find it difficult to reveal all about the research, however it is important not to deceive the participants. Information was not deliberately withheld from participants in this study. Issues were clarified and feelings following experiences were explored and there was no deception.

### **2.3.2.5 Privacy of participants**

Privacy is defined as *"that which normally is not intended for others to observe or analyse"* (De Vos 2002:69). Participants were allowed to reveal what they felt like saying, when they felt according to their beliefs without pressure. They were provided with adequate privacy and without embarrassment. The researcher ensured an environment that provided maximum privacy which included keeping information in confidence.



### **2.3.2.6 Actions and competence of the researcher**

De Vos (2002:69) emphasizes that before undertaking the research, the researcher must ensure that she is competent and adequately skilled. Investigating on HIV/AIDS issues is sensitive, thus the researcher's competency is very important. The researcher in this study was guided by scientific principles. She aimed at being objective, and refrained from making value judgements (Loewenberg & Dolgoff 1988 in De Vos 2002:70). Ethical principles identified in the proposal were followed under the guidance of experienced researchers from the university.

### **2.3.2.7 Debriefing of participants**

Researchers are encouraged to provide participants the opportunity, after the study, to work through their experience and its aftermath; by this activity harm may be minimised (Strydom in De Vos 2002:73). The researcher should discuss with the participants their experience of the research process so that if there are any unintended or unanticipated effects of the research, these can be monitored. Breakwell, Hammond and Fife-Schaw (2000:35-36) contend that researchers have a responsibility to ensure that if any active intervention is required to negate the effects of an investigation upon a participant, such intervention should be provided before he/she leaves the research setting.

### **2.3.3 Research population**

A population is the entire set of individuals who meet the selection or conform to set specification (Polit & Beck 2004:50; Burns & Grove 2001:366). Mouton (2002:134) describes a population as individuals with a common characteristic that the researcher is interested in. In this study, the population will comprise nurses working in VCT services in Swaziland and clients receiving these services. In qualitative research, the population consists of participants not subjects as their position is that of individuals who take part in the research, as they are not acted on but are active participants (Morse 1991 in Streubert & Carpenter 1999:22). These authors continue to state that individuals are selected because of their experience with the phenomenon of interest (1999:22).

There were two groups of participants identified and involved in this study; these were nurses working in VCT services in Swaziland and clients who receive these services. This chapter is about the research process and procedures while focusing on these two groups. Research process and procedure is the strategic framework for action which includes: Research method; Sample and Sampling Characteristics; Data Collection Methods; Data Analysis; Research Findings; Limitations and Recommendations.

In identifying and involving participants, the researcher established the research populating and sampling and as to how this was done.

### **2.3.3.1 Sample and sampling of nurses and clients**

A sample can be described as a selected element of the population considered for actual inclusion in a study (De Vos 2002:198). Since data collection for both nurses and clients is through unstructured in-depth interviews, the sampling methods for both groups were similar.

Sampling is defined as a subset of the population selected to participate in a research study (Burns & Grove 2001:365). This may be a group of elements such as individuals as will be the case in this study. Nurses who had been trained as HIV/AIDS counsellors and have worked in VCT services for over a year counselling, testing, treating opportunistic infections and distributing antiretroviral drugs constituted the sample.

Swaziland has developed a training manual for HIV/AIDS counsellors (MOHSW 2002:4). A large number of individuals have been trained on HIV/AIDS counselling skills in all the administrative regions of Swaziland (TASC 2003:2). The MOHSW (2005:8) reports that ten percent (10%) of Swaziland's population has utilized VCT services. The country has also reached the target of thirteen thousand (13 000) clients receiving ARVs in 2005 (MOHSW 2004:8). These individuals constitute the clients who could be and were included in the study.

### **2.3.3.2 Sampling criteria**

This is an effort to make the population as homogeneous as possible. Sampling criteria was based on research problem, purpose, design and practical implications of the research topic. A good participant is one who has good knowledge and experience, and is often what the research requires (Streubert & Carpenter 1999:22).

The following selection criteria had to be met for inclusion in the research study:

#### **For nurses**

- > Participants had to be registered nurses with the Swaziland Nursing Council and be working in VCT services in Swaziland.
- > They should have undergone an HIV/AIDS counselling skills training according to the MOHSW.
- > Both male and female nurses were included for gender representativeness.
- > All participants had to be fluent in English and SiSwati which are the official languages in Swaziland.

#### **For clients**

- > Participants had to have tested positive to HIV and were on antiretroviral therapy (ART).
- > Both male and female clients were included for gender representativeness.
- > Participants had to be fluent in SiSwati or English, or both.

Participants were identified through consultations and networking with stakeholders involved in VCT services in Swaziland. During the recruitment sessions the participants were informed that refreshments would be served as interviews would take 45 minutes to 60 minutes excluding introductions and explanations of study.

### 2.3.3.3 Sample size

Rich and dense descriptions of experiences in VCT centres determined the sample size. Saturation, which is described as the point at which data collection themes are repeated, also determined the sample size (Streubert & Carpenter 1999:22). Polit and Beck (2004:308) state that the sample size is largely a function of the purpose, the quality of the informants and based on information needs. In this study sample size will be determined by the quality of the information and repetition of discovered information on experiences in VCT centres (Polit & Beck 2004:57).

Following are details of participants who met the inclusion criteria for study (table 2.3)

**Table 2.2 Details of the participants who met the inclusion criteria**

Participants (n-13)	Gender	Age	Occupation	Receiving or Rendering
Participant 1	Female	46	Nurse Counsellor	Rendering services
Participant 2	Female	38	Nurse Counsellor	Rendering services
Participant 3	Female	32	Client (Housewife)	Receiving services
Participant 4	Male	30	Client (teacher)	Receiving services
Participant 5	Female	38	Nurse Counsellor	Rendering services
Participant 6	Female	34	Nurse Counsellor	Rendering services
Participant 7	Male	42	Nurse Counsellor	Rendering services
Participant 8	Female	51	Nurse Counsellor	Rendering services
Participant 9	Male	29	Client (Miner)	Receiving services
Participant 10	Male	22	Client (College student)	Receiving services
Participant 11	Female	40	Client (unemployed)	Receiving services-
Participant 12	Female	53	Client (housewife)	Receiving services
Participant 13	Female	26	Client (unemployed)	Receiving services

### **2.3.3.4 Sampling methods**

A purposive sampling method was used in this study when exploring experiences in VCT centres. Purposive sampling is judgemental since it involves the conscious selection by the researcher for informants to be included in the study (De Vos 2002:333). Selecting purposive sampling denotes a commitment to interviewing individuals who have had experience with a culture or phenomenon of interest (Streubert & Carpenter 1999:58). Creswell (1998:118) concurs when stating that selection of participants is crucial in qualitative studies as data must provide rich detailed and specific information. On interviewing participants, the researcher's wishes would be to acquire a special perspective because of their experience and knowledge of working in VCT services and receiving such services (De Vos 2002:198).

### **2.3.3.5 Pilot study on in-depth interviews (nurses and clients)**

A pilot study is a small version of the proposed study which can be used to develop a research plan (Polit & Hungler 1999:34). Huysamen (1993) in De Vos (2002:211) views the purpose of a pilot study as an investigation of the feasibility of the planned research. In exploratory studies piloting is necessary to address goals and objectives, population, data collection, fieldwork and possible errors. Kvale (1996:147) contends that pilot studies conducted before the actual interviews increase the researcher's ability to create new ideas. In qualitative research however, the pilot study may be less specific than in quantitative studies (Smith 1997:272).

The researcher conducted a pilot study of in-depth interviews in two VCT centres; one in urban and one in rural Swaziland. A nurse and a client were selected from each VCT centre. The aim for the pilot study was to:

- > refine the interview guide
- > determine the feasibility of data collection procedures
- > familiarize researcher with the technique required for audio-taping interviews (De Vos 2002:217)

### **2.3.3.6 Setting for data collection**

In qualitative research the setting is the place where individuals of interest live, where they experience life (Streubert & Carpenter 1999:21). The VCT centres in Swaziland are where experiences happen for both nurses and clients. These centres may be referred to as the cultural scenes or domains where all activities happen (Gillis & Jackson 2002:210). These authors continue to say it is important for the researcher to identify this social situation as it often helps in making more focused observations that lead to exploring the roles and relationships of the members (2002:210).

The participants who met the inclusion criteria were informed; dates and times were agreed upon. Permission was obtained to gain access to interviewing rooms most of which were at the place of work for the nurses. Clients were also interviewed in rooms where they receive VCT services. The scheduled time for the interviews was 60 to 90 minutes per participant including introductions and explanations of the study.

### **2.3.3.7 Role of the researcher as an interviewer**

In phenomenological research, the role of the researcher is that of an interpreter of the experiences of others (Gillis & Jackson 2002:208). Babbie and Mouton (2001:249) contend that errors during this phase can render the whole research undertaking futile when specific norms of interaction are not observed. The researcher has to ask questions, observe and make inferences about certain behaviours, thus making interpretations.

In qualitative research the researcher is a primary data collecting tool (Morse & Field 1997:57). As means to understand the phenomenon from the participants' perspective, the researcher had to explicate her prior beliefs (bracket) about VCT services in Swaziland (Brink & Wood 1999:167).

#### **> Bracketing**

Bracketing refers to a process of holding in abeyance prejudices, personal commitments, preconceived beliefs, assumptions and presuppositions to improve the rigour of the research (Brink

& Wood 1998:167; Cohen et al 2000:7; Polit & Beck 2004:253). The researcher made attempts to control her biases and preconceptions so that these could not interfere with the information given by participants (Holloway & Wheeler 1996:190). Temporarily forgetting everything about VCT services was done throughout interviewing. Polit and Beck (2004:253) contend that bracketing should be done throughout the research process especially during data collection so as to confront data in pure form. The researcher also attempted to avoid imposing her preconceived programme but to develop it from the data collected in the field.

### **> Intuiting**

Polit and Hungler (1999:247) describe intuition as the step where the researcher remains open or become absorbed in the meanings attributed to the phenomenon by those who experience it. Intuition requires that the researcher becomes immersed in the phenomenon under study; focus all awareness and energy on participants being interviewed to increase insight into phenomenon (Streubert & Carpenter 1999:49). Burns and Grove (2001:390) say intuition is an accurate interpretation of what is meant in the description of the phenomenon. In this study intuition was achieved through absolute concentration and remaining absorbed during the in-depth interviews and during data analysis.

### **> Inductive approach**

The various features of qualitative studies such as in naturalism, insider perspective and thick descriptions are an inductive approach (Babbie & Mouton 2001:272; Nieswiadomy 2002:95). Inductive reasoning begins with specific observations of actual events, things or processes and builds on these observations to make inferences (Grinnell & Williams 1990:293). Babbie and Mouton (2001:272) state that rather than beginning with an existing theory or hypothesis, the qualitative researcher begins with an immersion in the natural setting, describing events as accurately as possible, as they occur and eventually building second-order constructs. The emphasis in inductive approach is the developing generalizations from specific observations or moving from the particular to the general (David & Sutton 2004:36; Polit & Hungler 1999:9; Streubert & Carpenter 1999:8).

The interest of the researcher in this study was in the experiences of nurses working in VCT services and clients receiving the services. These were the participants she interviewed, allowing them to describe events as accurately as possible and as they occurred. From these, themes were developed, first using the language of the interviewees as was presented rather than abstract theoretical language (Terre Blanche & Durrheim 1999:141). The information obtained was used in the design and development of an empowerment programme for nurses working in VCT services.

> **Deductive approach**

The deductive approach is the process of developing specific predictions from general principles; in other words moving from general to particular (Polit & Hungler 1999:9). Within the deductive framework, the researcher used the study findings to predict certain events or develop a hypothesis about a phenomenon (Streubert & Carpenter 1999:8). Polit and Hungler (1999:9) emphasize that deductive reasoning is not itself a source of new information rather, an approach to illuminating relationships as one proceeds from the general to the specific. The data collected from the experiences of nurses and clients at VCT centres, illuminated the various needs of nurses. These needs were addressed with the design and development of an empowerment programme for nurses working in VCT services.

> **Saturation**

This is a term used to refer to a situation in data collection in which descriptions by participants become repetitive and confirm previously collected data (Gillis & Jackson 2002:185). Terre Blanche and Durrheim (1999:422) refer to saturation as the point where the researcher feels thorough exploration has been done and has acquired a satisfactory sense of what is happening. Saturation of data gives the researcher confidence that the description of the phenomenon has been captured.

### **2.3.4 Method of data collection**

Data collection is described as precise systematic gathering of information relevant to the purpose or specific objectives of a study (Burns & Grove 2001:794). One of the most frequent used data



collecting strategies is the **unstructured in-depth interview** (Streubert & Carpenter 1999:23). The research made use of both unstructured in-depth interviews and field notes.

#### **2.3.4.1 Unstructured in-depth interviews**

These interviews provide participants with full opportunity to fully explain their experience of the phenomenon of interest (Wimpenny & Gass 2000:1482). Polit and Hungler (1999:331) contend that unstructured in-depth interviews are conversational, whose aim is to elucidate the participant's perceptions of the world without imposing any of the researcher's views on them.

Kvale (1996:89) states that these interviews are considered the main method of data collection in phenomenology. Phenomenology is a research approach based in practice which aims at describing experiences as lived by the participants and interpreted by the researcher (Burns & Grove 2001:314; Stephenson & Corhen in Smith 1997:115). Critical truths about reality are grounded in lived experiences that are unique to an individual. In-depth interviews seek 'deep' information and understanding held by the real-life participants in some lived experiences (Gubruim & Holstein 2001:104). Krefting (1991:215) confirms that in-depth phenomenology interviews fare well as compared to the other data collection techniques in terms of trustworthiness of the information obtained.

The interviews took place in comfortable rooms at VCT centres on a one to one basis. The main question the researcher asked focused on 'live experiences' at VCT services. The question was asked in both official languages (English and Siswati) for clients and in English for the nurses. The questions were:-

##### **For nurses:**

*"Please tell me your day to day experiences of working at VCT services?"*

##### **For clients:**

*"Please tell me what experiences you have on receiving VCT services?"*

*"Ngicela ungijele lokuye kwenteke uma utofola lusito lapha eVCT?"*

An audiotape-recorder was used in collecting data and participants were informed of its presence and how it would help the interviewer in writing notes. Participants were assured that recorded materials would remain confidential.

During interviews, active listening was utilized in order to encourage the interviewing process. The principle of active listening was applied; it made participants feel listened to. Clients were thus relaxed and eager to relate their experiences. When concluding one interview, a client said *"noma awenti lutfo ngaloku lengikutshela kona; mine ngijatshuliswa kutsi kukhona umunfu lengimtshele ngalokwenteka lapha ka VCT!"* *"Even if you do not do anything about all I have said to you, I am happy that I have told someone about the things that happen at VCT!"*

The researcher employed verbal and non-verbal communication skills such as open-ended questions, clarification, paraphrasing and probing. Following are brief discussions of these.

#### ◆> **Open-ended questions**

These are questions that allow participants to respond in their own words and express feelings (Polit & Hungler 1999:334). Open-ended questions are meant to solicit more information from participants, such as *"Please explain what you mean by your own at VCT?"*

#### ◆ **Clarification**

Clarification aims to resolve ambiguity and confusion about meaning (Rice & Ezzy 1999:61). It involves the ability to ask the participant to clarify when responses are not clear or are vague (Uys & Middleton 1997:1000). The following question was asked by the researcher for clarity - *"Please clarify to me the people you interact with during one visit at the VCT centre?"*

## Paraphrasing

This refers to the repetition by the researcher in her own words, the participants expressed feelings and opinions to ensure that she understands correctly. The rephrasing of an answer may be an interpretation to some degree, to ensure clarification of data obtained; an example would be - *"You are sometimes confused by the nurses' behaviour towards you because you are HIV positive"*.

## Probing

Polit and Hungler (1999:347) state that the purpose of probing is to elicit more useful information from the participant than was volunteered during the first reply. Probing may also be used when the researcher realizes that the participant does not understand the question (Bryman 2004:122). Bernard (2000:198:225) identify seven types of probes intended to communicate to the participant that they should continue, these are:-

- > Silent probe: This consists of remaining quiet and waiting for participant to continue. Occasionally the researcher in this study would remain silent to allow a participant to deal with feelings; for example, when a client was relating how she felt when she was told she should not have a baby.
- > Echo probe: In this probe the researcher repeats the last thing said by the interviewee asking him or her to continue such as when the nurse said *"the supervisor said how come I only see four or five clients a day as compared to the nurse in Out Patients Department who sees more than twenty?"* The researcher's response was *"you see five clients a day when the nurse in OPD sees twenty, so your work is not the same"*.
- > The Uh-huh probe: The participants were sometimes encouraged to continue by making affirmative comments like Uh-huh, OK or I see; an example, was when the client told the researcher that she has decided to confront the nurse about the change of one of the drugs without telling her why.

- > Tell me more probe: This is a commonly used probe where the researcher invites participants to say more; an example; *"Please tell me more about the issuing of ARV drugs."*
- > Long question probe: When the researcher needs a long answer, she often uses this type of probe such as, *"What is it that the nurses do or say that makes you feel stigmatized?"*
- > Probing by leading: Leading questions are often discouraged in qualitative research, however to avoid "abbreviating" by the participant, long provocative questions are sometimes asked; for example *"This may seem obvious to you, but why are you uncomfortable counselling commercial sex workers."*

Much information was obtained as participants were able to grasp the lead offered by interviewer. The researcher was careful in using different types of probes to participants so that probes did not influence the content of responses. The researcher observed participant's body language to check for discomfort. A relaxed posture, consistent eye contact were maintained by the researcher. Interviews continued until data saturation (Gillis & Jackson 2002:185). Participants were provided with E20.00 for lunch or transport as a token of appreciation.

#### **2.3.4.2 Field notes**

Field notes are descriptive accounts in which the researcher objectively records what is happening during an interview (Morse & Field 1997:91). Bryman (2004:306) states that field notes should be fairly detailed summaries of events and behaviour and the researcher's initial reflection on them. These notes are much broader, more analytic and more interpretive as they represent the researcher's efforts to record information and to synthesize data (Polit & Hungler 1999:368). Polit and Hungler (1999:369) identify categories of field notes as; observational notes, theoretical notes, methodological notes and personal notes. In this study the following categories of field notes were used:

- > Observational Notes: These notes objectively described what was seen and heard by the researcher, such as events and conversation including time and place.

- > Theoretical Notes: These notes are interpretive attempts to attach meaning to what the researcher observes such as tension in participants when asked certain questions. In other words these are working hypothesis, concepts and hunches.
- > Methodological Notes: These provided instructions or reminders to researcher about how subsequent observations were made.
- > Personal Notes: These are comments which reflected the researcher's own feelings during the interviews.

Field notes were used to supplement the data collected through the tape recorded interviews (Bryman 2004:307; Morse & Field 1996:91). On terminating interviews, participants were provided with contact details of researcher for further communication should the participant wish to (Smith & Maurer 1995:478). The researcher at this stage prepared for data analysis.

### ***2.3.5 Analyzing identified concerns***

The purpose of data analysis is to preserve the uniqueness of the experiences of the participants and to understand the concerns of working at VCT services.

#### **2.3.5.1 Data analysis**

In qualitative research, data analysis begins when data collection begins (Talbot 1995:76, Streubert & Carpenter 1999:28; David & Sutton 2004:195). There is no clear point when data collection stops and data analysis begins as there is a gradual fading out of one and fading in of the other (Terre Blanche & Durrheim 1999:139; Bernard 2000:419).

De Vos (2002:339) and Dahlberg, Drew and Nystrom (2001:182) describe data analysis as a process of bringing order, structure and meaning to the mass of collected data. This process is active and interactive where data collection and analysis occur simultaneously and the invisible is made obvious (Polit & Hungler 1999:575). Gillis and Jackson (2002:185) contend that qualitative

researchers must immerse themselves fully in the data to bring order and meaning to the narrative data collected. Analysis involves extracting significant statements that allow identification of recurring themes and enter relationships (Polit & Beck 2004:254).

The process of analysis also include comprehending where the researcher strives to make sense of what is happening so as to thoroughly describe the phenomenon under study (Polit & Hungler 1999:579). The goal of phenomenological analysis is to arrive at some structure where essences and their relationship can be described (Giorgi 1997:248).

Data was analysed according to the steps suggested by Tesch (in Creswell, 1994:154-155). These steps entail the following:

- > Carefully read transcripts to understand the whole.
- > Read through an interview; write down ideas that emerge while asking yourself questions like *"What is the importance of the information gathered or what is it about?"*
- > Read all transcripts, make a list of all topics, and then cluster similar topics together.
- > Try to identify major categories and write these on the margin.
- > Create codes for similar topics; rearrange these to see if they become categories.
- > Find suitable wording for these and regroup them to categories.
- > To indicate relationships, draw lines between categories.
- > Recode the data if necessary for categories and sub-categories.

One theme emerged as the researcher scrutinized the data. Analysing data evidences the alignment with the fourth operation in phase 1 of the Intervention Design and Development Model, namely **analysing identified problems** (Rothman & Thomas 1994:28). At the end of this process the information was refined through data synthesis explained in phase 3.

#### **2.4 PHASE 3: DISCUSSION OF FINDINGS AND LITERATURE CONTROL**

Synthesis is defined by Polit and Hungler (1999:575) as putting together or combining of parts into a whole. Synthesizing is part of analysis where the researcher "sifts" the data, putting pieces together and getting a sense of what is typical with regards to the phenomenon (Polit & Hungler

1999:575). Rothman and Thomas (1994:140) contend that this process is in one hand tedious and on the other highly imaginative. It may be necessary sometimes to sift through hundreds of studies in order to group similar elements, and findings from diverse disciplines and contexts. Clusters of data comprising a consensus of findings must be constructed, and appropriate statements constituting generalization must be composed.

On systematic research synthesis, Rothman and Thomas (1994:38) state that it entails a degree of invention that makes a new integrated whole from the parts of a body of research findings. The importance of intellectual creativity in synthesis, according to Gibson in Rothman and Thomas (1994:140) is to "arrange the new facts and the old knowledge in consistent and satisfying patterns ... Its outputs ... increased understanding that comes when the new and strange are logically related to the old and familiar..... [it is] the power of producing new facts by extrapolation from well-established knowledge."

In this study, the researcher operationalised this phase as the discussion of research findings and literature control. See the following chapter for a comprehensive description of findings and literature control.

## **2.5 PHASE 4: DESIGNING AN EMPOWERMENT PROGRAMME**

Mullen in Rothman and Thomas (1994:163) describes design as a stage of purposive planned change that evolves to social interventions. Design comprises of designing an observational system and specifying procedural elements of the intervention (Rothman & Thomas 1994:28). The purpose of design in the Intervention Design and Development Model is the formulation of intervention constructs that ameliorate social problems. The development of an empowerment programme for nurses, based on research findings, is an intervention for problems often encountered in VCT services in Swaziland.

### **2.5.1 Concept identification**

Empowerment is the concept selected for the designing of a programme for nurses working in VCT services. Concept identification involves a mental formulation of a phenomenon

recognised by the researcher and wished to communicate. In identifying a concept, experiences, clinical practice or knowledge of the literature are often used. This process included the use of a work label that has been assigned a specific definition. Walker and Avant (1995:40) state that the concept selected should be significant and important to further programme in the area of interest, such as the VCT services. The particular meaning assigned to the concept empowerment will be discussed in chapter 4 where dictionary meanings and attributes are used that will enhance the programme design.

### **2.5.2 Concept analysis**

Concept analysis is a process, which involves the use of words to explain phenomena. Walker and Avant (1995:3) define concept analysis as a formal, linguistic procedure to determine the essential attributes of a concept. It is a technique or mental activity that requires approaches to uncover subtle elements of meaning (McKena 1997:58). The concept analysis of empowerment in designing of the programme has the following aims;

- To enhance focus that will provide a sense of direction to what the programme aims to achieve.
- To assist in clarifying and maintaining consistence in the achievements of the programme.
- To enhance the analytic skills of nursing practice.

### **2.5.3 Concept definition**

A definition is meant to provide a clarifying meaning to a concept. Smith (1997:241) define a concept as a general summary of the abstract aspects of life, such as empowerment, which have acquired meaning through common recognition or formal definition. According to Chinn and Kramer (1995:59), a concept is defined as a complex mental formulation of experiences which depends on certain variables to yield the concept of concern. The definition of empowerment in this study will be formulated from dictionary definitions, attributes and outcomes hoped for. The meaning of empowerment created in this study will give the programme its particular character (Chinn & Kramer 1991:107).



#### **2.5.4 Concept classification**

Concept classification of empowerment will depend on the variables that will constitute relationship formulation. In the design of the empowerment programme the relationship statement formulated should provide evidence that the programme will be effective. Clear statements regarding context are particularly necessary if the programme is to be applied in practice. Chinn and Kramer (1995:82) state that if in a programme, relationship statements lack empirical support, the following will happen

- The concept is likely to be faulty,
- The relationship statements are faulty,
- The empirical indicators for the concept are faulty, and
- The measurement for the empirical indicators is faulty.

These classifications can be rectified through returning to the concept analysis, theory construction process, examining empirical indicators and develop measurement processors that would accurately measure empirical indicators.

### **2.6 PHASE 5: DESCRIPTION OF AN EMPOWERMENT PROGRAMME**

In this phase, the intervention evolves through developing a prototype or preliminary intervention to a form that can be tested. The programme was described according to programme description guidelines proposed by Chinn and Kramer (1991:82), which are as follows:

#### **2.6.1 Programme Purpose**

The programme purpose is meant to provide specificity on why the programme is developed. Its aim is to suggest the boundaries of events that must be specific for the nurses, clients and the environment at VCT services. According to Chinn and Kramer (1995:107), a purpose can be explicit if embedded in the programme structure or can be a reasonable extension of the structure. In the description of the programme of nurses, the purpose that is a reasonable

extension of the programme will be used as it clarifies the clinical usefulness of the programme.

### **2.6.2 Programme Assumptions**

Burns and Grove (2001:720) define assumptions as that statement that is taken for granted to be true without proof or scientific testing. Assumptions are often difficult to identify because they are implied rather than explicit. In the development of the programme, the researcher will base the assumptions on beliefs and values about health, the nurses and nursing at VCT services. These assumptions must have a value orientation and a specific location within the programme.

### **2.6.3 Participants of the programme**

The participants of the programme will constitute the people who collaborate with activities at VCT services as issues and problems found there in, are of interest to themselves, society and research (Rothman & Thomas 1994:29). In developing the programme the researcher must identify specific participants.

### **2.6.4 Structural description of the programme**

A programme structure is a visual image that will provide the conceptual relationships within it. In the development of the programme for nurses working in VCT services, a visual structure must be provided to clarify the relationship between nurses, environment and outcomes. The development must also indicate the breath and power of the programme.

### **2.6.5 Process description**

In the development of the programme, the researcher describes the process from beginning to the outcomes hoped for. The process included:

- Identifying and defining concepts within the programme

- Identifying assumptions upon which the programme is based
- Describing boundaries that will suggest limits
- Formulating relationship statements.

### **2.6.6 Context of empowerment**

The context of empowerment relates to the situation in which it happens. Developing a programme for nurses working at VCT services utilizing the concept empowerment must consider the interaction of nurses and clients and the environment of varying degrees of illness and stress.

## **2.7 PHASE 6: GUIDELINES TO OPERATIONALISE THE PROGRAMME**

This phase examines how and why a programme does or does not work. Chinn further supports this and Kramer (1995:118) when stating that the researcher must ask if the programme serves its purpose.

At this phase of research the researcher used findings and literature on empowerment to develop and describe guidelines for to help nurse implement the programme. The researcher was also guided by programme evaluation criteria proposed by Chinn and Krammer (1995:). The criteria for programme evaluation are as follows:

### **2.7.1 Clarity**

This is an important aspect guide programme evaluating. The researcher must clearly define these concepts that are significant to the programme. The study appreciates semantic clarity where the use of language or words is important to convey the correct meaning with consistency in the evaluation.

In structural clarity the researcher maintains logical connections when evaluating the programme. This involves reflecting back the descriptive statements of relationships and asking questions like "can the structure be diagrammed?"

### **2.7.2 Simplicity**

Simplicity in evaluating a programme should be judged by the minimum number of descriptive components present and how these are related to each other.

### **2.7.3 Generality**

This criterion relates to how a programme can be applied to other areas depending on the scope of the concepts within that programme.

### **2.7.4 Empirical precision**

In empirical precision concepts contained in the programme should be linked with empirical reality. There should not be a mismatch between the concept defined and the reality abstraction provided by a definition. This criterion is influenced by semantic clarity.

### **2.7.5 Derivable consequences**

On evaluating a programme the researcher must find out the extent to which the programme produces the expected outcomes that are important to nursing practice.

Various strategies to ensure the trustworthiness of this study are discussed in the next section.

## **2.8 TRUSTWORTHINESS OF THE STUDY**

Trustworthiness is described as establishing reliability and validity of a qualitative research (Streubert & Carpenter 1999:28). The trustworthiness of research findings occurs when the researcher can convince the consumer that the results are worth paying attention to and worth taking account of (Lincoln & Guba 1985:290). Creswell (1998:194) and Lincoln and Guba (1985:290) suggest that a study is credible when the description and interpretation of human experiences are such that other people who share the same experiences can identify with the account. Trustworthiness of this study was ensured by using Lincoln and Guba's model which

introduced the concept of trustworthiness and authenticity (Creswell 1994:157-158). Streubert and Carpenter (1999:28) cite the following four criteria of trustworthiness, namely, truth-value, consistency, applicability and neutrality. These will now be discussed according to how they were integrated into study.

### **2.8.1 Truth-value or credibility**

This criterion is important in the assessment of qualitative research. It is used to assess the extent to which findings are a true representation of lived experiences of participants. Credibility aims at establishing confidence in the findings of the research (Lincoln & Guba 1985:293). Babbie and Mouton (2001:277) state that credibility is achieved through prolonged engagement, persistent observation, triangulation, referential adequacy, peer debriefing and member check. Following is a discussion of these.

#### ***2.8.1.1 Prolonged engagement***

Lincoln and Guba (1985) in Polit and Hungler (1999:427) describe this as an important step for data collection. The researcher spent some considerable time with the participants observing, taking notes and discussing experiences relating to VCT services. Trust and rapport were developed as some of the participants disclosed sensitive facts about themselves. Krefting (1991:218) contends that prolonged engagements enable the researcher to understand the culture and the environment which may influence the establishment of truth-value. The data was collected in VCT centres where experiences happened.

#### ***2.8.1.2 Persistent observation***

It is important for the researcher to persistently pursue interpretations in different ways (Babbie & Mouton 2001:277). The researcher observed that on discussing certain issues some of the nurses were anxious, until it transpired that they had not undergone the HIV testing thus they still had personal issues to deal with.

### **2.8.1.3 Triangulation**

This is defined as the use of multiple references to draw conclusions about what constitutes the truth (Polit & Hungler 1999:428; Cormack 2000:406; Gillis & Jackson 2002:416). Triangulation may also refer to the use of multiple methods of data collection with a view of increasing the reliability of a study. Denzin (1989) in Babbie and Mouton (2001:175) explain that "By combining methods and investigators in the same study, observers can partially overcome the deficiencies that flow from one investigator or method."

Triangulation in this study was executed by using data triangulation, investigator triangulation and theory triangulation. Data collection (triangulation) was in different forms, which were in-depth interviews, observations and field notes. The researcher corroborated with her two supervisors who are experienced in qualitative research. Cormack (2000:405) asserts that comparing the outlooks of research participants is another way of triangulation. In this study nurses and clients were used to bring a variety of perspectives. The study of different literature control sources (nursing philosophy, psychology and social sciences) provided theoretical triangulation.

### **2.8.1.4 Referential adequacy**

In referential adequacy, Babbie and Mouton (2001:277) refer to materials used in documenting findings. The researcher used audiotape cassettes and note books.

### **2.8.1.5 Peer debriefing**

The researcher had conversations with colleagues who were impartial and had experience in qualitative research relating to the results of the study (Krefting 1991). The colleagues hold Doctoral degrees and have been used by other universities as external examiners for doctoral students, assisted the researcher to "reduce the possibility of a biased or one-sided interpretations of the data (Polit & Hungler 1999:428)".

### **2.8.1.6 Member checks**

Researchers are encouraged to return to the participants for data and interpretation verification (Babbie & Mouton 2001:477). Polit and Hungler (1999:429) refer to this as feedback to study participants regarding the data and researcher's emerging findings and interpretations. Credibility was ensured in this study by interviews with four of the participants who identified with the themes.

### **2.8.2 Consistency or dependability**

Lincoln and Guba (1985:316) contend that when credibility in findings is determined, consistency or dependability is ensured. The research must provide the same results when applied by others using the same research participants in a similar context (Krefting 1991:220). Dependability was ensured through triangulation of data sources (ordered and dated field notes) and peer briefing where interview notes and documents were examined; an 'inquiry audit' notion (Babbie & Mouton 2001:278).

### **2.8.3 Applicability or transferability**

This is concerned with the generability of study findings to other settings, population and contexts. Transferability focuses on the extent to which findings can be applied in other study situations. These however are defined by the specific context in which they occur (Babbie & Mouton 2001:277). Transferability was ensured by thick description and purposive sampling.

#### **2.8.3.1 Thick description**

Lincoln and Guba (1984) in Babbie and Mouton (2001:277) contend that transferability is achieved through collecting sufficiently detailed descriptions of data in context and setting and reporting them with precision. In this study dense description of experiences of nurses and clients in VCT centres highlighted the empowerment needs of nurses working in VCT services in Swaziland. Included in the detailed description were the research methodology, literature control, verbatim quotations taken from the narratives and data analysis.

### **2.8.3.2 Purposive sampling**

A qualitative researcher uses purposive selection of participants and location to maximise the range of specific information required. Nurses and clients in this study were selected purposively to enhance transferability.

### **2.8.4 Neutrality or confirmability**

Morse and Field (1996:118) define neutrality as freedom from bias in the research procedure and results such that there would be agreement between two or more independent people about the data's relevance or meaning. In qualitative research neutrality should not be viewed on the characteristics of the researcher but on the neutrality of data (Polit & Hungler 1999:430; Krefting 1991:221). Babbie and Mouton (2001:278) state that neutrality of data can be achieved through audit trail. Citing Lincoln and Guba (1985), these authors say an audit trail enables the auditor to determine if the conclusions, interpretations and recommendations can be traced to their sources. An audit trail involves:

> **Raw data**

Recorded audio cassettes, field notes documents and results.

> **Data reduction and analysis products**

Summaries and write-ups of field notes. Field notes consist of observational notes (what is seen and heard by researcher), theoretical notes (interpretive attempts to attach meaning) and methodological notes (instructions on how process occurs).

> **Data reconstruction and synthesis of products**

This involves looking at categories that were developed, findings and conclusions.



> **Reflexivity**

Since in qualitative research, the researcher is part of the research process, it is important that she reflects on and discusses explicitly the likely impact of her own beliefs, theoretical orientation and the phenomenon of interest in data collection and analysis (Breakwell, Hammond & Fife-Schaw 2000:280). This was accompanied by reflexive personal notes.

## Strategies for ensuring trustworthiness in this study

**Table 2.9 Strategies to ensure trustworthiness**

Criteria	Strategy for accessing criteria	Action	Application
Truth value	Credibility	Prolonged engagement	<ul style="list-style-type: none"> <li>This action was maintained through conducting in-depth phenomenological interviews until data was saturated.</li> <li>Researcher's understanding of the environment at which data was collected (VCT)</li> </ul>
		Triangulation	<ul style="list-style-type: none"> <li>In-depth phenomenological interviews, observations, field notes and literature control were the skills and techniques employed by the researcher to ensure credibility.</li> <li>Different data sources were used (nurses and clients)</li> </ul>
		Peer debriefing	Prolonged discussions of research findings with impartial colleagues experienced in qualitative research
		Member checking	This was through testing analytic categories and interpretations with participants
		Authority of the researcher	<ul style="list-style-type: none"> <li>Research supervisors are experts in qualitative research and hold doctoral degrees in Nursing Science.</li> <li>Findings were presented at an international conference</li> </ul>
		Nominated Sample	<ul style="list-style-type: none"> <li>Purposive selection of the sample of participants (nurses &amp; clients)</li> </ul>
		Dense descriptions of methodology	Adequate description of the research methodology, literature control and verbatim quotations taken from the narratives
Applicability	Transferability	Triangulation	Peer debriefing where interview notes and documents were explained
		Dense Description of methodology	As discussed above
Consistency	Dependability	Raw data	These consists of recorded audio cassettes, field notes and results
Neutrality	Confirmability	Reflexivity	<ul style="list-style-type: none"> <li>Keeping field notes</li> <li>Identification of own biases to ensure that data was free from biases.</li> </ul>

## 2.9 CONCLUSION

The introduction of this chapter indicated that this study falls within the genre of Intervention Research, from which the specific methodology framework selected for the research process was the Intervention Design and Development Model proposed by Rothman and Thomas (1994:28). In this chapter the researcher discussed the various methodological steps involved in conducting this study, which were:

- > The adoption of phase 1 of the Intervention Design and Development and facilitated through the qualitative study using the exploratory, descriptive and contextual design.
- > The researcher described the qualitative research process, which included data collecting. Sampling was done through the purposive strategy for both nurses and clients.
- > Data verification was applied through use of Guba's model of trustworthiness which include:
  - o credibility
  - o transferability
  - o dependability
  - o confirmability
  - o ethical measures taken.
- > Phase 2 (information gathering and synthesis) was through using existing information such as the use of computers. In studying natural examples, the researcher used interviews, analysed and evaluated literature on programmes and practices (Rothman & Thomas 1994:10).
- > In phase 6 of the study, guidelines to operationalize the programme will be formulated utilizing Chinn and Kramer (1991:105) steps which are as follows;
  - o Clarity
  - o Simplicity

- o Generality
- o Empirical precision
- o Derivable consequences
- o Process description

Chapter 3 of this study is a presentation of detailed discussions of finding and literature control.

## CHAPTER 3

### PHASE 3: INFORMATION SYNTHESIS

#### *Discussion of findings and literature control*

#### 3.1 INTRODUCTION

In chapter 2 of this study, the research design and methods were discussed. This chapter presents the research findings together with data analysis and discussion with reference to literature in order to conceptualize the findings. The chapter describes the experiences of nurses working in VCT services and clients who receive these services. The chapter provides bases for the operationalisation of phase 1 (Problem Analysis) of the Intervention Design and Development proposed by Rothman and Thomas (1994).

Participants were identified through contacts. The purposive sampling method was used since the researcher was committed to interviewing individuals who had experienced working in and receiving VCT services (Creswell 1998:118). According to De Vos (2004:209), a study population must possess specific characteristics that represent all measurements of interest to the researcher. Consenting participants were given consent forms to sign prior to interviews. Data were obtained through interviews and field notes. Audio-tapes were used to collect data.

The researcher interviewed 11 participants (nurses and clients) after which saturation was reached. Participants were requested to describe their experiences at VCT services. This allowed participants to tell their stories in a narrative fashion. Each in-depth interview took 1 hour 30 minutes to 2 hours per participant. This included the time spent prior to the interviews explaining the research purpose and process. Bracketing was important to control the biases and preconceptions of researcher on VCT services so that these may not interfere with information given by participants (Holloway & Wheeler 1996:190).

The biographic profile of all participants was provided in chapter 2, (table 2.3.) Among these were participants on whom pilot interviews were conducted. The purpose for the pilot interviews was to assist the researcher in sharpening her interviewing skills.

### **3.2 THE RESEARCHER'S EXPERIENCE OF THE FIELD**

The researcher had no problem in obtaining permission from the authorities for the interviews. A letter from UNISA requesting the MOHSW to allow the researcher to conduct the study received a positive response from the Director of Health Services in Swaziland.

Nurse leaders expressed more interest in the study since the Swaziland Nurses' Association was planning on opening a wellness centre for nurses. Appointments were made with nurses in identified VCT centres that represented the four administrative regions of Swaziland.

A minor problem for some of the nurses was their tight schedules which necessitated conducting interviews after work or weekends; this interfered with their social life. Some nurses were reluctant at first to participate, stating that HIV/AIDS is a sensitive subject in which confidentiality should be maintained. The researcher reassured them that no names, dates and time were to be mentioned in narrating the experiences. Some procedures, such as weighing clients at VCT centres, are performed by non-professionals; this situation caused some of the nurses to be uncomfortable with the presence of the researcher. Since the researcher was a lecturer, nurses assumed she had come to check on their efficiency. The emphasis on the purpose of the research brought acceptance of her presence.

Appointments with clients were mostly on days scheduled for their VCT services since interviews were at the VCT centres. The queues are long for services at VCT centres. The researcher often found herself waiting for hours to interview a client, because clients were scared of losing their positions in the queue. Some clients wanted to buy food before the interviews were conducted since they had been at the centre for a long time. Clients were eager to tell their stories; happy that a health professional was listening to their experiences some of which confirmed the researcher's field notes. One client, at the end of the interview, commented that she hoped the information she had given would be used to effect some changes at the VCT centres.

The interviews were conducted in English and Siswati which made transcribing and coding the data for analysis a time consuming task. The transcribed and coded data was referred to an expert in qualitative research to confirm the findings.

### 3.3 METHOD OF DATA ANALYSIS

The narrative descriptions by nurses and clients of experiences at VCT services, were analysed using the method explained by Tesch (1990:142). This method includes identification of themes, verifying the selected themes through reflection on data, discussion with other researchers or experts in the area, categorizing the themes and recording of support data. Each text was read several times in order to reach a comprehensive understanding (Bryman 2004:412). Newman (1997:20) states that in qualitative research, focus is on stories, subjective meanings and definitions of specific cases that capture the essence of the phenomenon.

Analysis was done from data presented by participants and not from any super imposed theoretical framework. Tesch (1990:119) contends that interpretive qualitative researchers rarely use theoretical framework to construct an organizing system. In an effort to prevent pre-empting the findings, Parse's theory of human becoming was not used to identify the themes. Once data reduction had been achieved, then the theme, categories and sub-categories were discussed and supported by literature control.

In this study, trustworthiness of interpretations was maintained through Guba's Model (Lincoln & Guba 1985) and by recognizing that the participants were experts in VCT services experiences, while keeping recordings of thoughts, ideas and reactions to the interviews (Benner 1994:77).

### 3.4 THE THEME: CONSTANT EXPERIENCE OF STRESS

One major theme emerged from data analysis namely; **constant experience of stress** by the nurses and clients working and receiving VCT services respectively. The nurses expressed chronic exposure to the same type of work. Mallik, Hall and Howard (2004:193) contend that monotonous work may be stressful as an individual may fail to adapt. In highlighting emotions of individuals infected or affected by HIV/AIDS, and in support of the theme, Watts (1988) in Van Dyk (2005:214) quotes an HIV positive person saying "*AIDS is the stuff of all our nightmares, triggering many of our deepest fears*". From the data, the researcher deduced that there were various reasons for the participants to feel stressed, the reasons for the constant stress were categorised and sub-categorised in Table 3.1 for nurses and 3.3 for clients.

**Table 3.1 Theme, categories and sub-categories (NURSE)**

Theme	Categories	Sub-categories
Constant experience of stress	1. Psychological reasons	1.1 HIV is a complex condition 1.2 Staff shortage 1.3 Lack of social support 1.4 Lack of a supportive practice environment 1.5 Need for staff development
	2. Physical reasons	2.1 Constant exhaustion 2.2 Development of medical conditions

Constant experience of stress deals with the various ways participants experience stress at VCT centres while rendering service. Stress has been defined by Selye (1956) as non specific response of the body to any demand made on it (Lewis, Heitkemper & Dirksen 2004:112). Baron (1996:410) adds that stress is a process that occurs in response to events that disrupt the psychological and physical functioning. In general terms, stress occurs when people are faced with events they perceive as endangering their psychological or physiological well-being (Atkinson, Atkinson, Smith, Bern & Nolen-Hoeksema 1996:447). Participants communicated that working in VCT services is stressful, psychologically and physically.

### **3.4.1 Category 1: Psychological reasons for constant experience of stress**

People will experience stress if they appraise an event as stressful and perceive the demands posed by that event as exceeding their ability to cope (Kaplan, Saddock & Grebb 1994:575). The constant exposure to PLWHA at VCT centres, disrupts nurses' equilibrium which leads to stress (Smit 2005:23). According to Sullivan and Decker (2005:205), factors contributing to stress may be classified as organizational, interpersonal and intrapersonal. The organizational factors may include introduction of new policies or new assignments which nurses feel inadequately prepared for. Some nurses said



*"I have been moved from the operating theatre to this place (VCT centre). I feel I have not been adequately trained as a counsellor; what do I say to the clients".*

Any change in life that requires readjustments can be perceived as stressful (Atkinson et al 1996:479), These authors continue to say the more uncontrollable an event seems, the more it is perceived as stressful. Another nurse stated the following:

*"... there is a lot of paperwork to be done at VCT centres which leads to stress".*

Meyer, Naude and van Niekerk (2004:188) contend that paper work is often cumbersome which when combined with large numbers of clients results in stress.

Organizational stress can also result from the environment, task overload or the inability to do task assigned due to the lack of preparation of the nurses. The physical environment at VCT centres is characterised by overcrowding and clients who are at different levels of illnesses (MOHSW 2003:11). The following are excerpts from data.

*"There are so many clients at this VCT centre, one is always overwhelmed and discouraged".*

The interpersonal factors that lead to stress for the nurses at VCT services include strained interpersonal relationships (Sullivan & Decker 2005:204). Interactions between personnel working on job redesign and case management challenge the nursing care providers.

*"The client needed to be seen by the doctor, but the nurse working with him refused, stating that the doctor has seen the number of clients allotted for that day; I was upset, as I thought the client needs help".*

Individual role conflict can be the result of incompatibility between the individual's perception of the role and its actual requirements. Nurses may also feel under-utilized. Being under-utilized may be very stressful to someone who has high esteem needs and can lead to apathy, low productivity and job dissatisfaction (Sullivan & Decker 2005:208). The need to fulfil multiple roles is another source of stress. The conflict between family roles and professional ones may result in stress.

*". One of my clients has a habit of coming to my home to ask for advice on issues related to VCT services. My family does not like that".*

*"I sometimes feel depressed when there is no improvement in my clients' condition. I often feel inadequately prepared to be at VCT services".*

Some of the nurses expressed feelings of inadequacy. Swansburg and Swansburg (1999:596) explain that some individuals have a tendency of focusing on the negatives at the expense of the positives. The authors identify this as deficiency focusing that creates an increased sense of threat for the nurse; limiting his/her ability to solve problems and leading to stressful feelings.

Stress may lead to feelings of depression, helplessness and hopelessness (Pratt 1995:254). Nurses expressed various feelings and emotions related to working in VCT services. These included helplessness, depression and burnout.

### **Helplessness**

Helplessness is described by Seligman (1975) in Smit (2005:25) as a state that frequently results when events are uncontrollable; the motive to respond is depleted, and the ability to perceive success undermined with heightened emotionality. Limited motivation results from insufficient environmental opportunities where individuals overtime, cannot control outcome of events affecting their lives (Driscoll 1994:212). Nurses have verbalized feeling helpless due to constant confrontation with illness and death of clients and colleagues.

*"When you hear about the deaths of clients; you feel like you have failed these people or what is the use ... AIDS has no cure".*

### **Depression**

When nurses are depressed, they experience fatigue, grief associated with loss of control, or feelings of guilt and unworthiness (Morris 1995:254). Depression is characterised by loss of

interest and pleasure in activities, sleep disturbances, changes in appetite, and lack of energy (O'Brien, Kennedy & Ballard 1999:303). These characteristics compound the nurse's feeling of failure and inability to assist clients. Shives (2005:275) adds that depressed people also experience psychomotor retardation or agitation and have difficulty thinking, concentrating and making decisions. One nurse said:

*"I sometimes feel depressed when there is no improvement in my clients' condition. I often feel inadequately prepared to be at VCT services".*

### **Burnout**

Booyens (1998:145) defines burnout as an evolutionary process of growing emotional exhaustion, occurring in a nurse as a consequence of being exposed to chronic work related stress factors. Mallik et al (2004:194) stress that there is a negative association between productivity and burnout, observing that individual's problem solving abilities decreased under prolonged periods of distress. Burnout is another state commonly found in HIV care nurses. Winiarski (1997:35) agrees that HIV/AIDS creates more need than any one person can supply. Burnout is characterised by fatigue feelings of failure in work situations and colleague relationships are viewed negatively and sense of powerlessness and inadequacy (Jenkins & Elliot 2004:622).

*"I am forever tired, and I realize I am no more enthusiastic about my work..."*

#### **3.4.1.1 Sub-category 1: HIV/AIDS is a complex condition**

Nurses in VCT services noted that the HIV/AIDS epidemic has created a particularly challenging environment for the health worker due to its complexity. Transmission is commonly through sexual contact and exposure to infected blood and sexual fluids (Pratt 1995:370). In Swaziland sexuality issues are taboo subjects; nurses may feel embarrassed and uncomfortable about discussing these issues which may perpetuate the conspiracy of silence or denial. Because HIV/AIDS emerged among marginalized groups (homosexual men and prostitutes) it aroused contempt instead of compassionate care; it encouraged fear and neglect. On HIV/AIDS nurses said the following:

*"Our clients are very different, some do not want to test but just get the ARVs".*

*"Some of the clients do not want to be asked many questions; they just want the test without counselling".*

*"It pains me a lot; in the beginning you both agree on the time to spend together, but you are sometimes delayed when you realize that the condition of the client after result is not a good one".*

*"The confidentiality issues sometimes make it difficult for you to help the client if she/he has been seen by someone else previously".*

The care of people with HIV/AIDS is challenging due to its multidisciplinary nature, its medical complexity, the physical and emotional manifestations, the need for infection control measures and the associated stigma (Pratt 1995:370). In working with HIV/AIDS clients, nurses in VCT services have to confront their own attitudes, values, beliefs, traditions, habits and fears of becoming infected. (Winiarski 1997:26). This author continues to state that nurses who work in VCT services require broad repertoire of professional responses, skills and therapeutic styles that allow them to function as counsellors and case managers (1997:29).

In dealing with HIV/AIDS, counselling is a major intervention strategy. Counselling involves a continuing dialogue and relationship building between the client and the nurse with the aim of preventing infection and providing psychosocial support to those already infected (Pratt 1995:447). Okun (1992:10) defines counselling as emotional support and informational support to facilitate decision-making that help to achieve some degree of personal autonomy. Okun (1992:10) describes counselling as a form of helping which is both an art and a science. It is an art in the sense that personality, values, skills and knowledge of the counsellor at VCT services are subjective variables in the counselling process that is difficult to measure. Counselling is also a science in that counsellors learn structured helping strategies that are measurable in changing behaviour and has aspects of intellectual stimulation (Okun 1992:11).

The practical assistance by the nurse at VCT services is in helping the client deal with negative and positive results, treatment of opportunistic infections to delay the onset of illness, and directing

clients on taking the antiretroviral drugs. The complexity of HIV/AIDS is compounded by the fact that counselling should be culturally competent, sensitive to issues of sexuality, developmentally appropriate and linguistically specific (Pratt 1995:447).

According to the Second National Multisectoral HIV and AIDS Strategic Plan 2006-2008 of the Government of Swaziland, factors that contribute to the complexity of HIV/AIDS are related to the following drivers of HIV/AIDS. These also indirectly lead to stress development for the nurses working in VCT services as they have to deal with such factors in their counselling and management of the condition (MOHSW 2006).

> **Inadequate public awareness of the epidemic**

Nurse counsellors communicated confusion on who knows what on HIV/AIDS in Swaziland. Some studies done in Swaziland on HIV and AIDS awareness indicate that a high proportion of the population is aware, yet some studies still show that misconceptions exist. Misconceptions include claims of cure by faith healers and traditional healers (MOHSW 2006:8). That is the reason why some clients refuse counselling and treatments; they come to the centres when condition is advanced (MOHSW 2006:8).

> **Multi concurrent sexual partners**

The strategic plan indicates that there is a common practice of multiple sexual partnerships among people of Swaziland including the youth. Many of these are concurrent and this sexual network fuels the virus. It is often difficult for the nurse counsellor to get the risk factors from such clients since sexuality issues are taboo subjects and clients do not want to be seen to be promiscuous.

> **Cultural beliefs and practices with negative implications**

While some cultural beliefs and practices are believed to have positive attributes, some are perceived to have a potential for contributing to the spread of HIV/AIDS. Some of the cultural practices include polygamy, *kwenzisa* (arranged marriages), and *kungena* (widow inheritance). Nurses are challenged by these in their counselling and management, of HIV/AIDS.

> **Secrecy and denial of HIV infection**

Many infected clients do not want to know their HIV status as one nurse counsellor narrated. Some clients who know their status keep it secret even to their sexual partners. As a result partners continue to infect each other as they continue to have sex without protection. This may lead to pregnancy and to mother to child transmission of HIV. It is common for infected people to hide behind witchcraft. Public disclosure is very low and only among low profile personalities.

Other drivers of the epidemic which the nurses have to deal with are; rape and incest, exposure to pornography, mobility, break-down of morals, low condom use, abuse of power by men in sexual relationships, alcohol and drug abuse and prostitution.

When clients are at the point of taking ARVs, they need a "buddy" which means the nurse has to contact friends or family of client to discuss physical and emotional problems related to the disease. Such activities are not favoured by clients because the HIV positive status is still associated with promiscuity (Haines 2004:6).

Winiarski (1997:83) adds that HIV/AIDS is also said to be a political disease which lacks openness in most Southern African countries, leading to denial of its existence. Such state of affairs has made nurses' role as educators and counsellors very difficult and the success of their intervention uncertain.

**3.4.1.2 Sub-category 2: Staff shortage at VCT services**

Nurses interviewed reported that there is general staff shortage in most VCT centres. Staff shortage is one of the common problems experienced by most health agencies in developing countries like Swaziland (Mavundla 2000:1570). This is seen as one of the nursing profession challenges as nurses are overload, work beyond their scope of practice and are often exploited in the work place. Nurses at VCT services in Swaziland noted that there were inadequate numbers of nurses trained as counsellors in comparison to the large numbers of clients who come for VCT services. Some of the narratives were:

*"I am the only one. I have to see patients in the ward; people who have been referred by the doctor and those who come to the VCT centre on daily basis for counselling and testing".*

*"What happened is that one of the nurse counsellors was not at work... so I was alone working at the VCT and other ongoing cases and some who were sick".*

*"There are often large numbers of clients at VCT services and there are only few of us trained. Sometimes we are assisted by non counsellors who help with filling in of forms".*

Sullivan and Decker (2005:231) define staffing as a process of providing the appropriate numbers of nurses necessary to match actual or projected client health care needs, and will lead to the delivery of effective and efficient care. Health services (such as VCT services in Swaziland) should be guided by National Plan for Health Facilities which provide guidelines for staffing (Booyens 1998:37). Staffing should be based on the ratio of health workers to population served, however VCT centres in Swaziland are often crowded (Swansburg & Swansburg 1999:123).

The work at most VCT centres is during week days from 8 am to 4 pm. Nurses are either testing or distributing ARVs. Staffing and scheduling is an important responsibility of nurse managers, which when done appropriately results in higher quality care (Needleman, Buerhaus, Mattke, Stewart & Zelevinsky 2002:1716). Adequate staffing levels positively affect client outcomes (Potter, Barr, McSweeney & Sledge 2003:159).

Marquise and Huston (2002:263) contends, *"to determine staffing requirements, workload patterns must be examined according to the philosophy of that particular health service area"*. The philosophy in VCT services is about caring and helping individuals deal with anxiety and concerns (Okun 1992:8). Overcrowding makes it difficult for a short-staffed facility to provide quality care, which often leads to frustration, and stress for the nurses.

Existing human resource problems have been exacerbated by HIV/AIDS. In Swaziland both the quality and quantity of labour is being adversely affected by AIDS as highly trained and educated human resource is infected, get sick for a long time and eventually die (MOHSW 2004:6).

Workloads have increased through the growing demand for services such as counselling and testing, prevention and treatment of opportunistic infections. There has been an increase in the programmes addressing the HIV/AIDS epidemic yet the numbers of nurses have been reduced. Poorly planned HIV/AIDS treatment and care scale up, often has a detrimental impact on VCT services. In one of the referral VCT centres in the country there are six qualified nurse counsellors some of whom do pre and post HIV test counselling to more than 100 clients a day, while at the same time some provide ART to about 150 clients as a response to the 3 by 5 WHO initiative (Mbabane Government Hospital VCT Report 2005). Nurses have to work longer hours due to the growing demand for services and also cover for staff shortage.

In 2004, the MOHSW with the assistance of WHO, conducted a situational analysis of health workforce. The report revealed gross staff-shortage; stating that there is imbalance between the supply and demand for nurses in the country; presently the ratio of nurses to population is 28:10 000. The inadequacy or staff shortage is demonstrated in Table 3.2 below which indicates the number of vacant posts in major hospitals in Swaziland. Some of these nurses have been deployed to newly established VCT centres attached to these hospitals.

**Table 3.2 Deployment of nurses in four major hospitals in Swaziland**

Hospital	Established posts	Available staff	Vacant posts
Mbabane Government Hospital	163	150	13
Piggs Peak Government Hospital	44	29	15
Mankayane Government Hospital	44	29	15
Hlatikulu Government Hospital	75	46	29

The situational analysis report concluded by pointing out that a policy framework does not currently guide human resource development in the health sector. Another factor that contributes to staff shortages is that some supervisors have not had any preparation for their roles; training in management seems to be *ad hoc*.

#### **3.4.1.3 Sub-Category 3: Nurses experience lack of social support**

Health workers enjoy working in a work environment characterized by an *esprit de corps* where team members are responsible for each other's comfort and well being. Social support has been



defined by many researchers including Gottlieb and Selby (1989) in Stewart (1993:5) who define it as "processes of interacting in relationships and social structures that shore up coping, esteem, belonging, and competence through actual or predictable exchanges of tangible or psychosocial resources." Coffman and Ray (2002:536) agree and define social support as an interpersonal process that is context specific and involves the exchange of information. Social support is composed of emotional and instrumental support that includes an advocative interpersonal process and results in improved mental health (Finfgeld-Connett 2005:4).

Some research participants communicated the need for social support. Feelings of isolation and sometimes dissatisfaction with the work were expressed. In some VCT centres the managers of facilities do the VCT centre is attached to scheduling. Nurses are changed once a year; trained on the job and after a year they are rescheduled to other departments. These nurses believe that social support may enhance positive client outcomes, job satisfaction and reduced levels of burnout. Following are some narratives from the nurses:

*"If the counsellor has problems, there is no structure set up for assisting her/him. It is like one has to shoulder all the problems for the clients and self.... sort them out, at the end of the day go home with that burden".*

*"Sometimes after dealing with a particular case, I just want to share my experience with someone, not mentioning names of course, someone to tell me I have done well".*

In her research Finfgeld-Connett (2005:4-9), whose purpose was to clarify the concept of social support, various studies were quoted that categorized social support into:

± **Emotional support.** This support is intended to alleviate feelings of stress, anxiety, hopelessness and depression often experienced by nurses working in VCT services. Sharing ideas and experiences, expressing concerns, and offering encouragement are some of the exchanges included in emotional support (Tichon & Shapiro 2003:89). Participants communicated a need for debriefing time or an Association where someone would call when in need.

*"I wish we had an association or an organization we would consult when we feel real burdened".* Coffman and Ray (2002:538) support this statement when declaring that comfort can be obtained with the knowledge that someone is available when needed. However, it is difficult for these nurses to develop lasting relationship as they are disbanded after a year and are deployed to different departments. Emotional support can also be in the form of visits to a different environment where minds are diverted from the every day work (Simich, Beiser & Mawani 2003:875).

•4 **Instrumental support.** This is described as providing tangible support. In one VCT centre, once a year the nurse counsellors are given a mini-bus to visit Mozambique or South Africa to do some little shopping and each nurse is given a token of E120.00 to spend. One nurse shared the following:

*"Last year we went to Maputo for a weekend, it was great; we forgot all about our clients. It was wonderful interacting with each other outside the work environment".*

Social support is said to be esteem enhancing in providing stress-related interpersonal aid. It is empowering to the recipient and a form of advocacy (Coffman & Ray 2002:537; Stewart 1993:7). Jenkins and Elliot (2004:623) affirm that social support is beneficial to the well being regardless of the level of stressors to which individuals are exposed, by meeting important human needs, for security, social contact, approval, belonging and affection.

#### **3.4.1.4 Sub-category 4: Lack of a supportive practice environment**

The participants in this study reported a need for a supportive practice environment. It was apparent that they perceived a lack of activities that included interactions towards emotional support for esteem enhancing (Heller, Swindle & Dusenburg 1986 in Stewart 1993:5). Masiow (1954) in Swansburg and Swansburg (1999:485) declared that nurses want to experience acceptance, friendliness and a feeling of belonging. Additionally, these nurses wished for a professional nursing practice environment that had the following traits identified by Flynn, Carryer and Budget (2005:68).

- > Professional autonomy; defined as the right or opportunity to take actions or make independent decisions within the scope of nursing practice.
- > Collaborative relationship with physicians.
- > Access to resources needed to provide high quality care. Resources include adequate personnel, equipment, budget and time.
- > Organizational support which includes the presence of supportive managers, continuing education opportunities and opportunities to provide input into policy decisions.

Cutrona (1990) in Stewart (1993:3) contends that "*dimensions of support include emotional, esteem (appraisal), tangible (instrumental) information, and social integration with functional support (types of resources).*" Flynn et al (2005:69) concur that organizational attributes of a professional practice environment consist of decentralized decision making, interdisciplinary collaboration, adequate resources (staff, equipment and funding), and managerial support. These attributes are essential to the nurses' ability to perform complex functions and provide high quality client care. It is imperative for VCT centres to create and sustain professional practice environments that are characterized by better outcomes for both clients and staff. Such an environment is associated with job satisfaction and lower levels of burnout. Health workers are exposed to suffering of AIDS clients daily; it is not a normal situation, and it is not something these VCT services nurses should have to cope with without support.

#### **3.4.1.5 Sub-category 5: Nurses expressed staff development needs**

The nurses at the VCT services are uniquely affected by HIV/AIDS; because of such a situation, a need for increased knowledge about it was expressed. The participants recognized that they are at different levels in performing their duties. According to Sullivan and Decker (2005:268), nurses may receive preparation for duties, yet some people will not have developed all the skills and knowledge necessary to perform at the expected level as expressed by the following excerpts

*"We did introduction to counselling at college but I wish there was some refresher course before being expected to do this counselling".*

*"I do not feel competent to do this job; I hope there will be some workshops to upgrade us".*

*"We were trained for one week, I am enjoying what I am doing now, however, I wish I would advance to a diploma or degree in counselling".*

As knowledge about HIV/AIDS is evolving, nurse counsellors must be continually up-dated through continuing education programmes or staff development programmes. Staff development is important for nurses so that they may achieve career and job satisfaction. Swansburg and Swansburg (1999:174) state that to be successful in their careers, professional nurses need a sense of personal fulfilment and job significance that they are growing as persons. Staff development assists in correcting anxiety and uncertainty; inability to meet personal and organizational goals, dissatisfaction with human relations and being overworked or underutilized (Swansburg & Swansburg 1999:174).

Providing physical and emotional care to PLWHA is stressful to nurses. The stress may be compounded by the nurses' feelings of deficiencies in AIDS specific training that leads to insufficient and inadequate knowledge on HIV/AIDS care (Smit 2005:23). This author continues to state that, as nurses perceive themselves to have inadequate knowledge, they then see themselves as incompetent, which results in apprehensive feelings when confronted with HIV/AIDS clients. A significant knowledge base is required for the achievement of quality care at VCT services.

The nurses who have worked for sometime at VCT services and have gained some skills have a sense of accomplishment. These are the nurses who wish to advance in the counselling career. These nurses believe educational programmes on HIV/AIDS should be incorporated into basic and post-basic curriculum and continuing education programmes which would lead to the development of a cadre of supervisors who are counsellors.

Following is the theme, category and sub-category for clients.

**Table 3.3 Theme, category and sub-category for clients**

<b>Theme</b>	<b>Category</b>	<b>Sub-category</b>
Constant experience of stress	Psychological reasons	Clients experience stigmatization and discrimination

#### **3.4.1.6 Sub-category: Clients experience stigmatization and discrimination**

A major concern for all the clients that were interviewed was stigmatization. It was communicated that they felt depersonalized at VCT centres. This state is confirmed by reports on impact of HIV/AIDS by the MOHSW where communities highlighted stigma and rejection by all, including health workers (MOHSW 2006:10). Stigmatization in Swaziland stem from the belief that the infection is due to promiscuity or personal irresponsibility (Whiteside, Hickey, Ngcobo & Tomlison 2003:6). The following are excerpts from interviews with clients.

*"I was thirsty and asked to go and take water in the kitchen, the nurse told me to use the bathroom tap.*

*"I heard one nurse telling a colleague that she works with labaneligciwane (those with the germ or virus). They use derogative words when referring to us."*

HIV/AIDS related stigma is widespread and everywhere and it manifests itself in different ways. The MOHSW (2005:18) report, states that there is high awareness about HIV/AIDS in Swaziland but individuals are still stigmatized. Sometimes this state is fuelled by the behaviour of certain individuals or the media when portraying situation of hopelessness where else some PLWHA are living longer and productive lives.

Discrimination is a common occurrence at VCT centres. This is done in very discrete ways such as segregating equipment and little touching if any. In some societies PLWHA are sometimes seen as shameful because the infection is associated with unacceptable behaviour. Clients narrated the following excerpts:

*I have learnt not to shake hands with nurses as they simply ignore your hand".*

*"There are two scales at the centre; one for clients and one for nurses whom I suspect come for VCT services also".*

*"Weak clients are assisted by relatives on the scale the nurse only reads and record the weight without touching or helping clients".*

Because of discrimination, clients have kept their positive status a secret, which has led to defaulting on treatment. Though societal panic about AIDS has diminished, stigma and discrimination are still pervasive in Swaziland (MOHSW 2006:10). Research indicates that HIV/AIDS is as much about societal phenomena as about biological and medical concerns. The consequences of stigma and discrimination have prevented PLWHA from seeking or obtaining the health care and support they require.

This concludes phases 1 and 2 of the modified Intervention Research by Rothman and Thomas (1994). It consisted of data analysis of findings that emerged from interviews with nurse counsellors and clients at VCT services in Swaziland.

### **3.4.2 Category 2: Physical reasons for constant experience of stress**

The body reacts to stressors by initiating a complete sequence of innate responses to a perceived threat. A variety of physiological changes occur in the body such as increase in metabolism and air passages to the lungs when one is stressed (Marieb 2004:537). Chronic stress demands continuous adaptive efforts which may lead to the development of physical reactions (Atkinson et al 1996:488). Stanhope and Lancaster (2006:635) state that nursing is among the first 10 occupations with the most injuries and illnesses involving days away from work. The U.S. Department of Health and Human Services statistics indicate that there is influence of work on health (2000). Workplace hazards include biological and psychological agents (Roger 2003:32).

#### **3.4.2.1 Sub-category 1: Constant exhaustion**

Exhaustion is defined as the state of being very tired (*Oxford Advanced Learners Dictionary* 2005:403). Wolman (1973:131) defines exhaustion as a state of depleted metabolism rate resulting in fatigue and low responsiveness to stimulation. This means that the ways used to cope with the stressor have been used up. If adaptation has not overcome the stressor, the stress may spread to the entire body (Kozier et al 2004:1015).

Continued exposure to stressors drains the body of its resources and lead to exhaustion (Baron 1996:409). During exhaustion the body's capacity to cope with stress is depleted and susceptibility to illness increases dramatically. Exhaustion can also be a symptom of counter transference where the nurse may exhibit inappropriate emotional responses towards a client such as exaggerated anger (O'Brien et al 1999:58). Nurses reported that because of the long queues of VCT services they are often tired, which results in low responsiveness to stimulation. With reduced stimulation nurses became ineffective in their work. Following are some of narratives from nurses:

*"Most of the days I go home very tired and I come back to work the following day still tired".*

*"I find myself often tired and unable to sleep which makes me feel ineffective in my work".*

#### **3.4.2.2 Sub-category 2: Development of medical conditions**

Stress can have physical, emotional, intellectual and social consequences. The effects are often mixed because stress affects the whole person (Kozier et al 2004:1014). Physically stress can threaten a person's physiologic homeostasis. Stress may also have a direct effect on the immune system. Physical illnesses, such as peptic ulcers, hypertension coronary heart disease and migraine headaches can be consequences of chronic stress. A study in Kenya on challenges facing the Kenya Health Workforce indicates that 40% of absenteeism in nurses working in VCT centres was related to illnesses (<http://64.233.161.104/search?q=cache:ch9SZufQ.../AIDS,+stress&hl=en&ct=clnk&cd=23&ie=UTF-6/6/2006>). Some nurses said:

*"I have experienced headaches frequently; I have also been on sick leave more than once as the doctor suspected a clot in my brain".*

*"Since I started working here, I have been sick frequently than before."*

### 3.6 CONCLUSION

In this chapter the researcher discussed the findings that emerged from the data analysis of the nurse counsellors rendering services and clients who receive these VCT services.

The findings were compared to existing literature sources in an effort to confirm findings. The categories were as follows:

#### Nurses

- > These expressed experiencing constant stress and emotions in working with a complex condition and staff shortage.
- > Nurses experienced lack of a social supportive environment and social network
- > Staff development needs were expressed for skills development and career advancement.

#### Clients

- > Findings indicated that clients experienced stigma and discrimination.

The phenomenological interviews and field-notes in this study and supported by literature, confirm that nurses and clients have concerns related to VCT services. The findings revealed that working in VCT services is stressful, and thus there is need for development and description of an empowerment programme. Nurses do need to be empowered to develop competences for delivery of quality care and job satisfaction. Kinlaw (1995:65) states that empowered workers are happy and productive.

In chapter 4 the researcher will present phases 3 and 4 of the modified Intervention Research proposed by Rothman and Thomas (1994). The operations of Phases 3 and 4 that will be dealt with in this chapter are **specifying procedural elements of the intervention, developing a prototype or preliminary intervention and applying design criteria to the preliminary intervention concept**. This section consists of the development of a support programme for nurses working in VCT services in Swaziland.



## CHAPTER 4

### PHASE 4: DESIGNING AN OBSERVATIONAL SYSTEM

#### *Development of an empowerment programme for nurses working in VCT services in Swaziland*

#### 4.1 INTRODUCTION

In chapter 3 of this study, findings from data analysis were discussed in details. The theme, categories and sub-categories emerged; highlighting perceived concerns and needs of nurses working in VCT services in Swaziland. Nurses stated that they felt disempowered and lacked a supportive environment, hence the need for an empowerment programme.

This section of the chapter discusses the design of an empowerment programme for nurses working in VCT services. Mullen (in Rothman & Thomas 1994:33) states that, the design stage of the Intervention Design and Development Model is a purposive planned change: one of several alternative processes leading to the development of a social intervention. The author continues to say, that there are many design methods for programme development, however, the problem-solving model is the one often used by professionals to describe the process of intervention, as will be done in this study. The selected operation in phase 3 of the intervention research is **specifying procedural elements of the empowerment programme**.

Rothman and Thomas (1994:175) declare that summary statements formulated from research findings and theoretical work give direction to specifying procedural elements of the intervention. These authors also state that *"having acquired information from the knowledge base, it is necessary to manipulate that information in some meaningful fashion, to convert it into a form that will yield workable design concepts (1994:172)"*. These authors continue to state that the researcher must articulate in sufficient detail the product in order to be usable in the real world.

The following section focuses on empowerment as the major tool for intervention that leads to competence.

## 4.2 CONCEPT SELECTION

A concept is defined as an idea or a principle that is connected to something (the *Oxford Advanced Learners Dictionary* (2005:299). According to Chinn and Kramer (1995:78), a concept is a complex mental formulation of experiences. While Reed, Shearer and Nicoll (2005:12) define a concept as an abstract idea expressed in words; a generalization from observed events which may range from a single word to several sentences, to paragraphs. A concept can have a varying degree of abstraction; it can move from being empiric to being abstract on a continuum, and it is often formed from encounters with perceptible reality (Chinn & Kramer 1995:75).

At the beginning of this research, the researcher felt that nurses were disempowered. The research findings also revealed that nurses were disempowered and needed empowerment. Empowerment is the concept selected in this study.

Empowerment is a highly abstract concept, constructed from multiple sources of direct or indirect evidence as it cannot be observed, however links have to be made from symbolic concepts to concrete phenomenon (Mashele 2003:54). In this study, the researcher will clarify and develop constructs and a conceptual definition of empowerment.

### 4.2.1 Dictionary definitions of empowerment

The word "power" comes from the French word "pouvoir", meaning to be able (Zerwekh & Claborn 2006: 27). Thus the terms "empower" means to enable or to give authority [*Oxford Advanced Learner's Dictionary* 2005:421).

The *Concise Oxford Dictionary* (1991:384) defines empower as to give power to; authority to, make able.

"Empower" according to the *Collins English Dictionary* means to give or delegate power or authority, to enable or permit.

Webster cited by Turner (1996: 224) defines "empower" as: to give power or authority; to give ability to; enable; permit.

The *Collins English Thesaurus* (2004: 187)) defines "empower" as to authorize, enable, equip, emancipate, give means to, allow, commission, qualify, permit, entitle and delegate.

#### 4.2.2 Subject usage of empowerment

The above-mentioned definitions imply that power can be given to another person or self (Zerwekh & Claborn 2006: 28). According to Kinlaw (1995:65), human beings have a natural desire to fashion intentions and control outcomes; this is termed empowerment. This author continues to state that the full meaning of empowerment can only be realized when understanding that it is a process by which something quite new is being created.

Empowerment means embarking on a **process** that leads people to discover **competences**, create **new competences**, and find new ways to apply these competences in all encounters in their lives ( Kinlaw 1995: 7). This is a process whereby individuals feel **increasingly in control** of their own affairs (Arnold & Underman Bogg 2003:145; Hitchcock, Schubert & Thomas 1999:218).

Parson (1991) in Campton, Galaway and Cournoyer (2005:238) describes empowerment as an **active process** through which individuals become **strong enough to participate** in, **take control** of, and **influence institutions** and events that affect their lives. Empowerment is also exercising **psychological control** over **personal affairs** as well as **exerting influence** over the course of events in a socio-political arena (DuBoise & Miley 1996:26). According to Turner (1996:219), the empowerment approach is a unifying framework that presents an integrative approach to meeting the needs of members of certain groups such as the nurses working in VCT services in Swaziland.

Empowered nurses will **acquire information and skills** necessary for informed **decision making**.

Characteristics of empowerment identified by Stanhope and Lancaster (1994:478) include:

- > **Decision making and problem solving skills**
- > **Access and control** over needed resources

- > **Acquisition of instrumental behaviour** needed to interact effectively with others

During the empowerment **process**, nurses will be assisted to uncover their own inherent abilities, strengths, vigour, wholeness and spirit (Smith & Maurer 1995:7). Turner (1996:225) agrees and identifies the following as interlocking dimensions of empowerment:

- > The development of a more positive and potent sense of self.
- > The construction of knowledge and the capacity for more critical comprehension of social and political realities of one's environment.

Hitchcock et al (1999:222) provide a comprehensive summary of empowerment when stating that it *"provides new ways of being, doing and living"*.

Individuals can be helped to mobilize power with the following intervention methods identified by Campton et al (2005:238):

- > Enhancing self-awareness - nurses and clients may not understand that their behaviour, including thoughts and feelings may contribute to the problem. On the other hand, their strength may be used in problem solving through the technique of **feedback**.
- > Accessing information - nurses need to acquire information pertinent to their practice or environment. There is an old adage which says, information is knowledge, knowledge is power and power is freedom.
- > Securing resources - The capacity of both nurses and clients to solve problems lies on how they interact with the environment to acquire what they need.
- > Strengthening of social skills - Knowledge about communication processes is an empowering technique where support to others may be provided (e.g. listening and expressing understanding).
- > Facilitating decision making - Decision-making is a logical problem solving process which involves risks and responsibilities. Due to lack of experience nurses and clients may not be able to do this without the assistance of a skilled and experienced individual.
- > Finding meaning - Often nurses and clients feel helpless, hopeless and pessimistic; assistance in finding meaning in life is an empowering endeavour.

### **4.2.3 Benefits of empowerment**

In the practice of empowerment there are benefits or pay-offs resulting from the changes in behaviour of individuals. Kinlaw (1995:73) identified the following as benefits of empowerment; namely:

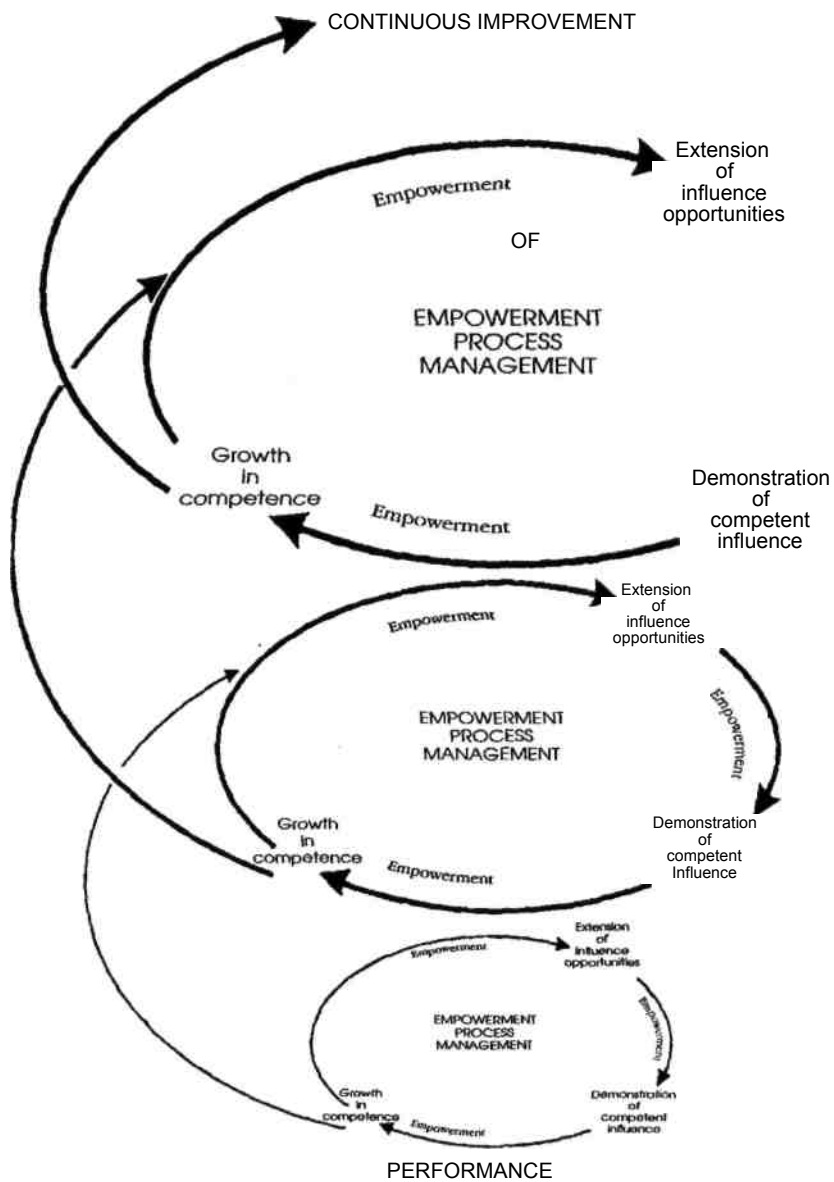
- > More contacts and interactions across the vertical and horizontal dimensions of an organization.
- > More self-initiated actions by individuals and teams.
- > More challenging or confronting of policies, practices, decisions and ideas.
- > More feedback among individuals across the boundaries of organisational units.
- > More investigation, inquiry and experimentation.
- > All these lead to improvement in the work environment, work processes and quality outputs.

Empowerment, according to Kinlaw (1995:65), should evolve and move from lower to higher levels of strength and opportunity. Empowerment is an active process that is cylindrical, self-reinforcing and self-enhancing. This author continues to say that empowerment should also progress through the following steps:

- > Define and communicate the meaning of empowerment within the specified context.
- > Set goals and strategies that become the framework for empowerment of a particular organization.
- > Train individuals to fulfil new roles that are consistent to goals and objectives.
- > Adjust the structure and system so that there is reduction in bureaucracy, creation of greater autonomy and freedom to act.

### **4.2.4 Explanation of growth of empowerment (adopted from Kinlaw 1995:66)**

The empowerment process for nurses is structured in three levels arranged in a cylindrical manner as demonstrated in figure 4.1; namely:



**Figure 4.1**  
**Diagrammatic representation of growth of empowerment**  
**Source: Kinlaw 1995:66**

- > Extension of influence opportunities.
- > Demonstration of competence in influence.
- > Growth in competence.

#### **4.2.4.1 Attributes of empowerment**

Attributes of empowerment are defined as qualities or features of a particular phenomenon (*Oxford Advanced Learner's Dictionary of Current English 2000:63*). The definition of empowerment by various authors emphasized certain qualities and features that the researcher saw repeatedly. These were identified to be the defining attributes of the concept empowerment. The following table (table 4.1) indicates these attributes of empowerment.

**Table 4.1 Attributes and outcomes of empowerment**

<b>Attributes</b>	<b>Outcomes</b>
> Process	> Increased control
> Active	> Acquisition of instrumental behaviour
> Integrative	> Self-awareness
> Unifying framework	> Finding meaning
> Growth is cylindrical	> Strengthening social skills
> Construction of knowledge	> Securing resources
> Control	> Competence
> Self-reinforcing	
> Integrative approach	
> Authority	
> Accessing information	

The following table indicates the final attributes identified in the empowerment process of nurses working in VCT services. Here a reduction strategy was used to develop the attributes and outcomes of the empowerment programme.

**Table 4.2 Final defining attributes**

Level	Procedure	Dynamics
1. Interactive processes	Facilitation in an enabling environment	Self-awareness  Internalization processes  Coping and problem solving
2. Reflective learning and feedback	Defining meaning of empowerment and information sharing	
3. Competency development	Development of competency skills or processes	

**Level 1.** At this level the empowerment process is based on interaction between facilitators and participants. The facilitator, who is a skilled manager, university lecturer or nurse, creates an enabling environment that enhances relationship building among participants that leads to self-awareness.

**Level 2.** Participants are engaged in reflective learning and feedback. Internalization of shared information occurs, empowering the nurse to better understand self and the environment at VCT services.

**Level 3.** As the process continues there is growth in competence and development of new skills such as problem solving and coping. There are new behaviours due to an increase in self-confidence and greater freedom of mental movement that stimulate curiosity, inquiry and learning so as to render quality care to clients at VCT services.

#### **4.2.4.2 Antecedents of empowerment**

Antecedents are defined as events that exist before the occurrence of the concept (Oxford Advanced Learner's Dictionary 2005:40). Antecedents are used to identify underlying assumptions of the concept identified. These cannot be attributes of the concept since they are the determinants of the occurrence of the concept (Strauss and Corbin 1998: 106). Antecedents are identified through tracking relationships back to the data to validate the categories that led to the construction of the concept (Walker & Avant 1995: 45). The following antecedents of empowerment were identified from the data:



- > The agents for empowerment must understand that human beings have a natural desire to fashion intentions and control outcomes.
- > In empowering nurses, the agents must respect the experiences of the nurses at VCT services.
- > All people in the empowerment process must develop self-awareness that will lead to openness, relation building and trust.

#### **4.2.5 Definition of empowerment in this study**

Empowerment is a continuous activity where nurses are provided with authority and support that will enable them to identify opportunities for growth. Empowerment is self-enhancing and interactive. Nurses will develop social skills through accessing information and securing resources that will facilitate decision-making.

This cylindrical process begins with self-awareness, which leads to growth and the construction of knowledge and competence, and the capacity for comprehension of social and political realities of the environment.

#### **4.2.6 Classification of concepts that form the empowerment programme for nurses working in VCT services**

In developing the empowerment programme for nurses working in the VCT services, the following aspects of activities proposed by Dickoff, James and Wiedenbech (1968) in Nicoll (1986:435) will be used.

##### **> Agent**

An agent is identified as a person or thing that has varying kinds of influence that act as precipitating causes of events (Wolman 1973:15). Stanhope and Lancaster (2006:215) emphasize that an agent's role is to gather and analyze facts and implement programmes. The agents in this study are the empowerers or facilitators; who are nurses trained, experienced and skilled in facilitation processes and in HIV/AIDS issues. The facilitators will define the meaning of

empowerment, set goals and strategies, and train the nurses through reflective learning and feedback that enhance **self-awareness**. Nurses will develop competences in dealing with HIV/AIDS issues.

> **Recipient**

Recipients are the nurses working in VCT services who will receive the empowerment process that will enable them to cope with situations at work and grow in competences such as problem solving.

> **Framework**

The context in this study is HIV/AIDS and the associated complexities such as its transmission, lack of cure, stigma and death of clients and nurses and the impact these have on VCT services in Swaziland.

> **Procedure**

The procedure entails the how of the empowerment of nurses. It involves facilitation by the skilled nurses and the nurses who will receive the empowerment process. The steps of the procedure are; (1) defining and communicating the meaning of empowerment, (2) setting of goals and strategies and, (3) training through reflective learning and feedback.

> **Dynamics**

The dynamics will be psychological, through interactive processes of self-awareness powering, nurturing, relationship building and trust. Nurses will identify the self and the environment which will result in a positive feeling or "adaptedness" (Turner 1995:390).

> **Terminus**

This relates to the end point or boundary of the empowering process and the results thereof. The focus of the empowerment programme is the development of growth in competence in problem

solving at VCT centres that may produce quality of care and job satisfaction. These may lead to adjustment of the organizations' structure and system.

Figure 4.2 is a conceptual diagram of empowerment for nurses working in VCT services in Swaziland. The nurses' environment is impacted upon by the various drivers of HIV/AIDS in Swaziland, which lead to the experience of constant stress. This stress is caused by psychological and physical factors. The context of empowerment concerns the influence of the agent over that recipient by utilizing the process. An enabling environment is created. The dynamics involve interactions that lead to self-awareness, which results in adaptedness and competence.

In summary, the researcher realized that empowerment is a broad concept. Kinlaw (1995:26) asserts that it can be found within the political, social, educational, and organizational realms in which the fundamental meaning is giving people greater influence. Empowerment in all spheres is intended to ensure success and continuous improvement; be it in individuals, families and communities that will eventually impact on Swaziland and reduce the incidence and drivers of HIV/AIDS.

Empowerment is viewed by Nokelainen and Ruohotie (2003:148) as a relational concept with individuals possessing a sense of authority and control. With empowerment, there are benefits or pay offs such as interactions, communication and self initiated actions. In empowered individuals, life and work become meaningful and enjoyable (Jooste 2003:233).

The process of developing an empowerment programme for nurses working in VCT services in Swaziland is discussed in the next chapter.

SWAZILAND

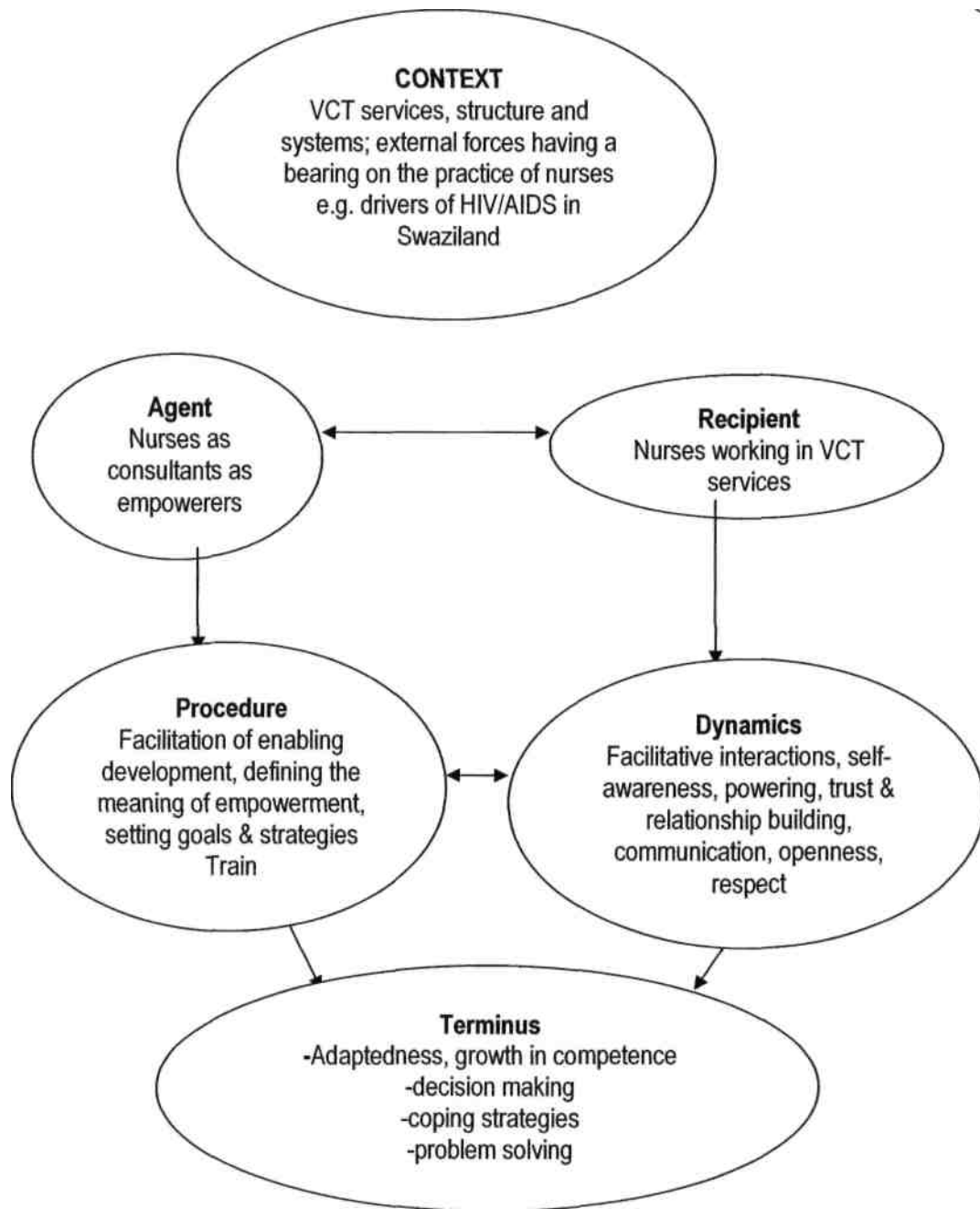


Figure 4.2

Conceptual diagram for the empowerment of nurses working in VCT Services in Swaziland

### 4.3 CONCLUSION

In this chapter, discussions focussed on the development of an empowerment programme. Empowerment was the concept selected. Discussions of empowerment included definitions, subject usage, attributes, antecedents and benefits. A concept diagram was used to clarify the process of empowerment.

## CHAPTER 5

### PHASE 5: EARLY DEVELOPEWNT AND PILOT TESTING

#### *Description of an empowerment programme for nurses working in VCT services in Swaziland*

##### 5.1 INTRODUCTION

A programme is defined by Collins English Dictionary (2004:439) as a plan or a schedule of doing things or embarking on an activity.

Programme development is defined by Rothman and Thomas (1994:20) as a process that is systematic, deliberate and varies greatly according to specific human needs. Programme development is part of staff development which greatly contributes to maintaining and developing the competence of nursing personnel (Kelly 1992: xiv). In developing a programme, it is important to articulate in sufficient detail the product in order to be usable in the real world (Rothman & Thomas 1994:67). According to Strickland and Fishman (1994:67) dramatic changes are taking place in health care and roles and responsibilities of nurses are different.

The research findings revealed that nurses working in VCT services experienced constant stress caused by psychological and physical factors. Developing an empowerment programme therefore is the best option to assist these nurses to attain the competence in their work that will lead to rendering of quality care and job satisfaction. Chinn and Kramer (1995:106), contend that the description of a programme consists of certain steps or components. These authors continue to emphasize that the researcher must answer some questions that assist in the description of a programme. The answers include information on the purpose, the concept, definitions, structure and assumptions. These will be described later in this chapter.

The following section is a description of the empowerment programme of nurses working in VCT services.

## **5.2 PROGRAMME STRUCTURE**

The empowerment programme for nurses working in VCT services in Swaziland comprises of the following:

- > Purpose of the programme
- > Programme assumptions
- > Participants of the programme

### **5.2.1 The purpose of the programme**

The programme's purpose is to provide a conceptual framework for the empowerment of nurses working in VCT services. The major goal for the programme is to reduce stress presently associated with VCT services and render quality care. As an empowerment programme, it adopts the ecological perspective, which endeavours to appreciate and understand people in their environmental context, described as the person-in-situation (Longclaws in Campton et al 2005:361).

**Ecology** refers to the study of patterns of interactions and relationships between and among organisms and their environment (Turner 1995:360). The ecological framework assists in organizing information about people and environment. People strive to fit-in with their environment. Turner (1995:390) describes the positive feeling of individuals when they view the environment resources as responsive "adaptedness". This author continues to say "*adaptive person - environment exchanges reciprocally support and release human and environmental potentials*". Stress may result if there is a perceived imbalance between environmental demands and capability to manage them with internal and external resources (Campton et al 2005:361). However, individual's attributes and situational elements such as societal preparation and empowerment for coping may relieve the stress as a good fit, between the internal and external demands and resources occur (Turner 1995:391).

With the empowerment process in place, adaptedness will be realized; nurses will learn new skills and behaviours for positive outcomes.

### **5.2.2 Programme assumptions**

In chapter 2, the researcher stated that assumptions are based on beliefs and values about health, the nurse and the environment. The assumptions this programme is based on, have been taken from Parse's theory of Human Becoming as indicated in the paradigm perspectives in chapter 1. In this programme:

- > The human being coexists while interacting with the environment in a reciprocal relationship.
- > The human is an open being, freely choosing meaning in situations.
- > Powering is a way of revealing and concealing imaging where the individual may find new ideas regarding future possibles in dealing with VCT services.
- > Participants should adopt an open and willing attitude for leaning and change.
- > Facilitators can facilitate the empowerment process which will enable both nurses and clients to find alternatives in dealing with encounters of stressful situations such as illnesses and dying of nurses and PLWHA. Nurses will learn to cope positively, solve problems and create positive working practice environment. Clients will interact with nurses towards positive and productive lives.

### **5.2.3 The participants of the programme**

This is an empowerment programme for nurses working in VCT services; however, other stakeholders will be invited to enhance interactions, learning, and growth. Participants for the programme will include:

- > Nurses working in VCT services
- > Supervisors and managers of agencies with VCT services
- > Clients receiving VCT services



It is important to include the people with whom to collaborate as they represent the population whose issues and problems are of interest to themselves, researcher and society (Rothman & Thomas 1994:29). The managers and representatives of nurses, clients and MOHSW will effect participation as these are the gate-keepers who control access to settings and individuals. Moreover, their collaboration provides a sense of ownership of the programme. According to Archer, Kelly and Bisch (1984:22-23), the collaborative processes stress the need for continuous and active involvement of the people who will be affected by the outcomes of the programme. The inclusion of these participants will generate vision, trust and ownership, which are identified as key principles that underpin the success of programme, and how these are engendered in the stakeholders ([Vitalplaces.com](http://Vitalplaces.com)). Kinlaw (1995:27) agrees that inclusion of these creates clarity on the empowerment process so that full and unqualified support is given.

Continuing education programme often consist of manageable group sizes of 15 to 20 people. Facilitators create a physical environment that is conducive to learning, and attend to the interpersonal aspects and characteristics of the adult learner (Kelly 1992:245). Such a learning environment has elements that contribute to continued professional growth. The dynamics of the group depends on facilitators who are conversant with group processes. Group processes include forming, storming, norming and performing which affect activities, interactions and sentiments; resulting in productivity, development and satisfaction (Sullivan & Decker 2005:159).

Changes that occur in health care delivery systems are often accomplished by group action as this has a number of advantages over actions taken by individuals (Clark 2003:281). Group work is important for consciousness - raising. The greater range of knowledge or expertise of group members provides a broader base from which to derive solutions to health problems (Stanhope & Lancaster 2004:554).

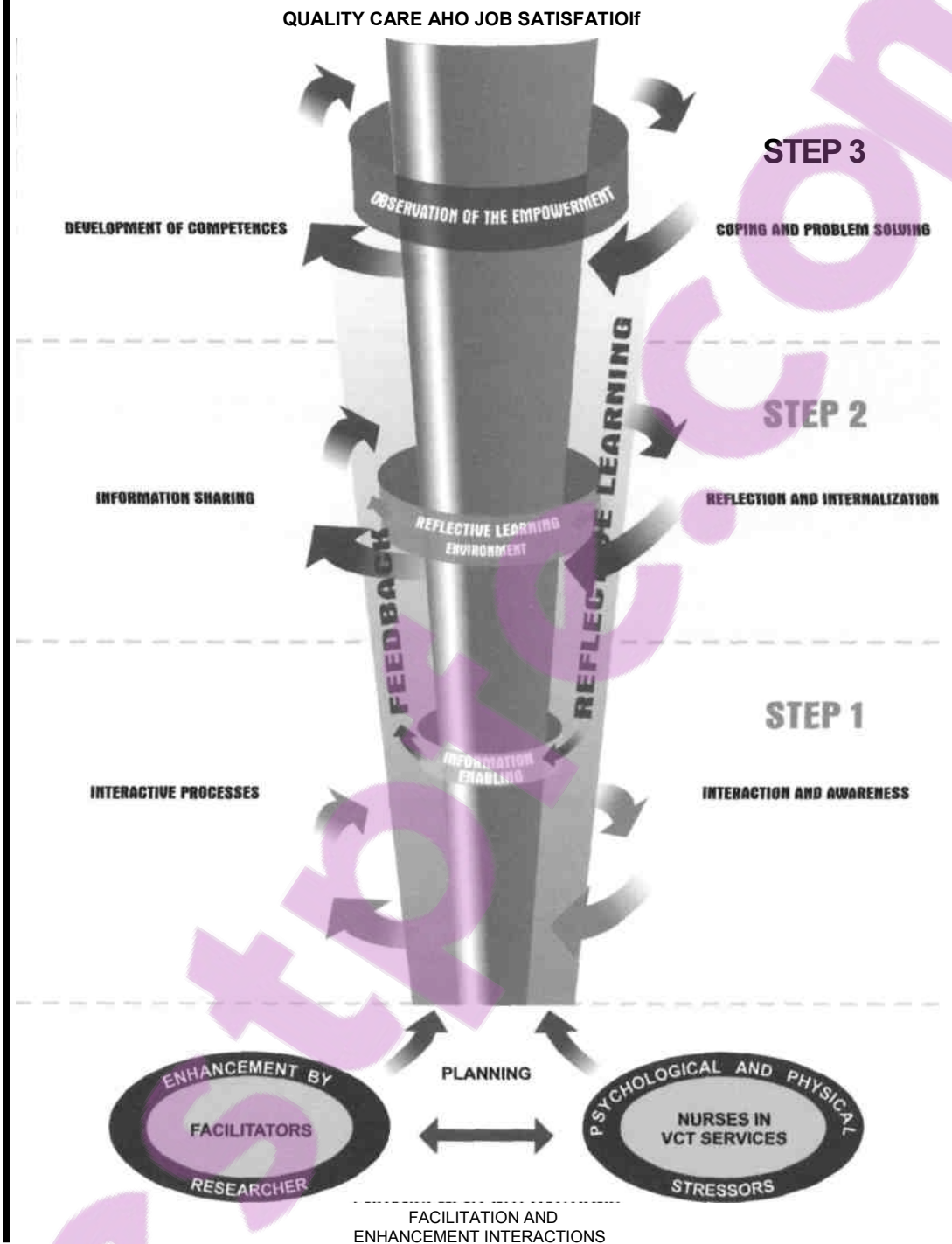
Following is the structural description of the programme.

### **5.3 OVERVIEW AND STRUCTURAL DESCRIPTON OF THE PROGRAMME**

Figure 5.1 is a structural representation of the empowerment programme for nurses working in VCT services. The oval structures at the base of he empowerment cylinder represent he following:

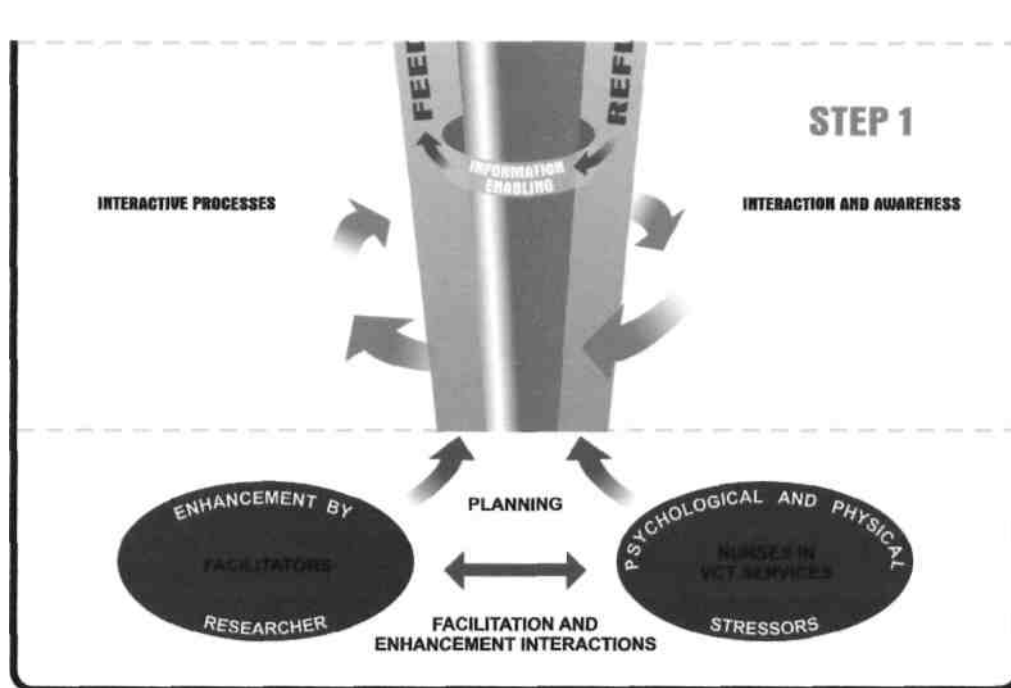
- > On the right is the environment in which the nurses experience constant stress from psychological and physical factors that lead to disempowerment.
  
- > The last structure represents the researcher interacting with facilitators where facilitators are enhanced with facilitation strategies from different sources.

The enhancement of facilitators is effected through the use of information obtained during identifying successful designing observational systems and specifying procedural elements of the empowerment programme such as feedback and reflective learning.



**Figure 5.1**  
*An empowerment programme for nurses working in VCT Services in Swaziland*

The operational levels in the empowerment process of nurses are congruent with Kinlaw's growth of empowerment model (1995:66). The programme begins with enhancement of facilitators by the researcher who identifies the psychological and physical stressor of nurses. Planning involves letters of invitation and objectives of the programme.



**Figure 5.2**  
**Interactive processes**

The first level is the initial step where facilitators plan the execution of empowerment process. The focus of this programme is illustrated by a bold cylindrical structure originating from the facilitators (trained and skilled managers, nurses or university lecturers) who are the initiators. Small arrows encircle the cylindrical structure indicating movement of activities that illustrate synergic opportunities inherent in the process in interactions, engagement and awareness. Kinlaw (1995:66) identifies this initial level of the empowerment as the extension of influence opportunities.

Activities begin with facilitators planning the execution of the employment process. Nurses and stakeholders are invited to an awareness workshop about the programme to empower nurses working in the VCT services in Swaziland. A workshop is considered to be one of the most effective methods even devised for group learning (Mellish, Brink & Paton 2000:172). The nurses

at VCT services are assumed to be dis-empowered and need empowerment to enable them to deal with stress.

An enabling and informative environment is created by facilitators. The process of empowerment at this level is depicted by the arrows moving in a circular upward manner indicating meaningful interaction between nurses and stakeholders.



**Figure 5.3**  
**Information sharing**

The second step of empowerment in the structure is again depicted by circular arrows encircling the bold cylinder, indicating a reflective learning environment. Participants of the empowerment programme review practices and look back on past experiences at VCT services while learning and reflecting on the meaning of these individuals will begin to undertake some initiatives that indicate a certain level of empowerment with self-managed feedback that facilitate dealing with identified psychological and physical factors.

The sides of the cylindrical structure are anchored by rein forcers that depict feedback and reflective learning that occurs at this level.



**Figure 5.4**  
**Development of competences**

The final structure indicates growth. Again and again the circular arrows indicate an upward movement representing movement from opportunity to demonstration of competence influence and new growth in competence (Kinlaw 1995:66). The arrows depict development of competence leading to growth in competence which is the goal for the empowerment programme. The arrows indicate increase in knowledge, coping strategies and ability to problem solving. These result from the ability to integrate learnt information through feedback and reflection that leads to making informed choices (Taylor 2000:4). The brightness at the top of the cylindrical structure signifies the end-points of the activity where nurses have developed new competences through the empowerment process.

Rothman and Thomas (1994:161) emphasize that specific guidelines should be formulated for effective implementation of the empowerment programme. These will be described in chapter 5 of this study.

Following is a detailed description of the empowerment process.

#### **5.4 THE EMPOWERMENT PROCESS OF THE PROGRAMME**

The empowerment programme for nurses working in VCT services in Swaziland focuses on empowering nurses and clients with psychological and physiological competences for their well being and for delivery of quality care while in partnership with various structures.

The Intervention Design and Development framework used in this study is based on the assumption that research findings can be converted into social interventions, hence the development of this programme (Rothman & Thomas 1994:12). The design of the programme is a problem-solving endeavour which includes search for existing knowledge or development of new knowledge and specification of alternatives (Glaser, Abelson & Garrison in Rothman & Thomas 1994:164). The design requires explicit involvement with the people who will be implicated in the practice implementation of the programme (Thomas in Rothman & Thomas 1994:428). The empowerment process is discussed according to the following:

- > Creating informative and enabling environment
- > Internalization processes or competent influence
- > Growth in nurses' competence

##### **Level 1            Creating informative and enabling environment**

At this level, the focus is on engaging all stakeholders and creating interest in the programme as these are the 'users' who will facilitate the implementation of the intervention activities (Rothman & Thomas 1994:12). Kinlaw (1995:35) concurs with these authors when stating that the initial step in an empowerment programme is full and open communication with everyone affected to gain commitment. It is envisaged that the programme will facilitate problem-solving by nurses at VCT services while creating trust on them to do the right things.

The goal of this level is interaction and self-awareness by participants through interactive processes. Facilitators identify the setting for the programme that are congruent to the learning philosophy identified. The philosophy can be empiricism or interpretivism. Settings often have profound effects on group behaviour in meetings (Toseland & Rivas 2001:178). The learning

environment must be conducive to learning, where the facilitators encourage the individuals in participatory learning within identified theories such as the Critical and Humanistic Theories of learning (Stanhope & Lancaster 2001:298-304). The Critical theorist encourages on-going dialogue while the Humanistic theorist (favoured in this programme) states that learners should be encouraged to examine feelings while engaging in self-expression and value clarification (Driscoll 1994:38). In promoting self-awareness, facilitators encourage participants to explore both the inner and outer sense of self. According to Burnard (1992:26 ), the inner experience is how one feels inside, that is, thinking, feeling, sensing and intuiting where else the outer experience is all that other see of us such as eye-contact, dress, movement, and proximity to others. Burnard (1992: 29) identify the following as reasons why self-awareness is necessary:

- > To enhance self understanding
- > To allow acceptance of others
- > To enable self to handle difficult situations
- > To increase conscious use of the self
- > To enable self monitoring
- > To enhance personal autonomy

Self-awareness will enhance group work in the empowerment process. Rogers (1970) in Turner (1996:84) emphasize that the process of change in group work is facilitated by:

- > Climate of safety
- > Mutual trust
- > Understanding and openness
- > Expression of immediate feelings and reactions
- > Transfer of learning to the other situations

In operationalising the above, the facilitators will define and communicate information, set goals and strategies for group work according to identified psychological and physical needs of nurses and clients at VCT services. These activities will be followed by training so that the meaning of the empowerment process is understood by all. Termination of participation will be discussed as this



may have adverse impact on individuals. These activities prepare the participants for activities in the next level.

## **Level 2 Internalization processes or competence influence**

This level emphasizes the importance of learning through feedback and reflective learning and internalization of these processes which leads to personal changes. Intensive participation by nurses and stakeholders is observed at this level. Participants demonstrate self-reinforcing and self-enhancing through feedback, learning and reflection on the identified needs. The internalization processes from the interactions and self awareness in the first level, provide self-managed feedback which motivates improved performances and lead to higher levels of self confidence (Kinlaw 1995:67). At this level, learning through feedback processes occurs.

### **◆ Feedback on psychological and physical needs**

Feedback is defined as information about how good or useful somebody's work is (Oxford Advanced Learners Dictionary of Current English 2001:429). However, feedback for empowerment is information that leads to improved performance of individuals or teams. Such feedback meets goals and predetermined standards, which impacts on behaviour and performance of others (Kinlaw 1995:107). This author continues to say that feedback to be effective should be self managed, modified and improved by the individuals concerned. Intense discussions of identified psychological and physical needs occur with feedback from self, group and facilitators. Nurses and clients internalize values through feedback that enhances change in behaviour for positive outcomes.

### **◆ Learning**

Learning occurs with acquisition of information, distribution of information, interpretation of information and informed actions (Kinlaw 1995:123). Learning is interactive and interdependent. Participants at this level will demonstrate learning when the acquired information on the psychological and physical needs is interpreted, reflected upon and informed actions taken. During

learning, participants will interact in mutual problem-solving conversations. Learning empowers, and empowerment stimulates the drive for more empowerment.

#### ***i-* Reflection**

According to the *Oxford Advanced Learner's Dictionary* (2005:1223), reflection is the process of sending back light or sound from a surface or mirror. Following are discussions on psychological and physical needs of nurses through reflective learning processes.

Turner (1996:224) defines empowerment as a reflective activity. This author continues to state that dimensions of empowerment through reflection result in:

- > *"the development of a more positive and potent sense of self*
- > *the construction of knowledge and capacity for more critical comprehension of social and political realities of one's environment*
- > *the cultivation of resources and strategies, or more functional competence for liberation"*

At this level facilitators aim at promoting commitment of participants to reflect on past experiences at VCT services through retrospection and introspection. Interactive and interdependent processes with the learning environment influence personal development and growth within the context of the empowerment programme.

#### **4- The reflective process**

Reflection is described by Boyd and Fales (1983) in John and Freshwater (1998:2) as the process of creating and clarifying the meaning of experiences in terms of self and in relation to both self and the world. Through reflection, the meaning and assumptions of experiences form basis upon which to make choices on future actions.

The concept of learning through experiences is credited to Dewey (1933) who was the first to write on reflection on experiences (Palmer, Burns & Bulman 2002:66). Reflection is based on life and human interests of being and knowing (Taylor 2000:1). Within nursing practice reflection is

expressed as a process of self-inquiry that enables individuals to realize desirable and effective actions; in other words, transforming self (John 2002:8; Palmer et al 2002:1). It is by self-inquiry (what has happened and what continues to happen) that nurses gain a sense of meaning and purpose relevant to their psychological and physical needs. Facilitators must persistently encourage nurses, clients, managers and supervisions to examine thoughts and feelings about the situation at VCT centres and the needs of those working there.

Figure 4.6 demonstrates a model of structured reflection by John and Freshwater (1998:4). This model provides steps on how an individual embarks on reflection. Nurses are encouraged to describe any of the experiences at VCT, the significance of this and consequence.

Figure 5.5 is an adaptation of the Model of Structured Reflection by John and Freshwater (1998:4).

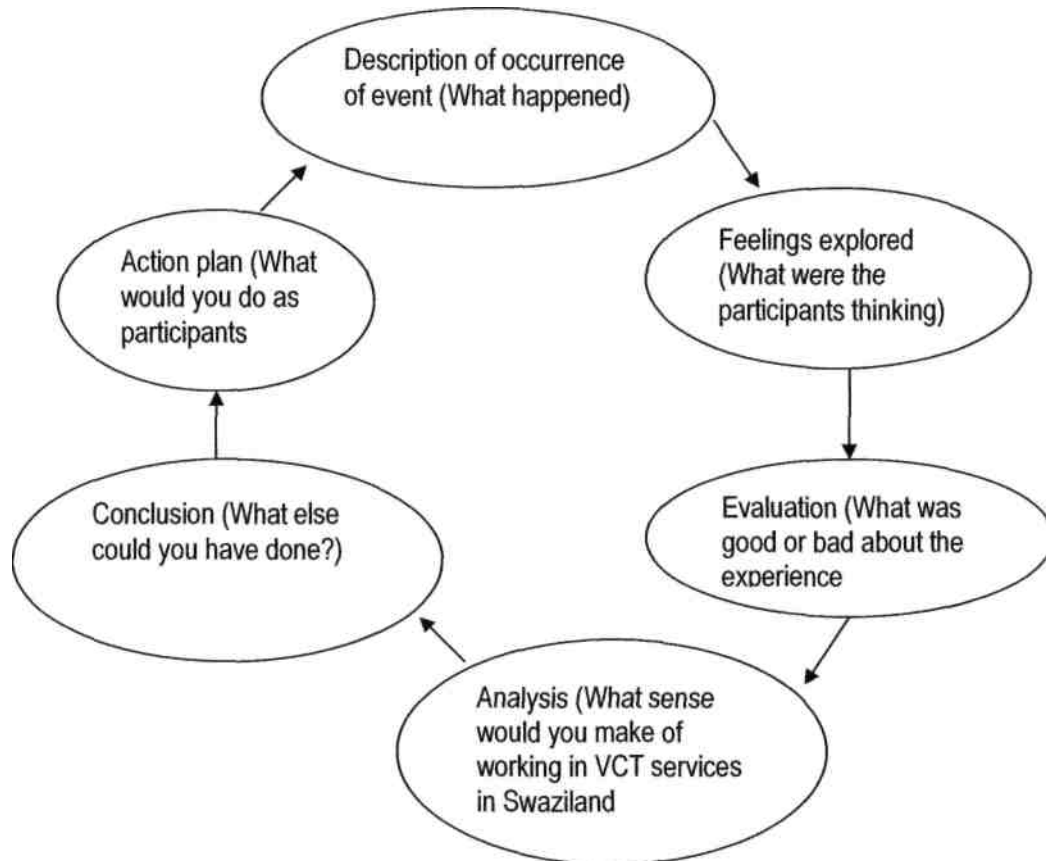
Write a description of the experience.  
 What are the significant issues I need to pay attention to?

*Reflective Cues:*

Aesthetics	What was I trying to achieve? Why did I respond as I did? What were the consequences of that for <ul style="list-style-type: none"> <li>• the client?</li> <li>• others?</li> <li>• myself?</li> </ul> How was this person(s) feeling? How did I know this?
Personal	How did I feel in this situation? What internal factors were influencing me?
Ethics	How did my actions match with my beliefs? What factors made me act in incongruent ways?
Empirics	What knowledge did or should have informed me?
Reflexivity	How does this connect with previous experiences? Could I handle this better in similar situations? What would the consequences be of alternative actions for: <ul style="list-style-type: none"> <li>&gt; the client?</li> <li>&gt; others?</li> <li>&gt; myself?</li> </ul> How do I now feel about this experience? Can I support myself and others better as a consequence? Has this changed my ways of knowing?

**Figure 5.5**  
**Adaptation of the Model of Structured Reflection**  
 Source: John and Freshwater (1998:4)

The model of structured reflection is in congruent with the reflective cycle by Gibbs (1988), where individuals first describe their experiences and feelings; evaluate experiences, analyse situation, conclude and develop an action plan for future occurrences (Palmer et al 1994:39).



**Figure 5.6**  
**Gibb's Reflective Cycle**  
 Source Palmer et al 1994:66

Taylor (2000) suggests that there are three kinds of reflection; namely:

- > Technical reflection: This is based on scientific method and deductive thinking that utilizes empirical knowledge to ensure scientific reasoning as a basis for work procedures (2000:151). In technical reflection nurses obtain information from various sources including the empowerment programme; this is then used to cope and solve encountered problems.
- > Practical reflection: This focuses on human interaction in social existence. It offers means of understanding the interpersonal basis of human experiences and creates knowledge to

interpret the meaning of lived experiences (Taylor 2000:174). In utilizing practical reflection, facilitators create an informative and enabling environment in which dialogue and discussions occur among participants at the workshop.

- > **Emancipatory reflection:** The emancipatory reflection leads to transformative actions as it involves human interaction with focus on how people interpret themselves in terms of roles and social obligations (Taylor 2000:195). The empowerment programme for nurses aims at transforming them to better understand themselves and the clients they serve at VCT services through reflection and self-awareness.

#### 4- Reflective learning skills

The facilitators of the empowerment workshop create an enabling environment in which participants learn reflective skills where cognitive (thinking), affective (feeling), and psychomotor (acting) domains of learning are examined (Dembo 1994:36). Each domain has behavioural competences that lead to the empowerment of nurses at VCT services.

#### 4 The reflective cognitive domain

This domain includes memory, recognition, understanding, reasoning, application and problem solving. The process involves learning steps and their behavioural components that facilitators utilize to enhance reflecting on the psychological and physical needs of nurses at VCT centres.

The learning steps identified by Dembo (1994:37) are as follows:

- > **Knowledge:** this step requires recall of information learnt
- > **Comprehension:** this combines recall with translation, interpretation and extrapolation by participants
- > **Application:** is a form of problem solving where new information is taken in and used in a different way
- > **Analysis:** at this step, communication is broken down into constituent parts to understand the parts and their relationship

- > **Synthesis:** this step involves building on previous steps by putting the parts back together into a unified whole
- > **Evaluation:** here the value of what has been learned is judged.

Cognitive reflective learning involves dialogic discussions with creativity and open-mindedness and being available for the learner or participant (Palmer et al 2002:103).

Table 5.2 illustrate the pattern of therapeutic work within guided reflection based on the concept of being available (adapted from John 1998:65).

**Table 5.2 The pattern of therapeutic work within guided reflection based on the concept of being available (adapted from John 2002:65)**

Clinical context		Guided reflection context
Concern	Being available to work with the client/practitioner Shared vision	Positive regard <ul style="list-style-type: none"> <li>• Participants nurses commitment</li> </ul>
Knowing the person		Knowing the nurses <ul style="list-style-type: none"> <li>• Creating a climate for disclosure of experiences</li> <li>• Knowing their practice</li> </ul>
Responding with appropriate ethical, informed and skilled interventions		Responding with an appropriate helping style <ul style="list-style-type: none"> <li>• Balance of challenge and support</li> <li>• Framing perspectives</li> </ul>
Knowing and managing self within a relationship		Knowing and managing self within a relationship <ul style="list-style-type: none"> <li>• Controlling the agenda</li> <li>• Managing own concerns</li> </ul>
Creating and sustaining an environment where being available is possible		Creating and sustaining an environment where being available is possible <ul style="list-style-type: none"> <li>• Practicalities of ensuring frequent continuity supervision</li> <li>• Conducive environment</li> </ul>

#### **4- The reflective affective domain**

The affective domain includes changes in attitudes and the development of values. Facilitators at this level of reflective learning influence what nurses, clients, managers and representatives feel, think and value. Behavioural component of the affective domain include:

- > Receiving information from stakeholders on VCT services.
- > Responding to what is being taught i.e. being empathic to psychological and physical needs of nurses.
- > Valuing information by responding with respect to needs of nurses working in VCT services and clients who receive these services.
- > Making sense of information; responding with warmth to issues of concerns on needs.
- > Organizing and adopting behaviour consistent with new value system by including nurses in decision making policies that affect practice to enhance job satisfaction.

#### **4- The reflective psychomotor domain**

This domain is involved with performance of motor skills as well as psychosocial skills. These may include a smile from the nurse when appreciated for a job well done; competence in dealing with anxious clients and accuracy in finding a vein to take blood. The ability to perform these activities indicates a degree of empowerment for the nurse. Facilitators must ensure participants have the necessary skill or ability, sensory image of how activity is done and opportunity to practice while feedback is provided.

As participants practice and assimilate reflective learning, nurses will have increased understanding and responsibility in providing quality care at VCT services, with the needed support from clients, managers, and the other structures involved with these services.

Following is the discussion on growth in competence of the nurses working in VCT services in Swaziland.

### **Level 3 Growth in nurses' competence**

The aim of this level is to emphasize the importance of development and growth in competence for nurses working in VCT services. The development of competency shall in these nurses results in a meaningful contribution towards quality care. Malucci (1981) in Campton et al (2005:449) define competence as an ecological concept; an outcome of interplay among person's capabilities, motives and the impinging environment. From these, flow attitudes, principles, skills and strategies that promote empowerment, unique coping and adaptive patterns where actual or potential strengths are mobilized. Competent individuals are more self-directed and goal oriented, leading to self-actualization (Zea, Reisin, Beil & Caplan (1997) in Miller & Mason 2001:36). Experiences of competency result in a sense of self-efficacy a generalized belief that one can influence other people and affect the events and conditions around them. To meet this duty, nurses at VCT services must be active life-long learners who keep up with findings of research or attend empowering workshops (Glanz, Lewis & Rimer 1997:253).

The development of competency skills related to VCT services results in quality care rendered to clients. Thus, it is an ethical obligation to develop and maintain competence. Development of competence includes the following identified by Cottrell (1976) in Stanhope and Lancaster (2006:349):

- > **Commitment;** the affective and cognitive attachment to a particular area such as VCT services.
- > **Awareness of self and others;** the clear and realistic view of one's own and other person's identities and positions on issues through reflective learning.
- > **Articulateness;** the technical aspects of formulating and stating one's views in relation to other people's views.
- > **Participation;** active involvement in activities that enhance quality care.
- > **Effective communication;** accurate transmission of information.
- > **Conflict containment;** the effective assimilation and management of true or realistically perceived differences.



In the context of this study, empowerment of nurses through the empowerment programme enhances competence in providing quality care at VCT services. The empowerment programme emphasizes the importance of development of relationships and awareness of self and others. This is in congruent to Parse's theory identified in chapter 1 of this study, which states that the nursing practice is an art of living human becoming. Some of the assumptions in Parse's theory specify that:

- > The human being is an open being in mutual process with the universe, co creating patterns of relating with others.
- > The human is open, freely choosing meaning in situation, bearing responsibility for decisions.

The empowered nurse has the ability to cope with encountered situations, thus transcending multidimensionally with the possibilities (Parse 1998 in George 2002:437). Once nurses are empowered through reflexive learning and feedback, competence is attained. This view of competence and human becoming is relevant to this study as its aim was to develop a programme to provide quality care by empowering nurses with skills and knowledge.

Guidelines for the implementation of this empowerment programme for nurses working in VCT services will be described in the next chapter.

## **5.5 EVALUATION OF THE PROGRAMME**

This section was introduced in Chapter 2 when the research methods were discussed. The following section is a synopsis of the evaluation process of the empowerment programme for nurses working in VCT services in Swaziland using the steps of both Rothman and Thomas (1994) and Chinn and Kramer (1995). Evaluation is phase 5 of the Intervention Design and Development Model proposed by Rothman and Thomas (1994:28). Thomas in Rothman and Thomas (1994:267) asserts that evaluation in intervention research is directed towards determining the effects of the intervention including its effectiveness.

The programme developed has been presented to peers and individuals experienced in programme design and development and also in qualitative research. In qualitative research, programme evaluation may be undertaken for a variety of reasons such as improving design and development, improving the quality of services provided, or determining the quality of service provided, or determining the impact of the programme (Clark 2003:345). Mullen in Rothman and Thomas (1994:179) states that programme evaluation may be undertaken for derivability, clarity, simplicity, generality and significance.

### **Derivability of the programme**

According to Mullen in Rothman and Thomas (1994:179), derivability relates to evidence collected from the study, by the researcher. This evidence indicates information formed that point at the need for the programme. Nurses working in VCT services communicated the need for programme that may assist them in dealing with issues at VCT services.

### **Clarity of the programme**

This refers to how the programme is understood by whoever reads it. It also relates to how it is used in solving and dealing with problems through learning from experience, called heuristics by Mullen in Rothman and Thomas (1994:179).

### **Simplicity of the programme**

Simplicity of a programme or parsimony refers to how simple and briefly a programme can be stated and still be complete in its explanation. The designed programme for nurses working in VCT services falls within the category of simplicity when looking at its completeness and brevity.

### **Generality of the programme**

The concept of generality refers to the fact that a programme can be applied to a wide range of situations (Chinn & Kramer 1995:32). This programme in this study has been developed for nurses

working in VCT services in Swaziland. However, the researcher believes that although it is specific for these nurses, it can be transferable with inputs here and there.

### **Significance of programme**

The significance of a programme is measured by its practical value or utility (Walker & Avant 1995: 135). The empowerment programme for the nurses working in VCT services is believed to enhance quality care for clients and job satisfaction for nurses. The researcher believes this is a major contribution to health care in Swaziland.

## **5.6 CONCLUSION**

In this chapter, the researcher discussed in details the development of the empowerment programme for nurses working in VCT services in Swaziland. The discussions included the steps involved in the empowerment process. The chapter concluded with a critical reflection of the programme utilizing information from Mullen in Rothman and Rothman Thomas (1994:179) and Chinn and Kramer criterion on theory evaluation (1995:130). These consider **derivability, clarity, simplicity generality and significance** of the programme.

In chapter 6 the researcher will describe and discuss the guidelines for the implementation of the programme.

## CHAPTER 6

### PHASE 6: EVALUATION AND ADVANCED DEVELOPMENT

#### *Guidelines to operationalise the empowerment programme for nurses working in VCT services in Swaziland*

##### 6.1 INTRODUCTION

In chapter 5 a comprehensive empowerment programme for nurses working in VCT services was developed and described. The researcher in this chapter proposes guidelines for the operationalisation of the programme. Guidelines are defined as systematically developed statements to assist practitioner decisions about appropriate directions to take for specific circumstances (Bryar & Griffiths 2003:149). According to Strickland and Fishman (1994:249), guidelines enhance the practice of nursing and advance the science of nursing. It is important to develop guidelines as these make nursing more visible to other professionals and policy makers. Bryar and Griffiths (2003:120) state that guidelines are likely to be more effective if they take into account local circumstances and are firmly based on reliable evidence.

##### 6.2 GUIDELINES FOR THE OPERATIONALIZATION OF THE PROGRAMME

The guidelines are proposed for the operationalisation of the empowerment programme and are formulated to achieve the following objectives:

- > To support the professional self-development of nurses working in VCT services in Swaziland.
- > To enhance rendering of quality care to clients.

##### 6.2.1 Objective 1: To support the professional self-development of nurses working in VCT services

The strategy for this objective will be as follows:

### **6.2.1.1 Level 1: Interactive processes**

This level is about the initial process where the researcher first holds meetings with the facilitators to discuss VCT services and the environment in which the nurses work. This is the enhancement and planning stage. The researcher identifies opportunities for creating awareness about the nurses' experiences. The nurses' needs are identified; and the recognition for the quest for empowering them so that they may successfully execute their work at the VCT services. Following these activities, facilitators prepare for the initial step of the operationalisation of the programme where resources are mobilized.

- > Participants are invited to empowerment workshops from targeted areas such as VCT centres and organizations.
- > Objectives and goals are clarified in the invitation letters.
- > Workshops are held at spacious facilities that enhance learning.
- > Participant groups should be of manageable sizes of 15 to 20 at a time.
- > Facilitators must enable full participation by all and create an environment of trust, respect and mutual understanding.
- > Facilitators must offer activities to engage groups in interactive processes.

### **6.2.1.2 Level 2: Information sharing**

At this level both participants and facilitators are actively involved. Emphasis at this level is information sharing within a reflective learning environment. Feedback and reflective learning are used to promote self-awareness.

Nurses expressed constant experience of stress due to complexity of HIV/AIDS, shortage of staff, lack of social support, lack of a supportive practice environment, and a need for staff development.

Facilitators should offer new knowledge and activities that will enhance the ability to cope and deal with the mentioned psychological and physical reasons.

Burnard (1992:1) proposes that nurses should develop self-awareness to discover themselves. This author continues to state that, "*caring, the basis of good nursing, depends upon you knowing more about who you are; a bit clearer about ourselves*". Self-awareness is said to be the first stage in learning how to use self as a therapeutic agent. In knowing self, an individual will identify his or her own way of coping and dealing with stress leading to self development (Burnard 1992:105). Facilitators should offer information and activities that will assist participants to explore how to know self through reflection and exercises that explore the concepts of:

- > The physical self. In exploring the physical self, activities include participants describing physical attributes of someone really liked, someone disliked and physical attributes of self. In comparing these, the nurses will discover the real self.
- > The self for others. Exploration of self for others includes writing descriptions of feelings experienced when in the company of liked and disliked people.
- > The social self. Participants write notes and respond to questions on how they feel and behave in social situations, as some people are uncomfortable when mixing or working in groups.
- > The sexual self. Facilitators encourage participants to explore attitudes towards sex, sexual identity and different sexual orientations.
- > The spiritual self. This includes activities and exercises that explore spiritual beliefs and feelings about other people's beliefs.
- > Darker self. Most individuals have some skeletons in the cupboard; those aspects they do not like about self. Participants should explore aggressive feelings towards others, certain sexual thoughts; thoughts and feelings believed to be "odd."

Facilitators must engage participants in reflection and exercises that examine:

- > Outer and inner self - In knowing self, the participants must develop knowledge on inner and outer experience of self.
- > The Johari window. This model is made up of four windows which aid in exploring the aspects of self using open areas, blind areas, hidden areas and unknown areas.

The following are methods of developing self-awareness:

- > talking to others
- > listening to others or music
- > counselling and co-counselling
- > chanting
- > keeping a journal or diary
- > group activities
- > assertiveness training
- > meditation

The information, reflection and exercises on knowing self should include aspects of thinking, sensing and intuiting which are included in the model of the inner and outer aspects of self as demonstrated in Table 5.1 below.

**Table 6.1 A model of the inner and outer aspects of self (Burnard 1992:26).**

Outer aspects of self	Inner aspects of self.	
Eye contact	Thinking	Feeling
Facial expressions		
Gestures		
Touch	Sensing	Intuition
Proximity		
Movement		
Dress	Experience of the body	
Paralinguistics		

### Thinking

Definitions of thinking by the *Oxford Advanced Learning Dictionary* (2000:1244) include:

- > Having a particular idea or opinion about something
- > Using the mind to form connected ideas or to solve a problem

- > Reflecting for a moment on what goes on inside your head

Facilitators must promote exercises that explore aspects of thinking by participants, and how they organize their thoughts.

Participants must be assisted to structure thoughts by taking notes, keeping references and writing reports.

## **Feelings**

Feelings are defined as emotions which are an important part of personal identity (Arnold & Underman Bogg 1999:98). These authors continue to say awareness of self profoundly affects how individuals experience another person's humanity. All individuals are better off identifying and releasing feelings.

Facilitators must engage participants in exercises that will explore:

- > Feelings associated with self
- > Tension in the body
- > Decision-making
- > Relationships with self and others
- > Situations in which to express or hide feelings
- > How to cope with feelings in nursing

## **Sensing**

Sensing refers to the use of the five senses; that is seeing, hearing, touching, tasting and smelling. These are experiences of the outside world, yet there are also inner experiences of sensing.

Facilitators should offer activities through which participants can explore all the senses, namely:

- > Visual sense through meditation on things seen



- > Listening through meditation on things heard, and effectiveness of one as a listener
- > The degree to which others are allowed to touch one

### **Intuiting**

Burnard (1992: 90) refers to intuiting as "*knowing beyond the senses*" or apprehension by the mind without reasoning. Facilitators should offer exercises that will develop focusing and meditation. Participants can explore all the senses such as:

- > Visual sense through meditation on things seen. These may be behaviour of individuals in relation to the environment at the VCT centre.
- > Listening through meditation on things seen, and listening through meditation.

Participants should practice keeping a journal where thoughts and feelings on self are recorded.

Finally facilitators should offer activities through which participants can explore the self and others. Nurses at VCT services work among people, it is very important for them to develop self-awareness while exploring relationships with others.

Activities include exploring relationships with colleagues, clients, supervisors and groups.

Participants should also explore communication skills, interpersonal skills, listening and responding skills.

### **6.2.2 Objective 2: To enhance rendering of care to clients**

This objective will be attained through utilizing Level 3 of the programme structure as follows:

### **6.2.2.1 Level 3: Competence development: Psychological support**

The aim in this is to strengthen competency skills. Facilitators must expose the nurses to opportunities that will develop the capacity to provide quality care. This may be done through:

- > Workshops and seminars for skills development
- > Relationship development with colleagues and supervisors to effect systems change
- > Clearly defining roles and commitment
- > Advocating for career advancement and registration with the Swaziland Nursing Council
- > Assisting with professional networking

### **6.2.2.2 Competence development: Physical support**

The body and mind cannot be separated from each other. Baron (1999:434) explains that maintaining evidence suggested that psychological variables interact in important ways with physical conditions to determine occurrence or progression of diseases.

Exercises done by participants should explore:

- > Awareness of the physical body of self and client that may hinder quality care provision.
- > Physical movements that may lead to exhaustion of the nurse and may lead to reduction of care for clients.
- > Concepts of attractiveness and sexuality.
- > Own physical health in relationship to stressors.

## **6.3 CONCLUSION**

In this chapter, the researcher formulated and described guidelines to be utilized in the operationalisation of the empowerment programme. These were discussed according to the levels of the programme structure.

The formulation was based on two objectives. The researcher assumed the guidelines will effect:

- > Support to the professional development of the nurses working in VCT services.
- > The enhancement of the rendering of quality care to clients.

Emphasis was on activities facilitated to explore self-awareness, skills building, relationship development and career advancement.

The following chapter comprises discussions on conclusion, limitations and recommendations for future endeavours.

## CHAPTER 7

### CONCLUSION, LIMITATIONS, AND RECOMMENDATIONS

#### 7.1 INTRODUCTION

In chapter 6, guidelines for the operationalisations of the empowerment programme were formulated and discussed.

In chapter 7, conclusions will focus on whether objectives were met. The chapter will also state limitations and recommendations for future endeavours and utilization of the empowerment programme for nurses working in VCT services.

#### 7.2 CONCLUSION

The Collins Thesaurus Discovery (2005:131) describes a conclusion as a deduction, inference, culmination, conviction and an outcome. This section of the study discusses its outcome.

The study was undertaken utilizing the genre of the Intervention Design and Development Model proposed by Rothman and Thomas (1994:28) as it was an intervention research. The purpose of the study was to empower nurses working in VCT services in Swaziland. The following section of this chapter looks at the extent to which the objectives of the study were met.

##### **7.2.1 Objective 1 To explore and describe the experiences of nurses working in VCT services in Swaziland and clients receiving these service (phase 1).**

The objective was achieved through conducting a study that was exploratory, descriptive and contextual in design. In-depth phenomenological interviews were used to collect data from nurses and clients. Consenting participants described in details their experiences at VCT services. The interviews provided the researcher with massive data from which the theme, categories and sub-categories emerged.

Findings revealed that nurses experienced constant stress resulting from the complexity of HIV/AIDS, staff shortages, lack of a supportive environment and a need for career advancement. Clients also expressed experiencing constant stress from stigmatisation and discrimination at VCT services. Literature control was used to validate findings from the data. Kinlaw (1995:65) confirms that stress is often accompanied by the development of psychological and physical symptoms including exhaustion and disempowerment. The findings indicate that the nurses needed an empowerment programme that would enable them to provide quality care to clients.

### **7.2.2 Objective 2 To design and develop an empowerment programme for nurses working in VCT services in Swaziland.**

The objective was met through the design and development of an empowerment programme using the Intervention Research Model proposed by Rothman and Thomas (1994). The steps of this model are **problem analysis and project planning, information gathering, design, early development, evaluation and dissemination**. The programme was described in details in Chapter 5. The steps of the programme include **(1) interactive processes, (2) information sharing and (3) development of competences**. The strategies to effect empowerment were feedback and reflection within a reflective learning environment. The results of the empowerment process were **interaction and self-awareness, reflection and internalisation and competence development**. A visual representation depicting the programme structure was created.

The study revealed that empowerment of individuals, especially nurses, is an essential characteristic for professionalism. An empowered nurse has the following characteristics; **decision-making and problem solving, access and control over needed resources, and the acquisition of instrumental behaviour** needed to interact effectively with others.

### **7.2.3 Objective 3 To formulate and describe guidelines for the operationalisation of the empowerment programme.**

The success of the empowerment programme lies in its operationalisation. It is important, therefore, not to isolate the programme but to align it with these other initiatives. The facilitators

that effect the programme need a map for directions. It is within this context that the guidelines for the operationalisation of the programme were described including the objectives to be met.

The researcher concludes by stating that the objectives of this study have been met.

### **7.3 LIMITATION OF THE STUDY**

The following limitations were identified during the study:

- > There were vast differences between private and public health facilities. The researcher therefore, is uncertain if research findings can be generalized, especially because the purposive sample was utilized.
- > The researcher is a lecturer and a counsellor, most of the nurses were known to her. This might have let some nurses to exaggerate or underrate experiences at VCT services. May be someone else would have achieved different findings.
- > May be it might have helped to interview the managers or supervisors of VCT centres for a different perspective.
- > The study was intensive with reference to time and labour especially in collecting data and transcribing from Siswati to English and vice-versa.

### **7.4 RECOMMENDATIONS**

The following recommendations were suggested for future endeavours.

- > A counselling course be included in the curriculum of nurses.
- > The developed programme for nurses working in VCT services be implemented in one region in Swaziland to assess its applicability and effectiveness.
- > It is recommended that the Intervention Design and Development Model proposed by Rothman and Thomas (1994) be utilized for future research efforts for nursing projects as it may reveal functional and dysfunctional elements of successful and unsuccessful projects such as the roll-out of antiretroviral drugs at VCT centres.

- > In future managers of VCT centres be included in the sample for collection of data to get their perspective of activities at VCT services.
- > Since Swaziland is small, it is recommended that all stakeholders in health care and social welfare are made aware of the empowerment programme for nurses.
- > Lastly, it is recommended that a follow-up study be undertaken which can focus on other issues at VCT services.

## 7.5 SUMMARY

The findings in this study suggest that the challenges of HIV/AIDS cause nurses working in VCT services to feel disempowered. In embarking in this study, the researcher wished to provide a support system that promotes empowerment and competence. The empowerment programme for nurses can make a meaningful contribution in the care of clients, job satisfaction for nurses and reduction in the prevalence of HIV/AIDS in Swaziland.

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