

A HEALTH EDUCATION PROGRAMME TO ENHANCE KNOWLEDGE AND  
COMMUNICATION SKILLS OF HEALTH CARE WORKERS SERVING PEOPLE  
LIVING WITH HIV/AIDS ON HAART IN NAMIBIA

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**ABSTRACT**

Namibian health care workers (health care workers) are affected in providing quality health care services to people who are living with HIV / AIDS (PLWHA) if they do not have the necessary knowledge, as well as adequate interpersonal communication and counselling skills. In a health care facility set-up, all patients either come from the community or are referred from the wards or other departments by health care workers. The health care worker as a (sender) conveys information (messages) and a patient (receiver) is expected to comprehend these messages and to respond by giving feedback to the sender who, in turn, provides feedback until the communication process is completed. The process should take place in a conducive environment without any interference, such as noise, to allow the swift completion of the communication process. The messages that both parties convey should be clear, accurate, coherent, and concise.

The purpose of the study was to develop a health education programme that would enhance the communication skills and knowledge of health care workers serving PLWHA on HAART in Namibia. The intention was to develop a health education programme (HEP) for strengthening these skills. The population comprised two groups, namely health care workers and HAART patients. A purposive sampling method was used for selecting 23 health care workers and 20 HAART patients. Data was collected through focus group discussions with health care workers and in-depth interviews with HAART patients. Tesch in De Vos, Krueger's and Casey (2009) theories guided the data analysis process. The programme was developed based on themes of the study and implemented by training health care workers and describing recommendations.

Trustworthiness validation utilised data credibility, transferability, dependability, and conformability. Ethical measures were observed throughout the study.

The researcher conducted the study in four phases. Phase I presented a needs assessment of the health care workers' experiences in interpersonal communication, counselling skills, HIV / AIDS management and health knowledge of PLWHA on HAART. Phase II represented the conceptual framework to illustrate the study results that were supported by the emerged themes and sub-themes discussed in Phase I of the research. Phase III comprised the development of a health education programme that enhanced knowledge and communication skills of health care workers who serve PLWHA on highly active antiretroviral therapy in Namibia. Phase IV presented the implementation of HEP that included a training workshop for health care workers and an evaluation exercise after the implementation of the programme. Three main themes emerged during data analysis. Theme one indicated that health care workers experienced a lack of sufficient communication skills that was necessary for addressing the health concerns of PLWHA on HAART. Health care workers responses indicated that they had insufficient knowledge and inadequate communication and counselling skills to deal with health needs of the PLWHA on HAART. From their responses, it also transpired that health care institutions experienced a severe shortage of information, education, and communication (IEC) materials and other resources for curbing HIV / AIDS.

From Theme two, it emerged that health care workers experienced a lack of exposure to knowledge about HIV / AIDS management. It transpired that health care workers were not getting any support from their health institutions in developing knowledge or in-service training on HIV / AIDS management. It was also surprising to note that there were no guidelines that clearly assisted them in engaging or communicating

with PLWHA on HAART. There was no structured supervision or quality assurance strategies that guided their superiors in monitoring their performance on the execution of daily activities, specifically in relation to HIV / AIDS Management.

Theme three exposed the insufficient availability of health information to PLWHA on HAART. It transpired that HAART patients did not have access to information on HIV / AIDS aspects; such as HIV prevention, adherence to treatment of HIV, blood results, sexual relationships, alcohol abuse, and nutrition. HAART patients also emphasised their need to be empowered in managing self-disclosure, stigmatisation, and discrimination. The health education programme that enhanced the knowledge, as well as the communication and counselling skills of health care workers for communicating successfully with PLWHA on HAART was finally evaluated in accordance with the guidelines of Schiavo and Quinn's (2007) evaluation process.

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## **DEDICATION**

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**DECLARATIONS**

I, **Mwakanyadzeni Abigail Chipare** declare hereby that this study is a true reflection of my own research, and that this work, or part thereof has not been submitted for a degree in any other institution of higher education.

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Mwakanyadzeni Abigail Chipare

**ACRONYMS AND ABBREVIATIONS**

AIDS            Acquired Immune Deficiency Syndrome

ANC            Antenatal care

ART            Antiretroviral Therapy

ARV            Antiretroviral



AZT	Azidothymidine
BMI	Body mass index
CACOC	Constituency AIDS Coordinating Committee
CD4 count	Cluster difference 4 count
CHS	Catholic Health Services
DHS	Demographic and Health Survey
EC	Effective communication
EP	Expert patient
EPMs	Electronic Patients Management System
FBO	Faith based organisation
HAART	Highly Active Antiretroviral Therapy
HCW	Health care worker
HIV	Human Immunodeficiency Virus
HIV-RNA	Human Immunodeficiency Virus Ribonucleic Acid
HTC	HIV Counselling and Testing
IDU	Injection drug user
IEC	Information, education, and communication
IMB	Intervention motivational behaviour

IO	Opportunistic infection
I-TECH	International Training and Education Centre on HIV
IVR	Interactive voice response
LGBT	Lesbian, gay, bisexual, and transgender people
MARPS	Most-at-risk populations
M&E	Monitoring and evaluation
MCP	Multiple concurrent partnerships
MoHSS	Ministry of Health and Social Services
MSM	Men having sex with men
MTC	Mobile Telecommunications Company
MTPIII	Medium Term Plan III
NGOs	Non-Governmental Organisations
NSF	National Strategic Framework
OPD	Out-Patient Department
PEP	Post-exposure prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PLWH	People living with HIV / AIDS
PMTCT	Prevention of mother-to-child transmission

RACOC	Regional AIDS Coordinating Committee
SADC	Southern African Development Community
SBCC	Social and Behaviour Change Communication
SMS	Short message service
STDs	Sexually transmitted diseases
STIs	Sexually transmitted infections
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV / AIDS
UNAM	University of Namibia
USAID VCT	United States Agency for International Development Voluntary Counselling and Testing
WHO	World Health Organisation

## **CHAPTER 1**

### **INTRODUCTION AND STUDY OVERVIEW**

#### **1.1 INTRODUCTION**

HIV / AIDS is a major, significant public health threat worldwide. According to the press release by Michael Elliot, at the World AIDS Day in Washington DC 28 November (2012), stated that AIDS has affected people from the most productive age of 25 – 49 years who are not only reproductive but who also contributed to the economy of the country. Notably, by the end of 2011 more than 8 million people were on life-saving antiretroviral treatment, up from just 300 000 in 2002; of that 8 million, more than 6.2 million are living in Sub-Saharan Africa. Actually, Namibia is sharing the same burden of increasing numbers of people who are on treatment, (UNAIDS Global AIDS Response Report, 2012).

#### **1.2 HIV / AIDS SITUATION IN NAMIBIA**

Currently, the number of people living with HIV are more than 180 000 and 93% are on Antiretroviral Therapy (ARVs) with a prevalence rate of 17.8%, and HIV incidences amount to 39 new cases daily, 75% hospitalisations, and 50% deaths due to AIDS related illness (UNAIDS Report on the Global AIDS epidemic, 2010). What is even more troublesome is that new HIV infections continue to outpace those patients added to antiretroviral treatment. More than 330 000 infants and children were newly infected with HIV in 2011, and 2.5 million total new infections occurred in the same year. This rate has been relatively constant since 2006. However, it was imperative for people living with HIV / AIDS (PLWHA) on Highly Active Antiretroviral Therapy (HAART) to understand their illness and become accustomed to a new lifestyle (UNAIDS on the Global AIDS epidemic, 2010). In the light of the abovementioned challenges, it is important that effective communication between health professionals and patients be adhered to.

Communication can be misunderstood or interpreted wrongly if it does not happen successfully. Communication aims at trying to convey information meaningfully amongst people. In order to communicate properly and accurately with the purpose of understanding and being understood, one has to communicate effectively. Effective communication is important because it affects our decision-making and respect, flourishes caring, builds trust, and creates an enabling environment.

According to Clark (2008), many problems that occur in treatment protocols for many diseases are the direct result of people failing to communicate information properly. In most cases, the communication process in the health sector involves at least two individuals. If not done correctly, it might lead to misunderstanding and confusion for both parties that cause substantial hazard. Kruijver, Kerkstra, Franke, Beusing and Wiel (2009) emphasise the importance of communicating accurate information. Unless patients are given relevant and sufficient health information that suits their health needs, it is very unlikely that they will participate. In other words, communicating health information improves patients' understanding of their diagnosis of the disease, facilitates learning about available services, and encourages them to participate in decisions making about their health. The communication process, however, depends on patients' educational level, cultural background, and their immediate needs (Kruijver, *et al.*, 2009).

Communicating health information to patients is essential for adapting to healthier lifestyles. It has been found that there is a positive correlation between information and responsible living (McGuire, 2009).

Darnton (2008) describes information persuasion and habits based on Bandura's conceptualisation of a social-psychological model for self-efficacy, which is defined as

“conviction that one can successfully execute to the behaviour required to produce the intended outcome”. However, the same report describes the self-efficacy concept as an attention-interest-desire-conviction-action.

Health care workers, furthermore, can persuade PLWHA on HAART by effectively communicating health information that draws their attention to act upon required behaviour. In reality though, the philosophy remains true that human nature always resists change (McGuire, 2009). Health information is recorded in any format; it can be oral, written, or electronic to address the physical or mental condition of an individual, health care provision, or payment (Medical Dictionary, 2012).

Coiera (2013) describes health information as essential to health that is usually given to patients by a health professional. Actually, health care workers’ responsibilities in providing information are of an interpretative, interactional, and of programmatic nature. The success of these responsibilities, therefore, depends on enhancing communication among health care workers when they simultaneously coordinate activities while considering availability of allocated resources for PLWHA on HAART and their health needs. Creating an enabling environment depends on making sure these functions become a reality, work process, standardised health information, and decision making criteria.

Nevertheless, with evolving health information technologies, health information is processed into knowledge that is converted into computerised data for use by health care workers to enhance communication and interaction with their remote patients with the purpose of encouraging them in decision making about texted diagnoses, testing, treatment, and health progress (Coiera, 2013). In other words, extensive health information technologies in the health sector enable health care workers to confidently communicate or disseminate health information to their patients, particularly to PLWHA on HAART.

For the same reasons, McGuire (2009) expresses that constructing attention and awareness, health care workers are supposed to present and expose patients to comprehensive knowledge that will persistently influence their behaviour. Yet, researchers choose to disagree with this concept by a perception that health information processing proceeds individual's final choices. However, Coiera's (2013) further analysis of the decision maker's abilities and verbal protocols demonstrates that information processing leads to preferential choice that varies due to requested tasks. This implies that patients' choice complexities should be examined clearly by the number of alternatives that are available. Alternatively, health care workers are supposed to be subjected to guidelines that direct dissemination of health information through activities or programmes that are suitable to PLWHA on HAART. Such guidelines might improve their abilities of health care workers to choose from accessible alternatives during decision making.

Nevertheless, since health information plays a pivotal role in the health sector, Mintzbg (2012) perceives health information as fundamental and necessary for health care systems. However, coordinating health information is based on patients' activities and availability of resources that can later be programmed or standardised to enable consistent management of health information (UNAIDS Global Report, 2012). Furthermore, health care workers who are dealing with PLWHA on HAART should not manage the health needs of their patients in a vacuum but should also involve other health care workers, since collectively they share more knowledge and prevention innovations on how to provide care and support to their patients.

Most importantly, in a health care system, health information is defined as data that is verified, accurate, and timely; specifically and purposefully organised for presentation in a context that gives it meaning and relevance that lead to an increased understanding and

decreased uncertainties. Additionally, the value of such health information solely lies in its ability to affect any health behaviour, decision, or outcome (UNAIDS on the Global AIDS epidemic, 2010). Consequently, at various health institutions, health care workers with insufficient skills end up bulldozing patients with distorted health information that leave them in dismay, confused, and devastated while trying to cope with the newly diagnosed AIDS disease (UNAIDS Global Report, 2012).

Nowadays in the world of health technologies, health information is conveniently processed into activities / programmes in the form of books, models, toolkits, internet Medical health websites, guidelines (commonly used to distribute scientific health information that can be used by health care workers too that improved knowledge during health care awareness activities), attitudes, and ultimately skills that benefit patients' health outcomes (UNAIDS on the Global AIDS epidemic, 2010).

In Africa and in Sub-Saharan countries in particular, consequently, health institutions face a shortage of human resources and poor infrastructure, which are exacerbated by the complexities of poor health information management that happens in a bewildering fashion. In most cases, health care workers are working under extreme pressures of an unending workload and minimum skills that are paralyzing progress in the providing quality health care services (Coiera, 2013). In Namibia, for instance, HIV / AIDS drugs have become free and accessible, since the introduction of ARVs intervention in 2003 at both public and district hospitals. Yet, the country still faces challenges in relation to health care workers shortages; on an average, the ratio is 947 patients per registered nurse and over 7 000 per medical doctor (UNAIDS Global Report, 2012).

These persistent challenges endured by Namibia are also felt in other Sub-Saharan countries.



Instead of addressing staff shortages in their respective countries, health settings still embrace bureaucratic systems that are spontaneously entwined with day-to-day management and operation of clinical decisions, as well as operational decision making in every department that is governing health care services. Equally, health information management should be acknowledged and coordinated by implementing different models that include specific activities; for instance patients' diagnosis, observation of patients' progress, and directing knowledge that assists clinicians with decisions making about patients' prognosis (Coiera, 2013).

However, due to the magnitude of the prevalence of HIV / AIDS, the importance of effective health information on health care systems is of utmost importance. Therefore, health information requires a combination of several skills that are fostering health information promotion that influences the effective self-management of the lives of PLWHA on HAART.

Indeed, managing health information on the serostatus of patients is an important part of coping with illness; including communicative and cognitive activities like seeking information, avoiding diagnosis, denial, coping with illness, and simultaneously interpreting perceived information. It necessitates innovative techniques for addressing health problems. There are existing programmes that can be expanded or improved upon, and there are untried innovations that should be considered for dealing with PLWHA on HAART (Gerd, 2011).

Additionally, these innovative techniques or programmes should be patient-driven. However, due to the improved health of PLWHA on HAART, priorities are changing after they have been diagnosed with HIV. Beforehand, patients had to endure considerable stress and suffering as a result of illness that contradicts their values of proper living. HIV illness also continues to have a negative impact on their interpersonal relationships. This happens to most PLWHA on HAART: inadequate health that interferes with individual freedom and disrupts

socio-economic lives (Gerd, 2011). However, health care workers have a responsibility to explain to PLWHA on HAART the factors that influence positive health and provide them with relevant health information, emphasizing the modes and role of information for PLWHA. They should also emphasise the prevention of secondary infection from their sexual partners to avoid virus strain in the already exhausted immune system and to protect themselves from opportunistic diseases that might lead to AIDS (UNAIDS Global AIDS epidemic Update, 2009).

Sub-Saharan Africa, parts of Asia, Central America, and the Caribbean have an HIV generalised epidemic transmission during heterosexual activity; contributing to more than one per cent of people who are living with HIV / AIDS (PLWHA) (World Health Organization, 2009). For instance, the research done on the initiatives for women and girl children (UNAIDS Global AIDS epidemic Update, 2009) empowers them with knowledge about the stages of HIV, i.e. when it enters their bodies and becomes part of their lives; including the array of physical, social, cultural, and interpersonal factors that collectively influence HIV transmission, disease progression, and health outcomes.

Despite inadequate skills of health care workers in addressing the health needs of PLWHA on HAART, some studies suggest that patients who are HIV positive rely more on health information from health care workers, family members, and friends than on other sources, such as the Internet and the media. UNAIDS Global Report (2012), however, states that information is essential and links it to human behaviour that identifies its totality in relation to sources and channels that are both passive seeking and used. In other words, individuals purposely seek information for behaviour reinforcement, yet the gesticulation of that knowledge remains unsatisfactory.

In Nigeria, for instance, the role of health information for PLWHA on HAART cannot be ignored and is indispensable for human development. Losce, in Edewor (2010), describes health information as the knowledge communicated or received about particular circumstances. In the case of PLWHA on HAART, health information is an input that reduces the level of uncertainty in any decision process, which is also a crucial factor for a healthy life. Access to quality health information is critical to many facets of health care design and delivery, according to Okwilagwe in Edewor (2010).

Making health information available to PLWHA on HAART is critical for minimising further HIV transmission (WHO Global Summary, 2009). Due to the accessibility of antiretroviral treatment, people living with HIV / AIDS (PLWHA) are able to live longer and lead healthier life styles. There are circumstances, however, where their health can be compromised by complications, such as delayed HAART initiation or opportunistic diseases that leave them bedridden, shifting all their needs to care and support.

In Rwanda, for instance, the most commonly perceived palliative care needs of PLWHA on HAART are medical needs, psychosocial needs, the need for financial assistance (77%), home-based care (47%), nutritional support (44%), pain relief, and the management of other symptoms (43%) (UNAIDS on the Global AIDS epidemic, 2010). Most PLWHA on HAART indicate these palliative care needs remain unmet; in particular the need for pain relief, symptom management, financial assistance, and nutritional support. Over 50% of health care professionals report that they are not trained in addressing the needs of PLWHA on HAART and in palliative care. They indicate that inadequate policy and resources are the main obstacles to the provision of optimal palliative care. Addressing unmet palliative care needs would enhance the quality of life of PLWHA on HAART (Sahara, 2007).

Notably, in resource limited settings, many PLWHA on HAART lack access to sufficient quantities of nutritious food. This causes additional challenges for the success of antiretroviral therapy (ART). Maintaining adequate food consumption and nutrient intake levels, as well as meeting the special nutritional needs to cope with the disease and ART are critical for PLWHA to achieve the full benefit of such a treatment (Tiyou, Belachew, Alemseged, & Biadgilign, 2012).

The Ethiopian Government - in their National HIV / AIDS Policy that constitutes care and support as the core of the rehabilitation component that deals with those patients already infected with and affected by the virus – also identifies the most important needs of PLWHA on HAART as the emotional and psychological, physical and socioeconomic, clinical and health care, as well as legal and human rights (UNAIDS Global Report, 2012). Furthermore, women of child bearing age indicate that they have a desire to have babies, yet in more African countries, such as Namibia, where HIV positive women are sterilized without their consent. This infringes on their fundamental rights of sexual and reproductive health and having children (Pooja, 2010). Consequently and due to cultural beliefs that influence the norms and values of various societies, practising polygamy is common in more African cultures resulting, in mitigating concurrent sexual partnerships. On the other hand, women are not allowed to negotiate safer ways before having sexual intercourse with their partners. Instead, they are coaxed into having unprotected sex that makes them vulnerable to sexually transmitted diseases (STIs) and further exposure to other HIV strains (Gerd, 2011). Other women face being stigmatised as soon as they disclose their HIV status to their sexual partners, family members, colleagues at work, and the community in general. This results in treatment failure, i.e. defaulting, gender-based violence, depriving women of, for instance, socioeconomic privileges, and some even contemplate committing suicide (Gerd, 2011).

Besides, there are various studies that have noted the essential methods of disseminating information to PLWHA on HAART are in accordance with their health needs. The Information-Motivation-Behavioural Skills (IMB) model, applied in other countries elsewhere in the world, recommends the use of diverse interventions by health care workers when providing information to PLWHA on HAART.

Additionally, care refers to services provided by members of the health fraternity for the benefit of their patients. Health care, on the other hand, describes the services offered by medical and allied health care workers to prevent, treat and manage illness, as well as to preserve mental and physical well being (Mifflin, 2007). Support is perceived as a tailored buffer for the individuals against adverse life events or illnesses by providing recourses for enhancing the quality of life. Social support can also be viewed as emotional support information sharing and provision of material resources and services. Social support is widely recognised as an important determinant of health and an essential element of social capital (World Health Organization, 2009).

The WHO Consolidated Guidelines (2013) seeks to promote a HAART treatment strategy that reaches out to marginalised and hard to reach populations who are infected by HIV. This strategy aims at engaging people in appropriate care, including HIV testing and antiretroviral treatment as soon as they become medically eligible.

A study conducted in Mexico made use of a multidisciplinary home care model for chronic and stable HIV patients. Health information technology was assessed in a low-resourced setting as an additional tool to assist with the routine care of HIV infected patients and for the training and education of health care workers through teleconferences, mobile phone calls, and e-health systems. All of these technologies had been used to support comprehensive HIV treatment programmes (Juha, 2009). Furthermore, the same tool was used for health

information processing in developed and some developing countries to solve communication problems as a prevention strategy for gay men.

In African-American settings, the health information technology tool was also used to improve health outcomes; including antiretroviral adherence, access to care for HIV infected prisoners, and clinical monitoring of HAART treatment experienced HIV infected patients (Rupert, 2011). There are many other examples of using health information technology tools. Germany, for instance, has introduced a nationwide telemedicine infrastructure that enables electronic health services in e-health ambulatory care while countries like South Africa uses mobile communication technology by means of SMSs for reaching out HIV positive people for the purpose of medication adherence. Nigeria has investigated the adaptation model potential of information and communication technology (ICT), while Australia has introduced electronic health records for residential aged care facilities to improve the effectiveness and efficiency of aged people (Shortliffe, 2012).

Against this background, this study focused on health care workers' knowledge and abilities in communicating health information that were relevant to the principal health needs of PLWHA, particularly those patients on Highly Active Anti-Retroviral Therapy (HAART), during their visits to Catholic Health Services (CHS) facilities.

### **1.3 NAMIBIA: COUNTRY BACKGROUND**

Namibia is a coastal country with an area three times greater than that of Great Britain. Its surface area is about 824 268 square kilometres. It is situated on the south western Atlantic coast of Africa, bordering Angola, Botswana, South Africa, Zimbabwe, and Zambia. Namibia is a sparsely populated country. The estimated population of the Namibian nation are 2.2 million of which 40% are young people under the age of 15 (UNAIDS Global Report on AIDS epidemic, 2010).

The current HIV / AIDS status in Namibia is based on the number of people living with HIV who have reached 180 000 in 2008; 93% are on ARVs. With a prevalence rate of 17.8%, new daily HIV incidences are 39, 75% get hospitalised while 50% of the deaths are due to HIV / AIDS related illnesses (UNAIDS Global Report on AIDS epidemic, 2010). Nonetheless, HIV / AIDS responsibilities are shared among the district hospitals, as well as private and public institutions.

#### □ **Description of research content**

CHS is a faith-based organisation and the second largest health service provider in Namibia, which operates in conjunction with the objective of the Namibian Government to address issues of alcohol and HIV / AIDS. Furthermore, CHS has four district hospitals and 17 health care facilities throughout the country, where it mainstreams the HIV / AIDS programme in a catchment area with a population of 300 000.

The CHS HIV / AIDS programme, furthermore, has about 800 health care workers of which 10% are working directly with HAART patients. The programme is funded by the President's Emergency Plan for AIDS Relief (PEPFAR), under the auspices of USAID Namibia through their capacity project (Intra Health). In addition, it provides integrated services; such as the prevention of mother-to-child transmission (PMTCT), antiretroviral therapy (ART), and voluntary counselling and testing (VCT). The four CHS district hospitals in three regions cares for a total of 20 429 enrolled HIV positive patients. The Kavango region has two hospitals: (1) Andara with 3 115 and (2) Nyangana with 3 059 patients respectively. The Oshikuku Hospital in the Omusati region has 12 100 patients and the Rehoboth Hospital in the Hardap region has 2 155 HIV positive patients in care. There are 13 191 patients on HAART (CHS, 2011).

However, HIV / AIDS is predominantly a sexually transmitted disease. Namibia has a generalised HIV epidemic where it is primarily transmitted by heterosexual activities. The increased prevalence rate among pregnant women was 18.8% in 2010 when compared with a non-statistically difference of 17.8% in 2008. The HIV prevalence peaked in the age group 35-39 at 29.7 per cent and in the age group 30-34 at 29.6 per cent (UNAIDS Global Report, 2012).

Equally, behavioural and contextual factors are identified as the driving force of HIV infection. Among the seven drivers of the epidemic, multiple concurrent sexual partners and alcohol abuse are regarded as the main causes of rapid spread of the virus among young people (MoHSS, 2009). In 2006, 16% of men and 3 per cent women of a sexually active age reported having more than one partner during a period of one year (MoHSS, 2008).

Despite the worldwide improvement in the quality life of persons on HAART due to access to effective treatment, it might encourage them to continue or to resume risky sexual behaviour. Worldwide, highly active antiretroviral therapy (HAART) is dramatically decreasing AIDS related morbidity and mortality (MoHSS, 2009).

Many HIV infected persons are living longer, healthier, and more sexually active lives as a result of the success of this programme. However, unprotected sex by people living with HIV / AIDS (PLWHA) is still an area of concern due to the risk of transmission between serodiscordant partners and the risk of re-infection with drug-resistant strains of the virus (Sarna, Luchters, Geibel, Chersich, Munyao, Kaai, Mandaliya, Shikely, Rutenberg, Temmerman, 2008). Even though positive effects of HIV disclosure have been identified, there are also potential consequences associated with disclosure; such as domestic violence and abuse, abandonment, and discrimination (Mlambo & Peltzer, 2011). For HIV positive

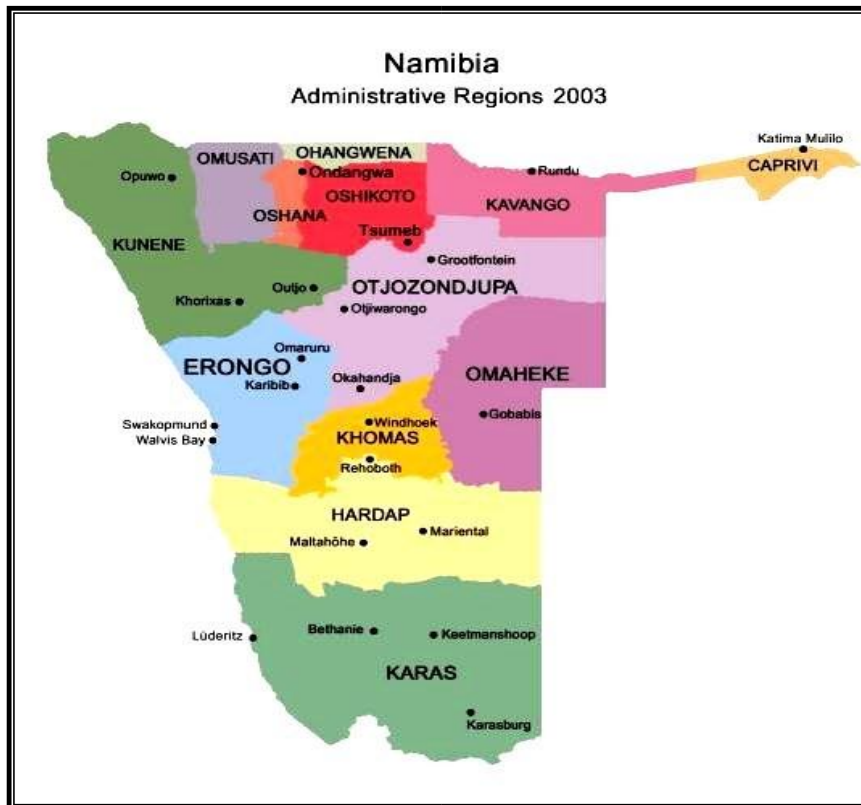


people who are on antiretroviral treatment (ART), HIV disclosure and sexual behaviour represent a great challenge in their relationship(s).

It is also concerning that PLWHA become less disciplined in relation to protective and preventative behaviour once their physical condition improves in response to HAART (MoHSS, 2009). An increase in risk-taking behaviour contributes to the transmission of HIV and other sexually transmitted diseases (STDs) (UNAIDS Global Report on AIDS epidemic, 2010).

HAART and sexual behaviour are linked in several ways. Gains that are experienced, in the form of improved quality of life and functional status, accompanied by the alleviation of physiological and social consequences of the disease, may encourage increased risk-taking with regard to sexual behaviour among individuals whose illness had previously inhibited those forms of behaviour. Individuals may also have erroneous ideas about the impact of HAART on disease transmission rates and may, therefore, believe that the risk of transmitting HIV is lower during HAART than it has been before initiating treatment.

The proven efficacy of HAART in reducing maternal-foetal transmission of HIV may reinforce these beliefs. Individuals with these beliefs may be less likely to use condoms consistently, may have multiple sexual partners, may not disclose their HIV status to their partners, or may neglect to learn about their partners' status (UNAIDS Global Report on AIDS epidemic, 2010).



**Figure 1.1: Researched regions: Omusati, Kavango, and Hardap**

The study was conducted at four CHS hospitals in three regions of Namibia; namely Kavango covered Andara and Nyangana, Omusati: Oshikuku and Hardap: Rehoboth Hospitals as illustrated in the map of the country.

#### **1.4 STATEMENT OF THE PROBLEM**

Namibia has various HIV policies and frameworks, operational policies, and resources that are supposed to direct and guide health care workers in dissemination of quality health information to people who are living with HIV (PLWHA), particularly those patients who are on highly active anti-retroviral therapy (HAART). However, it was noticed that health care workers had no knowledge and abilities in communicating effectively with PLWHA on HAART about their health concerns. Through ignorance, some workers gave inaccurate or no information at all to patients. It was clear to them that they were uncomfortable with sharing information that they were not sure of. Consequently, HAART patients were disadvantaged

by not receiving the necessary knowledge to improve their quality of life. These gaps were identified through the researcher's observations during health care workers' performance and quality assurance assessment at CHS district and public hospitals.

#### **1.4.1 Development of statement of the problem**

The researcher worked with CHS since 2008 in the HIV / AIDS field, particularly in the implementation of the HIV / AIDS programme. The researcher's responsibilities were to educate trainers in HIV / AIDS activities; specifically health care workers who were working closely with PLWHA on HAART. During supervision visits at health care facilities, the researcher observed that health care workers communicated in a formal way that prevented them from providing accurate feedback to HAART patients with regard to their health concerns. Also, there were no proper mechanisms implemented to promote the health of PLWHA and the public. That was problematic to those people who were infected with and affected by the virus. Particularly, it applied to the caregivers who were caring for PLWHA on HAART, as well as the ones who were assisting patients, who acquired the disease (HIV / AIDS) recently, to cope.

It was realised that health care workers lacked the ability that would enable them to effectively communicate health information accurately, clearly, and as intended to improve the quality of life of PLWHA on HAART. Health care workers' deficiencies in their knowledge and interpersonal communication and counselling skills were identified. On the other hand, PLWHA on HAART experienced inadequate access to health information that could provide them with knowledge about different health aspects, including addressing the myths and misconception of HIV / AIDS transmission and treatment.

These discrepancies prompted the researcher to conduct a needs assessment to interrogate the potential knowledge and skills of health care workers in order to disseminate quality health information to PLWHA on HAART. Most importantly, it included reviewing HIV / AIDS policies about health care services, including operational guidelines for staff development and AIDS activities / programmes.

Notably, those same gaps were identified in the national strategic framework for HIV / AIDS response (2010/11-2016). Its review of the health systems indicated that the levels of human and infrastructure resources at the time were insufficient with the result that the support and coverage of PLWHA on HAART were paralysed, both at the Pre-ART and the ART clinics. These inadequate resources would become even more significant if additional emphasis were to be placed on quality of service delivery to PLWHA.

Yet, the Namibian National HIV / AIDS Policy propagates the augmentation of the constitutional environment of human rights, gender equity, race, stigma, discrimination, and creating supportive implementation of HIV / AIDS programmes. The goal of the policy is to engage policies and frameworks that address HIV / AIDS issues to reduce new infections; to improve care, treatment, and support; and to mitigate HIV / AIDS in accordance to Vision 2030 (MoHSS, 2009).

The same goals were previously emphasised in various policies, such as the National Strategic Plan 2004 to 2009 that was extended to the 31st March 2010, and that was monitored by Medium Term Plan III (MTPIII) 2009-2010 of the country. These goals continue under the auspices of the Prevention Strategic Framework for 2010-2016 that addresses various components of HIV / AIDS; specifically reducing new HIV infections, most at risk population (MARPS), behavioural change communication (BCC), HIV / AIDS

gender mainstreaming, condom promotion, prevention of sexually transmitted infections (STIs), HIV counselling and testing, as well as care and support services (MoHSS, 2010).

Guidelines for HIV / AIDS Counselling and Sexually Transmitted Diseases (2001) cover basic training for health care workers and patient basic education pertaining to epidemic and pre-post counselling for HIV testing (MoHSS, 2009). Supporting guidelines, such as the Clinical Management of HIV / AIDS, also provide counselling and treatment management while the National Guidelines for Anti-Retroviral Therapy 2010 address issues like new regimens and the importance of medication adherence (MoHSS, 2010).

In spite of all those policies and guidelines, there was neither clear information nor directives about equipping health care workers with either knowledge or the necessary skills to facilitate communication with PLWHA on HAART, nor did they indicate the resource and infrastructure requirements of catering for this group. It was noted that the policies and guidelines did not contain:

- Knowledge and skills for empowering health care workers in ensuring delivering of quality health care and social support to PLWHA on HAART, sexual partners, families, and / or friends.
- HIV / AIDS inclusive programmes that provided health information to PLWHA on HAART at public and private health care facilities.
- Support / supervision for health care workers to improve their performance while addressing the needs of PLWHA on HAART.
- Universal IEC materials for PLWHA on HAART.
- Health policies that did not contain guidelines in HIV / AIDS education / counselling and training health care workers in the specialised field.

### 1.4.2 Understanding the study phenomenon

In order for the researcher to understand the study phenomenon, it was essential to ask the following questions:

- What were the factors that deterred health care workers to effectively communicate with PLWHA on HAART?
- What type of interpersonal communication, counselling skills, and HIV / AIDS knowledge did health care workers have?
- What type of health information given to PLWHA on HAART improved knowledge about their health?

## 1.5 DEFINITION OF KEY CONCEPTS

### 1.5.1 Communication

According to the Oxford dictionary, it is imparting or exchanging information by speaking, writing, or using other mediums or channels of communication (Oxford dictionary, 2013). In this study, *communication* means sharing or dissemination of health information by health care workers to PLWHA on HAART. Yet, effective communication happens when at-risk individuals with functional limitations are given the same information provided to the general population, using a method that is understandable and timely (Oxford dictionary, 2013). In this study, *effective communication* involves active listening and abilities to express one well in both spoken and in non-spoken gestures that are appropriate and culturally acceptable. This includes expressing emotions and needs.

### 1.5.2 Dissemination

It is an act of spreading something, especially information, or widely circulating / disseminating public information (Oxford dictionary, 2013). In this study, *dissemination*

refers to what health care workers do to promote health through the use of technologies, information education, and communication materials.

### **1.5.3 Facilitate**

According to Webster, (2012) facilitate means to increase the likelihood, strength, or effectiveness of behaviour or a response. In this study, *facilitate* means health care workers who effectively facilitate discussions with PLWHA by asking them appropriate questions.

### **1.5.4 Health**

It is the state of being free of physical or psychological disease, illness, or sickness (Oxford dictionary, 2013). In this study, *health* means the well-being of PLWHA on HAART who acquire knowledge from health care workers who provide them with information.

### **1.5.5 Health care worker**

Health care workers are clinical or other health sciences members of staff, including those involved with primary health care, who have regular, clinical contact with patients ((Oxford dictionary, 2013). In this study, *health care workers* are nurses or community counsellors who provide care and directly work with PLWHA.

### **1.5.6 Health education programme**

It is a health education programme directed at the general public that attempts to improve, maintain, and safeguard the health care of the community (WHO 2009). In this study, *health education* is perceived as systematic knowledge and skills that enhance health care workers' knowledge and skills to facilitate communication that reinforces responsible behaviour of PLWHA on HAART.

### **1.5.7 Health promotion**

Health promotion is a process of enabling people to increase control and to improve their health as a mediating strategy between people and their environment, synthesising personal choice and social responsibility in health (WHO Global summary of AIDS epidemic, 2009). In this study, *health promotion* is viewed as strategies and tools that enable health care workers to disseminate effective health information to HAART patients, PLWHA, and to the public in general.

### **1.5.8 Highly active antiretroviral treatment (HAART)**

HAART is defined as a combination of three or more antiretroviral medications taken orally at specified times to suppress the action of the HIV virus (Kaiser, 2008). HAART is a combination of protease inhibitors taken with reverse transcriptase inhibitors to treat AIDS and HIV (Oxford dictionary, 2013). In this study, *HAART* means treatment given to PLWHA that improves their health.

### **1.5.9 Programme**

It refers to the planning of a series of events, objects, or performances (Oxford dictionary, 2013). In this study, *programme* means a series of instructions and skills given to assist health care workers with facilitating communication and reinforcing behaviour of PLWHA on HAART to live positively.

### **1.5.10 Knowledge**

Knowledge is the psychological result of perception, learning, and reasoning (Oxford dictionary, 2013). In this study, *knowledge* means information and skills acquired by both



health care workers and PLWHA on HAART that improve their understanding of HIV / AIDS aspects.

### **1.5.11 Skills**

Abilities that have been acquired through training (Oxford dictionary, 2013). In this study, *skills* are the tools and knowledge acquired by health care workers to effect change in the lives of PLWHA on HAART.

### **1.5.12 Responsible behaviour**

The term is disambiguated as follows:

*Responsible*: Someone who is behaving properly and sensibly, without needing to be supervised (Oxford dictionary, 2013). *Behaviour*: A manner of acting or controlling oneself. An event that occurs when something passes from one state or phase to another (Oxford dictionary, 2013). In this study, *responsible behaviour* refers to all actions taken by HAART patients to protect themselves from developing drug resistance, becoming STI and HIV infected, or re-infected with the HIV virus. It refers to persons who bring their sexual behaviour under control by making conscious choices to protect them and their partners from the consequences of the disease.

## **1.6 THE PURPOSE OF THE STUDY**

The purpose of the study was to develop a health education programme that enhances the communication skills and knowledge of health care workers who serve PLWHA on HAART in Namibia.

## **1.7 THE OBJECTIVES OF THE STUDY**

The objectives of the study were to:

- assess the knowledge and interpersonal communication and counselling skills of health care workers in facilitating communication with PLWHA on HAART at health care facilities of the CHS in Namibia.
- determine types of information provided by health care workers to PLWHA on HAART at health care facilities of CHS in Namibia.
- develop a conceptual framework from the findings of the study.
- develop and implement a health education programme that assists health care workers to facilitate communication with PLWHA on HAART.
- evaluate the effectiveness and feasibility of the health education programme after implementation.

## **1.8 THE PHILOSOPHY OF THE STUDY**

The philosophical foundation of this study is based on the naturalistic paradigm that views reality not as a fixed entity but rather as a construction of an individual. Constructivist studies describe philosophical knowledge as being rooted the premises that reflect the construction of one's experiences and one's own understanding of the world around one. The assumptions are that individuals generate their own rules and mental models that contribute to their own learning experiences.

In other words, constructivist philosophy simply refers to the processes of adjusting mental models to accommodate new experiences. Hence, the learner actively receives and processes knowledge from his / her environment (Gustine, 2013). In this case, the individuals who had participated in the study were health care workers and HAART patients. The researcher, therefore, placed a heavy emphasis and understanding on the human experiences as they were lived. However, health care workers and patients reacted to this theory by constructing reality incrementally by means of experience, language, and concepts (Ross, 2013). Furthermore, the

philosophical assumptions were paradigmatic: The interrelated and overlapping principles of epistemology, axiology, otology, and methodology assisted the researcher in conducting this study.

## **1.9 PARADIGMATIC ASSUMPTION OF THE STUDY**

A paradigm is a particular view and perspective of the complexities of the real world. Paradigms for human inquiry are often characterised by the manner in which they respond to basic philosophical questions. A paradigm is also viewed as a set of basic beliefs (or metaphysics) that deals with ultimate or first principles. At the same time, it represents a worldview that defines, by its holder, the nature of the “world”, the individual’s place in it, and the range of possible relationships to that world and its parts. In this sense; it includes the patients, their beliefs, relationships, families, and the community they are living in Denzin in (Polit & Hungler, 2008).

Paradigmatic perspectives were employed by the researcher as described in Blanche & Durrheim, Desmond (2012), understanding the nature of inquiry according to four dimensions: Epistemology, methodology, axiology and ontology.

### **1.9.1 Epistemological assumptions**

Epistemology specifies the nature of relationships between the researcher (knower) and what was known while methodology specifies how a researcher practically studies whatever he / she believes is known. It has been demonstrated by other researchers that epistemology is concerned with providing a philosophical grounding for deciding what kind of knowledge is possible and how we can ensure that it is adequate and legitimate. Epistemology, however, is the way in which we acquire knowledge. The relevance of epistemology is defined by Levy in (Rogers, 2012) as the assistance to researchers in understanding and acquiring knowledge. In this study, knowledge was acquired by applying constructionist theories that permitted the

researcher to explore the views and comprehension of the different participants within the subject context while recognising that each participant might have experienced a different understanding of the same situation, as well as the subsequent flexibility. The researcher interacted with participants and contained findings that were common due to these interactions.

Interrelationships between interpretive and constructivist philosophical theories reveal that individuals have no access to the real world, suggesting that only their knowledge is perceived in the world (or worlds) and, therefore, it is meaningful on its own terms and can be understood through careful implementation of their procedures (Rogers, 2012). Epistemology theories, furthermore, guide the methodological process that assists with the interpretation of this knowledge while focusing on the understanding, interpretation, and application of personal experience and prior knowledge rather than simply making detached observations. This framework equally accepts and influences science and personal experiences (Rogers, 2012).

### **1.9.2 Methodological assumptions**

Methodology comprises how the knowledge is obtained. The importance of methodological processes in qualitative research are delineated by Blanche *et al.* (2012) who suggest that, in reality, a researcher should assume that people's experiences are subjective and should be taken seriously (ontology). However, these experiences should be observed by interacting and listening to what the participants tell us (epistemology). Methodological processes assist with the interpretation of these experiences.

In this study, therefore, knowledge was gathered by using an inductive process. Deductive and inductive processes are major pillars in scientific research, since they provide the initial

systematic approach to the phenomenon that is essentially intended for scientific investigation. Induction, more importantly, is an approach based on past experiences while deduction draws conclusions that are founded on logical argument (Rogers, 2012).

The explanation of the phenomenon in this study was examined by using data that had been collected about the needs of health care workers and HAART patients. Engaging interpretations were grounded in participants' experiences and in a flexible design that was contextually bound and that emphasised the narrative information that was based on qualitative patterns and analysis (Chapter 2).

### **1.9.3 Axiological assumptions**

Axiology emphasises the values that are closely associated with ethical considerations of a study and ontology specifies the nature of reality that gets studied. Axiological assumptions are closely related to the epistemological principles. These assumptions are derived from the branch of philosophy that explores the role of values which are closely associated with ethical considerations of a study.

Axiological understanding requires a researcher to acknowledge existing values and biases when conducting scientific research. The theory also acknowledges the relation to critical realism acceptance of certain levels of subjectivity within a study. The research findings should reflect the perspectives of both the researcher and the participants (Rogers, 2012).

In this study, the researcher acknowledged that participants (health care workers and patients) had values in relation to their diagnosis, treatment, and the support and assistance that were provided. However, these constructed values differed, since they were based on the own understanding of the participants' world they had created themselves. At the same time, these

values had to be balanced in a way that they were either comprehensible, or immediately valued and shaped as they were understood.

These assumptions also focus mostly on the determination of human nature. Some philosophers argue that the theory is perceived as being based on individuals' determinants of the environment and constructed by what they believe (Putman in Wedawatta, 2011).

An axiological theory is also closely related to the epistemological, ontological, and methodological assumptions and assumptions about human nature. The important question is whether values can be suspended in order to understand, or do values mediate and shape what is understood (Wedawatta, 2011).

#### **1.9.4 Ontological assumptions**

Ontological theory perceptions are concerned about the world. Although some researchers view it as a fact that each one of us experiences from our own point of view, each one of us experiences a different reality. As such, the phenomenon of "multiple realities" exists (Krauss, 2012). At the same time, constructivist ontology posits that no objective reality exists. Rather, there are multiple realities that are constructed by human beings who are experiencing a phenomenon of interest. People impose order on the world in an effort to construct meaning from perception; meaning is embedded in cognition and not in elements external to us. Information that impinges on our cognitive systems is screened, translated, altered, and perhaps rejected by the knowledge that already exists in that system. It results in idiosyncratic knowledge that gets purposefully constructed (Krauss, 2012).

In this study, ontological principles were analysed as the existing reality of persons who were diagnosed with HIV and who were on HAART treatment. They needed care, health information, and support. According to Coady and Lehmann (2007), such a reality is created

as a consequence of individuals' perceptions and reactions that prompt them to react to external stimuli. Furthermore, participants constructed their own understanding of the phenomena of health information to patients by reflecting on their own experiences.

The researcher also acknowledged that conducting research without considering the fundamental views of HAART patients violated their reality. At the same time, the researcher acknowledged that researchers were perceived as unique individuals who were not immune to biases. A number of other studies support this theory and urge researchers to remain vigilant because they too are equally susceptible to bias due to individual perceptions (Krauss, 2012).

### **1.10 SUMMARY**

This chapter covers the introduction of the study, the demographic background of Namibia, problem statement, objectives and the philosophies on which qualitative research methods are based. Hence, the importance of information in general gets reviewed with the purpose of indicating how essential it is in communication particularly, in the health sector. It also addresses the health information programmes reviewed from various studies conducted elsewhere in developed and developing countries. Besides that, the chapter covers the importance of processing information among individuals and patients in general and particularly those patients who are living with HIV / AIDS. Therefore, the information that contributes to the processing of knowledge that influences behaviour of individuals and patients is also acknowledged. This information gets used by health professionals when making decisions about patients' diagnoses and medication prescriptions. Actually, information is vital for communication and knowledge provision between health professionals and their patients, particularly those ones on HAART. Additionally, the chapter sketches a clear picture of the skills deficiencies experienced by the health care workers for addressing the misconceptions of HAART patients and the consequences of not changing

their behaviour which is fuelling the further spread of HIV. It provides a detailed picture of the global HIV / AIDS situation, including Sub-Saharan Africa and the SADC region. The chapter provided an overview of the seriousness of the accumulation of new infections globally, which includes the Namibian situation and the contributions CHS are making to health care delivery in Namibia. The research design and method are discussed in the following chapter.

## **CHAPTER 2**

### **RESEARCH DESIGN AND METHOD**

#### **2.1 INTRODUCTION**

This chapter presents an in-depth analysis of both the research design and methodologies. It supports the main aim of developing a health education programme that enhances communication skills and knowledge of health care workers in Namibia who serve people living with HIV / AIDS on highly active antiretroviral therapy. A needs assessment was conducted as a baseline for information required from the two targeted populations of health care workers and PLWHA on HAART. The study was conducted in four phases: Phase 1 – which was the needs assessment, Phase 2 – consisted of the developing a conceptual framework based on the study findings, Phase 3 – entailed the developing and implementing a health education programme, and Phase 4 – concluded with evaluation of the programme.

#### **2.2 PHASE I: NEEDS ASSESSMENT**

The specific objectives of Phase 1 were to:



- assess HIV/AIDS knowledge and interpersonal communication skills of health care workers in facilitating communication with PLWHA on HAART at health care services in Namibia; and
- finding out the types of information provided by health care workers to PLWHA on HAART at health care services in Namibia.

### **2.2.1 Research design**

The research design and methods for phase 1 will be discussed now: Babbie, Mouton & Strydom (2011) describe research design and methodologies as pluralistic methods commonly used in qualitative research. The methods of a research design emphasise the understanding of the research phenomenon. These methods include various processes that are supported by methodologies and choices for creating a phenomenology that allows for a platform of pursuing investigation curiosities that result in the coherent and effective systems of procedural choices.

In this study, the research design provided a structured framework that served as a guide in orientating the researcher on how to conduct the research. In other words, the research design helped the researcher to understand the research topic by employing a qualitative approach served as the foundation for the methodology, i.e. the approach that best suited to the objectives of the study. In this study, a qualitative approach encompassing explorative and descriptive was followed. The study, furthermore, was also contextual in nature.

### **2.2.2 Qualitative approach**

A qualitative approach was selected to conduct this study because it was regarded as a systematic, subjective approach that could describe people's lived experiences, with the ultimate aim of elucidating the meaning that people attached to their experiences. In addition,

a qualitative design is inductive and emanates from the field where the research study is conducted. In this study, the Andara, Nyangana, Oshikuku and Rehoboth Hospitals were the field of research. The qualitative approach was considered a good choice for this research because it relies on the principle that regards human beings as mindful, self directing, and as continually constructing and reconstructing their social reality (Silverman, 2012).

### **2.2.3 Explorative design**

The study was also explorative in the sense that it explored the needs of both targeted groups; i.e. health care workers' interpersonal communication and counselling skills deficiencies, inadequate HIV / AIDS knowledge, non-existing policies and guidelines, needs, and experiences of PLWHA on HAART. According to World Health Organization report in AIDS intervention in health sector (2009), which described the living with HIV / AIDS, as well as scrutinising existing policies that supported the frameworks and guidelines and supposedly prioritised the health needs of PLWHA on HAART (WHO, 2009).

According to McGivern (2012), explorative design explores issues or topics under investigation. In this study, an exploratory approach gave the researcher pertinent information and assisted with the formulation of the initial answers on the experiences of health care workers and PLWHA on HAART. In addition, an explorative design provided a detailed plan for the identification of the researched problem by clarifying its nature and defining the theories in terms of how and where information was collected. Exploratory approach, furthermore, occurs first in order for descriptive research to be effective (Coughlan, Cronin, & Ryan, 2007).

The latter organises the data gathered during the exploratory process. In this case, the researcher pursued health care workers' experience in interpersonal communication and counselling skills and the health needs of PLWHA on HAART before moving on to the describing the needs.

#### **2.2.4 Descriptive design**

The study employed a descriptive or eclectic approach with the intention to answer research questions in such a way that it painted a clear picture of the participants (health care workers and PLWHA on HAART) who were investigated. In this case, this approach included understanding the describing factors that deterred health care workers from effectively communicating with PLWHA on HAART, interpersonal communication and counselling skills, HIV / AIDS knowledge, existing guidelines, and different aspects that improved knowledge of PLWHA on HAART. In most cases, a descriptive design is also used by the researchers to examine some of the key issues that are facing researchers and policy makers (McGivern, 2012).

However, the purpose of description in this study was to communicate accurately the magnitude, variations, and significance of a situation in terms of describing the lack of health care workers' experience in interpersonal communication and counselling skills and inadequate studies about the health needs of PLWHA on HAART (Coughlan, *et al.*, 2007). It was necessary for creating a clear picture of the relevance of information provided by health care workers and PLWHA on HAART.

### **2.2.5 Contextual Design**

The study was conducted in the context of the Catholic Health Services. The information gathered was interpreted and consolidated in a structured way (Holtzblatt & Beyer, 2013). In this study, a contextual design represented the sites where the lack of health care workers' experience in interpersonal communication and counselling skills and inadequate health needs of PLWHA on HAART were studied. The study context focused on the Catholic Health Services (CHS). In this study, the researcher endeavoured to contextualise and consolidate the roles of health care workers at CHS health facilities, since they were perceived to be responsible for providing health care services to PLWHA on HAART. At the same time, the study explored and consolidated health care services provided to HAART patients by health care workers each time they visited CHS health facilities; namely the Andara, Nyangana, Oshikuku, and Rehoboth Hospitals.

A contextual design, furthermore, enabled the researcher to consolidate the perceptions of HAART patients in respect of their experiences about their health needs in real-life situations.

### **2.2.6 Research methods**

Research methodology focuses on the principles and ideas on which a researcher develops procedures and strategies (methods), in understanding the research description method. In this study, the methodology focused on research processes that guided the researcher during sampling and employing data collection instruments while maintaining objectivity and minimising biased procedures in relation to the participants, i.e. health care workers and HAART patients (Babbie *et al.*, 2011).

### **2.2.7 Study population**

A population is any defined group that is selected as a subject for research. Brynard and Hanekom (2008) define population as an integral part of a research method. It does not refer to the entire population of the country but rather to particular objects, subjects, phenomena, cases, events, or activities specified for the purpose of sampling. Melville and Goddard (2012), describes population as the oxygen molecules in the universe of molecules or as the supercomputers in the world of computing that are subjected to research and analysis. It also includes all the members, or units, of a group that can be clearly defined in terms of its distinguishing criteria, whether they are people, objects, or events. The population of this research study consisted of two groups: Group 1: Health care workers (all nurses and community counsellors) and Group 2: People living with HIV / AIDS who were on HAART. The two groups who represented the population of the study are sequentially discussed below:

The study targeted population all health care workers who were working directly with PLWHA on HAART and who provided health care services in CHS. The population size of health care workers from four main hospitals were two nurses and three community counsellors at the Andara Hospital, two nurses and four community counsellors at the Nyangana Hospital, two nurses and four community counsellors at the Oshikuku Hospital, and one nurse and five community counsellors at the Rehoboth Hospital..

The study targeted the PLWHA on HAART population who went for health care services at the four main CHS hospitals in the regions, i.e. the Andara and Nyangana Hospitals in the Kavango region with 11 PLWHA on HAART patients who took part in the study, the Oshikuku Hospital in the Omusati region with six patients, and the Rehoboth Hospital in the Hardap region with four PLWHA on HAART.

### **2.2.8 Sampling and method**

A sample is a subset of a population that is used to represent the entire group (Melville & Goddard, 2012). In this study, a purposive sampling method was used to select the participants. Purposive sampling is one of the non-probability sampling methods that are most suitable for conducting qualitative research. The purposive sampling provided the researcher with sampling criteria strategies for the selection of relevant group participants (health care workers and HAART patients) according to the research topic. Participants for both groups (health care workers and HAART patients) were selected for the purpose of this study. The sampled group participants are to be discussed sequential below:

The purposive sampling selection was done by including all four of the main CHS district hospitals, namely Andara, Nyangana, Oshikuku, and Rehoboth. The invitation letter for health care workers to take part in the study was sent through the Principal Medical Doctor in-charge of each health care facility.

The researcher set criteria for health care workers to participate. Health care workers were included according to the following criteria:

#### **□ Inclusion criteria**

Health care workers who were all nurses and community counsellors providing care to PLAWHA on HAART and who were:

- working for the Catholic Health Services at four main health care facilities in Andara, Nyangana, Oshikuku, and Rehoboth (Figure 1.1).
- providing direct health care services to PLWHA on HAART.
- were employed at a Catholic Health Services health care facility for at least one year.

### □ Exclusion criteria

The study excluded health care workers who were not working for the Catholic Health Services, those HCWs who were working for the CHS for less than one year, and the ones who were not working directly with PLWHA on HAART.

These cadres were all nurses and community counsellors who met the inclusion criteria. The same process was followed at all four health care facilities and a total number of TwentyThree (23) health care workers were selected (Table 2.1).

**Figure 2.1: Health care workers matrix**

CHS facilities	Total number of health care workers	Nurses	Community counsellors
Andara	5	2	3
Nyangana	6	2	4
Oshikuku	6	2	4
Rehoboth	6	1	5
Totals	23	7	16

The selection of PLWHA on HAART was done in CHS health care facilities to represent the desired population of the study. The selection of the PLWHA was done according to the following:

### □ Inclusion criteria

PLWHA on HAART aged between 15 and 49 years (legal age for consenting to interviews), who were on HAART for a period of at least one year. HAART patients who were visiting the health care facility on the day that the interviews were conducted.

## □ Exclusion criteria

This research study excluded all HIV positive patients who were not on HAART and who were either younger than 15 or older than 49 years. Patients who were on HAART for less than a year and the ones who were not being treated at a Catholic Health Services facility were also excluded.

A total number Twenty (20) people living with HIV / AIDS on highly active antiretroviral therapy (HAART) who met the inclusion criteria were purposively selected by utilising the patients' register. The same process was repeated at the other facilities (Table 2.2).

**Figure 2.2: HAART patients' matrix**

CHS facilities	Total Number HAART Patients	Sex	
		Female	Male
Andara	5	3	2
Nyangana	5	4	1
Oshikuku	6	3	3
Rehoboth	4	3	1
Totals	20	13	7

### 2.2.9 Developing research instruments

Two research instruments were developed to collect data, namely focus group discussions aided by a guide with questions and in-depth interviews.

### 2.2.10 Focus group discussions

In this study, focus group discussions were perceived as an appropriate way of collecting qualitative data. Onwuegbuzie (2009) defines a focus group discussion as a small group of six



to ten people engaged in an open discussion about a particular topic or set of issues that is facilitated by a skilled moderator. The group is large enough to generate a rich discussion but not so large that some participants do not get the opportunity to contribute. The advantages of a focus group discussion as a data collecting method is that it is reliable; data is collected from a number of individuals simultaneously; it is less threatening to many research participants; and it happens in a familiar environment where they can freely discuss perceptions, ideas, opinions, and thoughts.

The researcher of this study conducted four focus group discussions among twenty-three health care workers participants. The size of the focus groups at the four CHS district hospitals was: Five at Andara, six at Nyangana, six at Oshikuku, and six at Rehoboth as reflected in Table 2.2. These discussions were aided by a question guide that was used by the researcher and the fieldworker. (Annexure E).

Three types of questioning criteria were administered in designing the focus group question guide:

- Engagement questions: Introduce participants to and make them comfortable with the topic of discussion.
- Exploration questions: Encouraging engagement.
- Exit question: Clarification and summarising the discussions.

### **2.2.11 Fieldworker training**

The fieldworker, a final year social work student, was trainable and fluent in spoken and written English. Before training, she was orientated about the importance and background of

the study. Then she was trained on focus group discussions, techniques, ethics, and measures in case the need for her arose to specifically explain and assist illiterate participants who were among HAART patients with completing the informed consent forms. Mostly, her responsibilities were to operate the audio recorder and to make sure that all information was captured comprehensively, to translate from English to vernacular languages, as well as to take notes.

### **2.2.12 Focus group techniques**

An appropriate definition was compiled before the desired focus group discussion was selected. This was imperative for understanding the type of focus group individuals who were relevant to the research topic. The focus group guide was developed with nurses and community counsellors in mind; they were the cadres who were working very closely with HAART patients, meaning that they were qualified key informants for this study.

- Focus group acquainted the researcher with goal generation for discussions, maximising the number of different ideas and opinions from as many different people in the time allotted.
- The ideal amount of time of 45-90 minutes was set aside for each focus group discussion to allow productive participation of individuals in the focus group.
- All focus group discussions were structured around a set of pre-determined questions, meaning that a maximum of six questions and follow-up questions were developed to allow for an uninhibited discussion among participants. That stimulated views, valued comments, and reconditioned ways of their thinking by sharing ideas. Focus group cohesion and probing mechanisms were applied during the discussion to allow health

care workers to elaborate extensively on the point under discussion and reserved group members were encouraged to contribute their views.

- In this study, a homogeneous approach was ideal in selecting focus groups, since health care workers shared the same profession and duties. Homogeneity levels were the playing field and reduced inhibitions among people who might probably never see one another again.
- One focus group from each of the four CHS facilities was selected and discussions were facilitated according to their respective hospitals to acquire rich or insightful information about their patients. The importance of these groups was that all the focus groups utilised the same discussion guide until the information they shared reached the point of saturation.
- Focus group participants were given an opportunity to respond to questions in an amicable manner, since they were not privileged to see questions themselves. Therefore, the focus group participants understood the questions put to them fully, since the questions were short and to the point, focused on one dimension at a time, unambiguously worded, Open-ended or sentence completion types, non-threatening or embarrassing, and worded in a way that health care workers expressed themselves until the point under discussion was exhausted.

### **2.2.13 Focus group process**

Focus group discussions were facilitated by the researcher with assistance of the fieldworker.

The researcher was mindful of particular traits. She had to listened attentively and be sensitive to the responses of participants. The researcher respected the groups' autonomy and believed in their immense education and experiences. Although the researcher had adequate

knowledge of the research topic she refrained from being bias. Furthermore, she builds rapport with the group although showing group cohesion and authority as well as group dynamics. On the other hand the fieldworker had to run the audio recorder during the session; take some notes in case the recorder fails or the tape is inaudible. In every focus group discussions, both the researcher and the fieldworker welcomed participants, offered them food and assisted them with any other logistics required for smoothing the group discussions process.

Nonetheless, all participants had a verbal consent before commencing the group discussions.

Norms and values of the groups were emphasized that participants respected other participants' comments, ideas and emotions without criticisms at all cost, (Krueger & Casey, 2009).

Before the researcher asking the first focus groups discussion question, she inserted an ice breaker to try and ease the tension and increase the comfort in the playing field. The researcher posed her questions to accommodate every participant within the group to have an opportunity to respond to the questions, at the same time using the core counselling skills (verbal and non-verbal) in responding to those questions. In some cases, researcher used the group dynamics skills to bring aboard quiet and withdrawn participants allowing them fully participation throughout focus group discussions. This encouraged the researcher be vigilant and tactful in dealing with the challenging the participants involvements. She demonstrated her leadership position within the focus group discussions; active listening also using verbal (paraphrasing, agreeing / disagreeing in some instances remained neutral), (Onwuegbuzie, 2009).

#### **2.2.14 In-depth interviews**

The study employed in-depth interviews aided with unstructured (open-ended) questions in collecting data from PLWHA on HAART. Twenty HAART patients were interviewed in their respective health care facilities. The interviews continued until information required was saturated. Krueger and Casey (2009) note that in-depth interviews as qualitative method of collection proceed confidentially within a secured conversation between interviewers and respondents. An interview is the most appropriate tool for a needs assessment in a situation where the researcher inquires by means of open-ended questions that elicit depth of information from HAART patients (Onwuegbuzie, 2009).

The researcher introduced a general theme on which information was required and motivated the interviewee to disclose the information freely. The question was, *“Tell me what you talk about with health care workers each time you visit the health care facility?”*

#### **2.2.15 Fieldworker**

A fieldworker was trained on the research ethics and interviewing techniques (Section 2.2.11). The main task for the fieldworker was to translate the interviews from English to vernacular languages, as well as to audio record the discussions and to take some notes.

#### **2.2.16 Interviewing techniques**

The researcher had adhered to research ethics before conducting the interviews. All participants were required to complete informed consent forms before the interviews could proceed (Annexure G). Those participants who were illiterate consented by means of a thumb print after the study phenomena had been completely explained by the field worker. All translations to vernacular languages were done by the field worker, since she was proficient in speaking the main local languages. Confidentiality was guaranteed and was explained well

in the informed consent form that every participant was required to complete before interviews proceeded. The interviews allowed the researcher to gather relevant information from HAART patients during their routine follow-up visits to the hospital. The interviews were conducted individually at four health care facilities; namely the CHS hospitals in Andara, Nyangana, Oshikuku, and Rehoboth.

### **2.2.17 Pilot testing**

Pilot testing was conducted at the Onandjokwe Hospital. Section 2.3.5.12 describes the pilot testing of the tools and the subsequent changes that were made.

A two-day pilot test were conducted during focus group discussions and in-depth interviews at the HAART clinic of the Onandjokwe Hospital under the auspices of the Lutheran Church that did not form part of Catholic Health Services where the study was going to be conducted. The Onandjokwe Hospital had the same setup as the CHS hospitals with a HAART clinic that was part of the primary health care services. Community counsellors and nurses provided health care services to the HAART patients.

### **2.2.18 Focus group discussions**

Conducting the focus group discussions was aided by the guide. The group comprised two community counsellors and four nurses who were working with HAART patients directly. The guide included six questions with follow-up open-ended questions. The outcome of the discussions was successful; no changes to the tool were made.

### 2.2.19 HAART patient interviews

In-depth interviews with HAART patients were conducted by the researcher with the assistance of a fieldworker who translated proceedings into local languages. HAART patients who took part in the interviews were between the ages of 15 and 49 years and on HAART for at least one year. The interviews were conducted until data saturation occurred.

### 2.2.20 Issues that surfaced during pilot testing

Due to time constraints on the day of pilot testing, the researcher managed to interview 10 out of 15 HAART patients who attended health care services on that day. The fieldworker presented the questions to the participants that were, in turn, translated into local languages. Although, some the participants struggled to comprehend the interview questions due to too many medical terms that were used.

The interview questions for HAART patients were simplified and translated to suit their level of understanding, since most of them were not familiar with medical concepts.

Medical words or terms that were simplified were:

- **CD4 count:** to the amount or number of soldiers in the blood that protect us from the enemy
- **Viral load** to the amount or number of the enemies (HIV) in the blood.
- **Drug resistant** to when the (ART) medicine failed to work.
- **Disclosure** to tell someone about your status or illness.
- **HIV / AIDS stigma and discrimination** to when people subjected a person because of his / her HIV /AIDS status.

- **Family planning** to when you want to have or not have children.
- **STIs** to diseases that are caused by having unprotected sex.
- **Health education** to information that HAART patients are given by health care workers.

The questions were simplified and translated into local languages. The interview questions were presented in English by the researcher followed by the translation into local languages.

The interview questions were condensed. The questions that were excluded were the ones about HIV / AIDS knowledge and sexual behaviour change. These questions were perceived to lead the patients' responses.

#### **2.2.21 Preparation of data collecting venue**

Data collection venue preparation was done simultaneously at each individual facility for health care workers and HAART patients respectively.

#### **2.2.22 Venue preparations for health care workers**

The focus group discussions were held in a conference room at every CHS hospital. This room was adjacent to the waiting room that was the patients' first point of entry when visiting the health care facility. Furthermore, geographically the conference room was consigned at the same location at all CHS facilities. This made the research field work much easier to facilitate because the venue was private and patients could slip in and out without being noticed by passers-by.

Each conference room had a big round table with 12 chairs around it and a door that was closed each time the research discussions were in progress. In the corner of the room there was a small wheeled tea trolley that was used to store some refreshments and snacks for



participants. The purpose of the refreshments and snacks was to put the participants at ease and to make them relaxed. Every focus group discussion lasted 45-90 minutes. During focus group discussions, health care workers were excused from their duties of providing health care services in order to participate fully without any distractions.

### **2.2.23 Venue preparations for HAART patients**

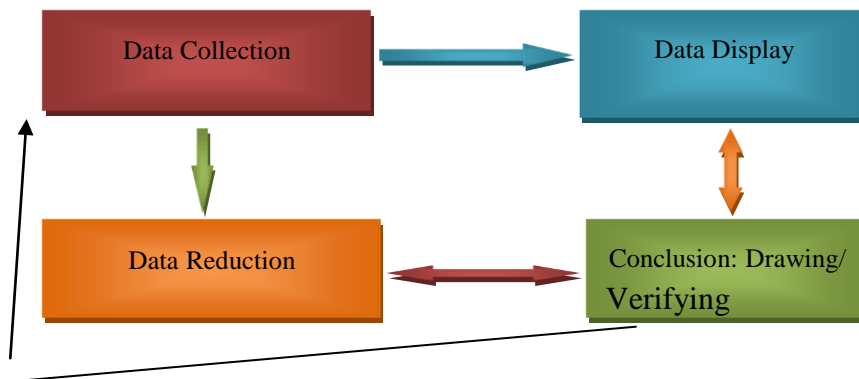
Interviews for HAART patients took place in a friendly and conducive environment for participants. Each hospital provided a private room / office where patients felt comfortable and that was located adjacent to other examination rooms. It facilitated unobtrusive participation. The interview rooms had a waiting area where patients were allowed to wait comfortably on the settees made available for them. Conversely, next to the waiting area there was a room that was secure and private. Furthermore, every time when a patient was being interviewed, no one could hear what was going on inside. Inside the interview room, there were four chairs and a big table that could comfortably be used by groups of four people. The room was big enough and allowed both research team and participants to move around freely.

The researcher prepared the list of names of patients who fitted the desired description based on the inclusion criteria and who were booked for follow-up visits on the same day when the interviews were conducted. Patients with names appearing on the list were referred to the researcher by nurses or community counsellors. Patients were referred to the interview room where the researcher and field worker conducted the interviews as part of their routine checkups in order not to arouse any suspicion. Before the interviews took place, the informed consent form was completed by the participant (HAART patient) through the

assistance of the fieldworker. Every information on the consent form was explained and translated into local languages by the fieldworker. Participation was voluntary.

### 2.2.24 Data analysis

Data analysis is an eclectic process that is based on the theory of Tesch (1968) in Krueger and Casey (2009). It occurs simultaneously and iterative with data collection, data interpretation, and report writing (Creswell, Miles & Huberman, 2012). Furthermore, data analysis is based on phenomenological data reduction by means of interpretation-decontextualization and re-contextualization (Marshall, Rossman & Tesch in McLaughlin, 2012).



**Figure 2.3: Overview of qualitative analysis (Miles & Huberman, 2012)**

In other words, qualitative analysis (Figure 2.1) is illustrated as the “process of making of an omelette”; eggs are broken and scrambled to produce the desired result (Dey, 2012). The description of this process of breaking down bits and seeing how these bits are interconnected provides a new account based on the researcher’s re-conceptualisation of data. Tesch in Krueger and Casey (2009) prescribes eight steps in data analysis based on bracketing and phenomenological reduction procedures as explained by Dey (2012).

**Step 1:** Data reduction is a process during which the mass of qualitative data obtained from, e.g. focus discussions and in-depth interviews was reduced and organised during coding, writing summaries, discarding irrelevant data, etc. In this study, the researcher transcribed health care workers' discussions from the audio recordings and transcribed them into text and read all 20 responses from HAART patients in order to gather some ideas and insights for screening irrelevant information that could be analysed at a later stage.

**Step 2:** Health care worker's discussions and HAART patients' responses were reduced into small segments and divided into themes and sub-themes.

**Step 3:** The researcher made use of procedures, such as bracketing and phenomenological reduction to group units according to a general meaning Tesch in (Krueger & Casey, 2009). In this study, data was segmented into relevant and meaningful units.

**Step 4:** The researcher categorised segments of data gathered according to the experiences and responses of participants by highlighting the potential points of interest (memo-ing) or jotting down the significance of data relevancy in relation to the phenomenon under investigation.

**Step 5:** The researcher reviewed the relevant units listed to eliminate the redundancies from the units with relevant meaning, renewing the efforts of bracketing the phenomenon under investigation (Krueger et al, 2009). In this study, the researcher clustered units according to relevant themes and sub-themes.

**Step 6:** The researcher categorised and reduced the themes by grouping similar themes and drawing inferences and relationships among them. At this stage, themes listed were coded and categorised according to variables of the phenomenon under investigation.

**Step 7:** The researcher continued coding and categorising units listed until data integrity was achieved. In other words, the researcher used bracketing and phenomenological reduction procedures until data desired was saturated to allow the acquisition of a preliminary data analysis.

**Step 8:** At this stage, the researcher interrogated all clustered units of meaning to determine whether there were more central themes that expressed the essence of those clusters (Krueger et al, 2009). The researcher used various methods of phenomenological analysis to reconstruct the inner world and experiences of health care workers and HAART patients.

### **2.2.25 Strategies to ensure trustworthiness**

The aim of trustworthiness or validity in a qualitative inquiry is to support the argument that the findings of the inquiry are worth paying attention to. In this study, trustworthiness was achieved by paying attention to four criteria: Credibility – strategies of ensuring true value, transferability – strategies to ensure applicability, dependability – strategies to ensure consistency, and confirmability – strategies to ensure neutrality (Shenton, 2012).

The measure to ensure trustworthiness is to be discussed in details the following paragraphs below.

Table 2.3 summarise the strategies of used in this study to ensure trustworthiness and all four strategies will be explained.

**Figure 2.4: Four strategies to ensure trustworthiness**

Strategy	Criteria	Application
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Credibility	<input type="checkbox"/> Prolonged engagement in the field	A period of up to 10 – 18 months was spent scrutinising the health care workers' experience in interpersonal communication and counselling skills and the health needs of PLWHA on HAART. Extensive research during the generation of the model.
	<input type="checkbox"/> Reflectivity	Incorporating field notes. To merge field notes with information gathered from participants (health care workers and HAART patients).
	<input type="checkbox"/> Triangulation	More than one data collection method
<b>Strategy</b>	<b>Criteria</b>	<b>Application</b>
		was used: interviews, focus group discussions until saturation reached, field notes, literature control.
	<input type="checkbox"/> Peer scrutiny debriefing	Two experts a Doctor and Professor as supervisors, internal & external examiner, provided constructive criticism on the first draft of report (feedback).
	<input type="checkbox"/> Member validation <input type="checkbox"/> Act of returning to participants to see if they recognize the findings	Continual evaluation was done through checking findings with participants.
	<input type="checkbox"/> Frequent debriefing	On-going debriefing sessions with the institution supervisors were contacted in relation to the progress and challenges of the study.
	<input type="checkbox"/> Reflective commentary	The researcher re-evaluated the progress of the study by continuously monitoring the validity of the study and acquiring feedback from colleagues and the steering committee.
Transferability fittingness	<input type="checkbox"/> Sample <input type="checkbox"/> In depth description of demographics of participants and rich description of findings supported by quotations from participants	Purposeful sampling of health care workers and PLWHA on HAART

Dependability	<input type="checkbox"/> Dependability audit dense description of research methodology, stepwise replication of interviews and code-recode procedure <input type="checkbox"/>	The research methodology and fully described.
Confirmability	<input type="checkbox"/> Confirmability Audit observation <input type="checkbox"/>	A chain of evidence was provided of the whole process. Objectivity avoiding being biased

### 2.2.26 Credibility

The credibility strategies were demonstrated in two ways: (1) to carry out an inquiry to ensure credibility and (2) to demonstrate the credibility of the outcomes of the findings that could be validated by the participants and other researchers. This also demonstrated the purpose of qualitative research that appreciated the phenomena of interest through the eyes of the participants; the participants were the only ones who could legitimately judge the credibility of the results (Trochim, 2006).

In the following paragraphs, credibility strategies are discussed in details. In this study the essential credibility strategies are: Triangulation, Peer scrutiny, Member checking with participants, Frequent debriefing and Reflective commentary.

### 2.2.27 Triangulation

Triangulation was used for study validation. The researcher through triangulation shared some transcripts of the study with other colleagues from different disciplines to provide their own interpretation or different perspectives about information gathered. The different disciplines of importance from the health and education fraternity and included medical doctors, nursing managers, pharmacists, public health education and CHS management staff.

Validity refers to whether the findings are true and certain; “true” in the sense that research findings accurately reflect the situation, and “certain” in the sense that research findings are supported by the evidence (Lisa, David, & McDonald, 2012). Triangulation is a method used by qualitative researchers to check and establish validity in their studies by analysing a research question from a multitude of perspectives (Lisa, *et al.*, 2012). Nonetheless, the researcher employed a variety of methods and techniques to validate the study (Table 2.4).

**Figure 2.5: Triangulation validation**

Data triangulation	Theory triangulation	Methods triangulation	Environment triangulation
<b>Sources involved in triangulation –</b> <ul style="list-style-type: none"> <li>• Nurses</li> <li>• Community counsellors</li> <li>• PLWHA on HAART</li> </ul>	<b>Triangulation involved Health &amp; Education Professional Fraternity:</b> <ul style="list-style-type: none"> <li>• Medical Officers</li> <li>• Nurse Managers</li> <li>• Pharmacy</li> <li>• Public Health Education</li> <li>• CHS Management Staff</li> </ul>	<b>Triangulation involved multiple qualitative research methods:</b> <ul style="list-style-type: none"> <li>• Focus group discussions</li> <li>• In-depth interviews</li> <li>• Field notes</li> <li>• Tape record machine</li> </ul>	<b>Triangulation involved different locations for inquiring data at CHS Hospitals:</b> <ul style="list-style-type: none"> <li><b>Kavango region</b> <ul style="list-style-type: none"> <li>• Andara</li> <li>• Nyangana</li> </ul> </li> <li><b>Omusati Region</b> <ul style="list-style-type: none"> <li>• Oshikuku</li> </ul> </li> <li><b>Hardap Region</b> <ul style="list-style-type: none"> <li>• Rehoboth</li> </ul> </li> </ul>

*Sources: Lisa, Guion, David, Diehl, Place and Debra McDonald, 2012*

The researcher benefited from the use of triangulation, including increasing confidence in the research data that created innovative ways of understanding the factors that deterred health care workers from effectively communicating with PLWHA on HAART, revealing unique findings, challenging or integrating theories, and providing a clearer understanding of the problem (Lisa, *et al.*, 2012).

- **Peer scrutiny:** The researcher gave study presentations to the UNAM Post Graduate committee, academics, and peer members and benefited from their constructive criticism (feedback).
- **Member checking with participants:**
  - The researcher examined herself and assesses the methods and nature of knowledge produced and outcome of the study comparing with other previous research findings to assess the degree to which the study results were congruent to the past findings (Shenton, 2012).
- **Frequent debriefing:** The researcher had collaborative sessions with MoHSS, UNAM, and CHS supervisors updating them on the progress, her experiences, and emerging issues with regard to the study. Consequently, these sessions gave the researcher an opportunity to discuss other alternatives and to receive guidance on managing the study.
- **Reflective commentary:** After the researcher had acquired feedback from the colleagues and the steering committee, she re-evaluated the study through reflective commentary. Guba and Lincoln in Shenton (2012) state that commentary has a key role to play in progressive subjectivity, or to monitor the researcher's own developing constructions that was critical for establishing credibility.

### **2.2.28 Transferability**

In this study, the researcher inquired whether the findings of the research can be applied from one study to the other answering to the research question. This move was important to uncover the inconsistency in the study. According to Merriam, in Shenton (2012) states that external validity is most concerned with the extent to which the findings of one study can be applied to other situations. Therefore, this paper trail strengthened the researcher ability to



transfer the conclusions of this inquiry to other cases or to repeat as closely as possible the procedures of the study.

### **2.2.29 Dependability**

Here the researcher inquired the logic of research processes. Furthermore, a researcher is responsible for describing the changes that occur in the setting and how these changes affect the way in which the researcher approaches the study (Trochim, 2006).

In this study, the concept of dependability contributed to trustworthiness by reporting the research processes comprehensively, thereby enabling the researcher to repeat the whole process if the desired results were not achieved. Most attention was focused on research multi-disciplinary approach. In-depth coverage that allowed the reader to understand the methods and effectiveness of the phenomenon under investigation focused on: (a) the research design and its implementation, by describing what was planned and executed; (b) the operational detail of data gathering, addressing the minutiae of what was done in the field; (c) reflective appraisal of the research, evaluating the effectiveness of the process of inquiry undertaken (Bruce & Mazulewicz, 2008).

### **2.2.30 Confirmability**

In this study the researcher seeks to confirm audit of the study findings by observing the chain of evidence provided. Confirmability criteria neutral and can only be achieved through application of true value.

The term refers to the degree to which the results could be confirmed or corroborated by others scholars in a field (Trochim, 2006). Bruce and Mazulewicz (2008) regard the concept

of confirmability as the objectivity that a qualitative researcher should maintain. In this study, the researcher maintained objectivity by trying to avoid being biased. In terms of the study, the researcher employed the guidelines and format of the University of Namibia in presenting the study results. The data gathered, methodologies, research process findings, and interpretations reflected the experiences and ideas of the participants rather than the characteristics and preferences of the researcher.

### **2.2.31 Reasoning strategies**

Reasoning strategies provide more meaning to inductive principles in research sciences. The term refers to social processes that are scientifically used by researchers who proceed from various grounds in order to arrive at various claims in attempting to convince the audience (Toulmin, 2012).

The study is conducted through inductive reasoning, inference, bracketing, and reflexivity.

### **2.2.32 Inductive reasoning**

Burns & Grove, (2012) defined inductive reasoning as moving from specifics to larger or more general concepts of knowledge. An inductive approach is one of the main processes used during qualitative research, where the socially constructed nature of reality is emphasised.

In this study, an inductive process was utilised during data recording and analysis that attempted to uncover the deeper meaning and significance of human behaviour and experiences, including contradictory beliefs, behaviour, and emotions (Burns & Grove, 2012).

In the context, the researcher interrogated the complex and rich understanding of participants' (health care workers and PLWHA on HAART) about their knowledge, interpersonal communication skills, and experiences pertaining to health information dissemination that improved knowledge of their patients that could afterwards be generalised to other larger groups.

In this study, inductive reasoning or a bottom-up approach was used in data collection and analysis. Data collection was through focus group discussions and transcribed in-depth interviews recorded and then later translated and compared to field notes that were then desegregated into main themes and sub-themes to try and consolidate the meaning and experiences of participants (health care workers and PLWHA on HAART).

### **2.2.33 Inferences**

An inference strategy demonstrates beforehand whether information was either accurate or inaccurate, either logical or illogical, either justified or unjustified (Burns & Grove, 2012).

In this study, the researcher drew some inferences that were supported by data presentation and interpretation that was collected through focus group discussions and interviews gathered from health care workers and PLWHA on HAART as factual information. Chalhoub-Deville, Chapelle and Duff (2006) explain the connection that links data generated and interpreted during which intended conclusions are convergence of theoretical arguments to empirical evidence from multiple sources.

Supposedly, during an inferences scenario in the case of HIV infection, an individual who had just received his / her positive blood test result might conclude that he / she was going to die of the virus. However, that might not be true.

### **2.2.34 Bracketing**

In this study, application of the bracketing process happened through data collection, analysis, and interpretation of the findings.

Actually, the bracketing process occurred from the beginning of the research process and continued throughout the research. Gearing and Given (2008) outline the purpose of bracketing as a rigorous process that suspends internal and external suppositions to allow the focusing on a specific phenomenon to understand or see it as it is. Fischer (2009) defines the bracketing process as an investigative identification of vested interests, personal experiences, cultural factors, assumptions, and hunches that could influence how researchers view the study data.

### **2.2.35 Bracketing process application**

This was done by taking field notes throughout data collection and during data analysis, the researcher was examining and reflecting upon data collected.

The researcher's engagement in interviews and focus discussion questions were compared to external sources or colleagues who were not involved in the research with the purpose of uncovering preconceptions and biases. Bracketing interviews conducted prior to, during, or following data collection seeks to uncover internal and external factors that could hinder the researcher's ability to engage and clearly listen to participants health care workers and PLWHA on HAART. View the bracketing integration in Figure 2.6.



**Figure 2.6: Integration of Bracketing**

### 2.2.36 Reflexivity

In this study, the researcher applied the reflexivity process as a measure of knowing the “truth” about oneself as a researcher and research relations. Gillam (2010) describes that reflexivity awareness are used by researchers to spontaneously respond to multiple influences that affect their research process.

Application of the reflexivity process:

- The researcher continual re-evaluation involved examining her assumptions and preconceptions and how those affected her research decisions when selecting, wording, or interviewing participants.

- The research relations part of the reflexivity process permitted the researcher to build rapport with participants (health care workers and PLWHA on HAART) while recognising that situational dynamics could affect responses to questions.

### **2.3 PHASE II: DEVELOPMENT OF CONCEPTUAL FRAMEWORK**

A conceptual framework was formulated by applying a health education approach to communication for the development of the programme that sought to consolidate the participants' needs, visa vie health care workers and PLWHA on HAART – based on data presented during Phase 1 – in order to prepare for the educational intervention. The detailed conceptual framework is discussed in Chapter 4 of this study.

### **2.4 PHASE III: DEVELOPMENT AND IMPLEMENTATION OF A HEALTH EDUCATION PROGRAMME**

The health education programme draft was submitted to the CHS executive management committee for discussion with the Ministry of Health and Social Services. Their discussion scrutinised the feasibility of the programme in the context of the policy frameworks of both the CHS and MoHSS. The purpose of the submission was to request permission to conduct the study.

As a result, the health education programme was scheduled and implemented for an agreed period of one month at four CHS health facilities, i.e. Andara and Nyangana (North East Region) Oshikuku (North West Region), and Rehoboth (Hardap Region).

The adoption of the health education programme was motivated to CHS, MoHSS, other AIDS coordinating bodies, organisations, stakeholders, and the fund donor community. The development of the program will be discussed in chapter 5.

## **2.5 PHASE IV: EVALUATION OF THE HEALTH EDUCATION PROGRAMME**

The health education programme was evaluated after that one month of implementation. The health education programme evaluation process is extensively discussed in Chapter 6.

Thereafter, the researcher was available to respond to any comments, corrections, additions, omissions identified, and amendments in accordance with the policies and frameworks of the MoHSS. The final health education programme was peer reviewed by research professors at the University of Namibia Research Committee, Research Board of the MoHSS, and the CHS executives; they were all satisfied with the outcome.

## **2.6 ETHICAL MEASURES**

Conducting research implies the acceptance of responsibilities. A researcher is responsible to fellow researchers, to participants, and to society in general and, most importantly, to the researcher's own integrity (Melville, *et al.*, 2012). A high professional standard in relation to confidentiality was strictly maintained during this study. De Vos (2009) identifies ethical measures that are of utmost importance for the researcher.

### **2.6.1 Authorisation**

Permission to conduct the study was sought and obtained from the University of Namibia Post Graduate Committee. In addition, the written proposal was reviewed by the committee to ensure that it conformed to ethical standards of scientific research. Written permission to interview patients on HAART and to hold focus group discussions at Catholic Health Service facilities was requested from the director of Catholic Health Services. The ethical research included the protection of the human rights, literature, and experiences of health care workers and HAART patients.

### **2.6.2 Rights to autonomy and self-determination**

During the study, the researcher explained the phenomena adequately to HAART patients in order for them to understand the study topic and its significance. It allowed them the opportunity to autonomously decide whether they wanted to proceed with the interviews or not. Autonomous individuals acted intentionally, with understanding, and their influences were not controlled. HAART patients had self-determination and an ability to make informed decisions based on the cultural beliefs and values to participate in the study without any penalty. The concept of autonomy reinforces the right to be free from unwanted interference that is associated with legal justifications for curtailment of that autonomy (Pantilat & Isaac, 2008).

### **2.6.3 Rights to beneficence**

In this study, the researcher specified the importance of HAART patients to express their experiences to be heard by not denying them their autonomy and freedom of choices when responding to questions that were considered uncomfortable to answer. Pantilat & Isaac (2008) emphasises that beneficence action is taken for the benefit of other people. Therefore, these actions were beneficial, prevented or removed harm, or improved the situations of other people. In addition, participants were informed clearly about the benefits of the study. The purpose of the study was to enhance communication skills and knowledge of health care workers who were serving PLWHA on HAART in Namibia. The researcher assured the participants of providing feedback in the format of a study results summary. The participants were not promised any money or materialistic benefits. Corbin & Morse (2007) state that informed consent guidelines of participants should not be based on promises or guarantees of benefits that might encourage or influence their participation.



#### **2.6.4 Rights to privacy and confidentiality**

In this research, HAART patients had all their rights to privacy reserved. It was a priority of the researcher to make sure that identification of any participant was neither revealed nor shared without his/her permission. In addition, the right to privacy enforced the principles of anonymity by not writing the participants' names or personal details on the consent form. The right to privacy was explained to all participants. The researcher ensured that neither names nor personal detailed data could be linked to other people without their permission.

With regards to confidentiality, all information gathered from health care workers and HAART patients was treated with the strictest confidentiality. The data obtained from the participants was used for the stated purpose of the study and no other persons would acquire that information without permission from either party, i.e. health care workers and HAART patients or any other person for that matter. These conditions are reflected in Le Beau (2009) who states that confidentiality refers to refraining from divulging information shared by someone to other people. No names of participants were revealed or mentioned throughout the study therefore, no information was traceable to the participants.

#### **2.6.5 Rights to fair treatment and risks**

HIV / AIDS stigma always is attached to PLWHA. In this study, HAART patients were guaranteed that no discrimination or judgement would be enforced if they decided to withdraw their participation in the interviews. Moreover, if there were any suspicions of unfair treatment brought to the attention of interviewers, necessary steps would be taken to rectify the suspicion or discrimination. Relevant information in correcting mistreatment this regard was respectfully and courteously provided to the participants.

Furthermore, expected risks and discomforts that might have been faced by the participants were clearly explained to the participants prior to the interviews. The content of expected risks protect HAART patients from either being victimised by health care workers for voluntarily giving information that was detrimental to their work, or from being stigmatised and discriminated against by their peers for their participation in the study. However, in some cases HIV positive people were facing emotional distress by being reminded of their unpleasant past experiences.

#### **2.6.6 Rights to informed consent**

Pritchard (2008) considers informed consent as binding when it is obtained from either the subject or the subject's legally authorised representative. In this study, it had to be documented in a manner that was consistent with the MoHSS laws and regulations of research subject protection. Permission to conduct the study was granted by the research governing bodies of Namibia, under the auspices of the Ministry of Health and Social Services after all research instruments had been submitted and scrutinised, including the informed consent form of the subjects under study.

In this study, health care workers gave their verbal consent prior to their participation. Most HAART patients were illiterate, therefore, they faced challenges in completing consent form. The fieldworker assisted them (HAART patients) by explaining and completing the informed consent form while using their thumb prints as signatures. In addition, all participants were given sufficient information about the interview purpose and procedures of the study. That included the expectations of the researcher from the participants during the interviews and the duration of the interviews.

## 2.7 SUMMARY

This chapter presents the qualitative research design and methodologies used in the study. In-depth discussions covered most of the qualitative research that utilised explorative, descriptive designs and contextualization of processes. The chapter outlines the research methods that deal with the study population, sample and sampling, purposive sampling, data instruments and collection, and the pilot study that had been conducted. In addition, this chapter focuses on the philosophical and phenomenological nature of the study. The phenomenological process of the study is discussed; including the inductive reasoning, reasoning strategies, inferences, bracketing, and reflexivity. The chapter also includes detailed discussions of the study phases.

- **Phase I:** A needs assessment was conducted based on the specific objectives of the phenomenon that was investigated.
- **Phase II:** This phase included the conceptualisation framework of the study findings.
- **Phase III:** Developing and implementing a health education programme.
- **Phase IV:** Evaluation of the programme.

Lastly, the chapter covers the principles of ethical codes for conducting research. Chapter 3 deals with the data analysis and literature control.

## CHAPTER 3

### DATA ANALYSIS AND LITERATURE CONTROL

#### 3.1 INTRODUCTION

This chapter presents information about the data analysis and literature control. It continues from Chapter 2 that gives an account of the various designs and methodologies of this research study (Phase 1). The chapter further explores, describes, and contextualises health

care workers' experiences with regard to communicating with PLWHA on HAART. Furthermore, the chapter emphasises the conceptualisation of the study findings, the development of a health education programme model that could assist health care workers to effectively communicate with their patients, and synthesising the outcomes of the study.

These outcomes determined the factors that deterred health care workers from effectively communicating with PLWHA on HAART, their existing skills, health information about HIV / AIDS, different aspects to improve knowledge of PLWHA on HAART, and types of counselling services provided.

All study participants from four CHS hospitals were purposively selected according to certain inclusion criteria. The 23 health care workers – who worked directly with HIV positive patients and 20 patients who participated – were between 15 and 49 years old. The information from all four CHS hospitals revealed that the majority of PLWHA who participated in the study were female and most of them were not married. However, the researcher was interested to know about the experiences encountered by female, as well as male participants in relation to the following questions:

What factors deterred health care workers from effectively communicating with PLWHA on HAART, their existing communication skills, health information about HIV / AIDS, different aspects that improved the knowledge of PLWHA on HAART, and types of counselling services provided.

Data was collected from all four CHS district hospitals in Namibia. Four separate focus group discussions aided by a discussion guide were held with health care workers. Information gathered was recorded and transcribed from the audio recordings and field notes. In addition, the researcher facilitated in-depth interviews with PLWHA on HAART with the

assistance of a fieldworker / translator who translated questions from English into vernacular languages. This process was repeated during all the interviews until saturation of collected information occurred.

## 3.2 RESEARCH FINDINGS

### 3.2.1 Qualitative data analysis

The data analysis steps and process were executed by using the models of Krueger & Tesch in Leech & Onwuegbuzie (2007). The details of these processes are presented in Chapter 2.

### 3.2.2 Discussions of main themes and sub-themes

Three main themes and seven sub-themes are discussed in this section. This discussion includes quotations of responses from the participants that are supported by a literature control. The themes and sub-themes are presented in Table 3.1.

**Figure 3.1: Main themes and sub-themes**

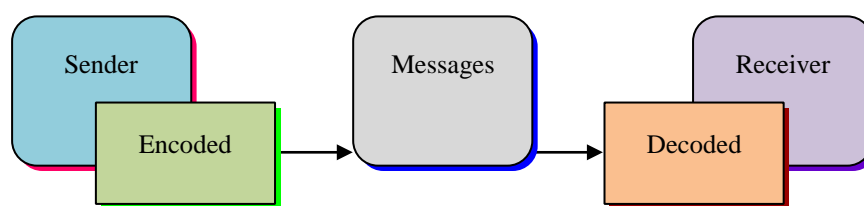
Main theme 1	Sub-themes
Health care workers experiencing lack of sufficient communication skills to address concerns of PLWHA on HAART	<ul style="list-style-type: none"> <li>• Lack of experience in interpersonal communication and counselling skills</li> <li>• Lack IEC materials for disseminating health information to HAART patients</li> </ul>
Main theme 2	Sub-themes
Health care workers experiencing lack of exposure to HIV / AIDS management	<ul style="list-style-type: none"> <li>• Lack of support in developing knowledge through inservice training to manage HIV / AIDS</li> <li>• Lack of guidelines that clearly assist health care workers to engage in the management of PLWHA on HAART</li> <li>• health care workers experience lack of supervision from the superiors to be able to manage HIV / AIDS</li> </ul>
Main theme 3	Sub-Themes

<p>PLWHA on HAART (patients) experience insufficient information on aspects of HIV / AIDS essential to their health</p>	<p>Participants (HAART patients) experienced a lack of information concerning the following:</p> <ul style="list-style-type: none"> <li>• The prevention of HIV</li> <li>• Adherence to treatment of HIV</li> <li>• Blood results</li> <li>• Sexual relationships</li> <li>• Alcohol abuse</li> <li>• Nutrition</li> </ul> <p>Participants (HAART patients) indicated the need to be empowered to enable them to manage disclosure, stigmatisation, and discrimination</p>
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### **3.2.3 Main theme 1: Health care workers experiencing lack of sufficient communication skills to address concerns of PLWHA ON HAART**

Communication is an act of transferring information from one person / place to another (Oxford dictionary, 2013). According to Webster, (2012), communication is perceived as an act or process of transmitting information in the context of ideas, attitudes, emotions, or objective behaviour. As a process, communication comprises a sender and receiver(s) who are conveying information by using communication channels.

Adler, Procter and Towne (2011) describe communication as a process between at least two people when one person conveys messages or information to another. Moreover, these messages are mentally created in a form of images that a person desires to communicate to another. Messages / information can include ideas, thoughts, pictures, and emotions. Transferring such an image to another person, the *sender* must first transpose or translate the images into symbols that *receivers* can understand. Symbols often are words but can also be pictures, sounds, or sense information, e.g. touch or smell. Only through symbols can the mental images of a sender have meaning to other people. The process of translating images into symbols is called *encoding* (Figure 3.1).



**Figure 3.2:** *Source: Chipare (2012) Communication Model*

The encoded messages can be transmitted to the receiver in various ways. Spoken / verbal communication includes face-to-face conversations and communication by means of a telephone, radio, television, and mass media. Non-verbal communication involves body language, gestures, dress code, actions, and even our scent. Written communication takes place by means of letters; email, books; magazines; the Internet; other mass media; and visualisation like graphs, charts, maps, and logos. However, in order for one to encode messages / information accurately for the receiver, one needs to have communication skills.

According to the definition in the Lexicon dictionary (2013), communication skills are the abilities of understanding language, communicating it expressively, and interpersonal communication skills. Therefore, in order for a health care worker to provide quality health care services, it is essential to communicate properly with patients / clients. To this end, a sender (health care worker) needs to have communication skills.

In this study, it was found that health care workers experienced a lack of communication skills that prevented them from effectively communicating health information to PLWHA on HAART. According to Meliones, Alton, Mericle, Ballard, Cesari, Frush, & Mistry (2008), developing communication skills require health care workers to have the ability of communicating information accurately, clearly and as intended, and improving quality care. Furthermore, health care workers need to have the ability to speak appropriately with a wide variety of patients / clients while utilising appropriate non-verbal communication; for

instance the way they attend to their clients, maintaining good eye contact demonstrating a variety of vocabulary, listening effectively, presenting ideas appropriately, write clearly and concisely, and working in groups.

In other words, effective communication (EC) is vital to health care workers and their patients. Therefore, EC is more than exchanging information but also includes understanding the emotions behind that information. It can improve relationships at home, work, and in social situations by deepening one's connections to other people by means of effective teamwork, decision-making, and problem solving. It is perfectly supported by interpersonal skills (in counselling) and non-verbal communication (body language) that include various communication skills, such as attentive listening (ability to manage one's stress, and capacity to recognise and understand one's own emotions and the emotions of other people) (Robinson, Segal & Segal, 2011).

In health systems, communication is regarded as essential to health providers and patients, particularly the ones with chronic diseases such as diabetes, and HIV / AIDS. Patients expect to be given information by health care workers each time that they are seeking health care services. Some studies indicate that patients trust information that is provided by health care workers more than any other sources of information. This is recorded in a study about information preferences (Robinson, *et al.*, 2011).

However, the challenges only emerge when that information is not being communicated effectively. With the emergence of technologies, communication has improved in health systems, for instance Namibia, in partnership with the US government, has utilised Electronic Patients Management Systems (ePMS) for investigating the risks of anaemia associated with Zidovudine (AZT), the first line antiretroviral drug that is part of HAART (Wily,2011). This



comes in the time when health care workers in countries of Sub-Saharan Africa are facing challenges during imparting health information to patients that prevents the crippling effects of HIV / AIDS, intervention efforts, and slowing down the pace of distributing antiretroviral (ARVs) treatment (UNAIDS Global AIDS Epidemic Update, 2009).

Insufficient communication by health care workers consequently disadvantages patient care by dangerous errors in treatment (UNAIDS Global AIDS Epidemic Update, 2009). Health care workers need to have abilities to communicate effectively in order to provide information to HAART patients about their health needs by incorporating it with prevention, adherence, disclosure, blood results, nutrition, alcohol abuse, sexual relationships, and stigmatisation challenges they face every day.

□ **Sub-theme: Lack of experience in interpersonal communication and counselling skills**

Interpersonal communication skills are subconscious skills that develop throughout one's lifetime. These skills can be called life skills, social skills, soft skills, peoples' skills, or communication skills that encompass various techniques (Robinson, *et al.*, 2011).

Counselling is an interpersonal, dynamic communication process between a client and a trained counsellor that is bound by a code of ethics and practice to resolve personal, social, or psychological problems and difficulties. Counselling requires empathy, genuineness, absence of any moral or personal judgment, and the respect necessary to assist the client to explore, discover, and clarify ways of dealing with a concern (UNAIDS Report on Global AIDS Epidemic 2010). Both interpersonal and counselling skills are used every day in communicating, interacting, or in problem solving with other people either individually or in groups. Interpersonal and counselling skills consist of:

- **Verbal:** Effective verbal or spoken communication depends on a number of factors; such as listening skills, and clarification by using techniques like openness, reinforcement, active listening, empathising, creating congruence, probing, reflecting, clarifying, and summarising (Robinson, *et al.*, 2011).
- **Non-verbal communication:** It refers to implicit messages, whether intentional or not, that are expressed through nonverbal behaviour. Non-verbal communication utilises various gestures; including facial expressions, tone and pitch of voice, and attending (physical distance between the communicator and receiver); to convey messages / information from one person to another. These are gestures that allow people to understand the information put across to them by reinforcing or modifying what is said, for instance, the nodding of the head reinforces relationships among two people, it gives appropriate feedback, and regulate the communication flow, (Robinson, *et al.*, 2011)..
- **Listening skills:** It is the ability to accurately receive messages / information during the communication process; it is the key to all effective communication, (Robinson, *et al.*, 2011).

Moreover, proficiency in both interpersonal and counselling skills is essential for conveying information from the sender to the receiver, particularly professionals who deal with patients and / or clients from different walks of life.

The study outcomes indicated that health care workers showed a lack of interpersonal and counselling skills when addressing different HIV / AIDS aspects of PLWHA on HAART.

This was evident in the following statements from health care workers:

*“Some of us don’t even know where to start in tackling AIDS issues, during our professional training we didn’t include AIDS counselling”.* Health care workers from Hospital A further

argued that providing health information to patients was complicated and that there were no HIV / AIDS experts in that area. In addition, the same concerns were shared by their colleagues at Hospital B who experienced difficulties in communicating with patients due to cultural factors that hindered them from talking about sexual issues with the opposite sex or elderly people because of the misconceptions attached to the disease, *“It is too difficult for us to communicate with patients yet they are entangled into their cultural and religious customs”*.

The same perceptions are identified in other studies where health care workers who are working with a diverse population perceive patients’ culture as a barrier to care, since they struggle to communicate with patients due to cultural barriers (Modo, Modo & Enang, 2011). With regard to interpersonal and counselling skills based on field notes taken throughout discussions with participants, this study draws attention to the fact that majority of participants:

For instance, male health care workers were not comfortable to address female patients on sexual issues as evident in the following quote: *“We are uncomfortable talking to women about sex issues”*.

Younger health care workers found it difficult to address sexual issues with elderly person. According to them: *“Culturally, it was unacceptable for younger people to address adults”*.

Health care workers were also uncomfortable with communicating or counselling teenagers who were on treatment because: *“It was difficulties [sic] of communicating to young people about treatment due to their understandable [sic] level”*.

In addition, it was found that in the case of death of a patient, for instance, health care workers indicated that: *“We don’t know how to break bad news to the family of the deceased and also providing bereavement counselling”*.

It was also noted that health care workers of antenatal PMTCT women experienced a lack of interpersonal and counselling skills because: *“We don’t have abilities to express ourselves when it comes to talking to expectant mothers”*.

Similarly, health care workers from Hospital C and D, who were pessimistic about providing counselling, experienced that in their working environment there were no private counselling rooms, limited resources and / or time allocated for counselling sessions, and most patients were hungry pregnant women with babies who travelled for long distances.

*“How can you expect us to briefly talk to patients who are hungry about their private issues in a public arena?”* To further elaborate, these two hospitals (C & D) were situated near the borders where most of their patients crossed the borders from neighbouring countries; such as Angola, Botswana, and Zambia to seek health care services.

Effective communication was perceived as a burden to health care workers who struggled to cope with an influx of patients who were crossing the borders and causing hospitals to be congested to their maximum capacity, and the unavailability of supplementary food to feed pregnant mothers and children who travelled long distances.

*“Our hospitals are always full to the capacity and there is not time to provide counselling to these patients because they will be exhausted, hungry and not pay attention to whatever information conveyed to them, all they thought about was to get their tablets and endure long distance back home since it was far”*.

Similar reactions are shared in UNAIDS Progress Reports (2012) that countries in subSaharan Africa are still facing challenges in providing quality health care services to PLWHA due to inadequate communication skills, support structures, resources, and infrastructure. Furthermore, it is noted that the notion of excellent communication skills are associated with the delivery of highly quality care. Similar views are shared by Robinson, *et al.* (2011) on the benefits of communication skills that assist clinicians and patients – in relation to health information – with exchanging and promoting diagnostic accuracy, patients’ knowledge, understanding, health outcomes, clinician-patient satisfaction, adherence to a treatment plan, patients’ trust in clinicians, and reducing medical errors.

## **Conclusion**

In Subtheme 1, health care workers reflected with mixed feelings about their abilities to communicate effectively with their patients. Health care workers exhibited this when faced with challenges of communicating about sexual issues with opposite sex patients, addressing the same issues with elderly people, providing information to teenagers, bereavement counselling, and talking to expectant mothers.

### **□ Subtheme: Lack of IEC materials for disseminating health information to HAART patients**

Information education communication (IEC) refers to tools used to transfer knowledge to a targeted audience with the aim of assisting with the promotion of positive change (Edewor, 2010) The types of IEC materials are, e.g. graphic and audio-visual resources that include brochures, posters, display boards, bill boards, DVDs, slides, flip charts, flip cards, and counselling cards. It also includes mass media like radio, television, movies, newspapers, and magazines. IEC materials are categorised as either printable, or electronic. Printable resources

include posters, brochures, flipcharts, newspapers, and magazines while electronic materials include radio spots, television spots, and movies. Health information should benefit PLWHA by the way it is presented to them. It should be informative, localised, simple, accessible and easy to follow.

In this study, IEC materials are regarded as additional health information that is provided to HAART patients and members of the public (reachable and hard to reach) that promotes health and raises awareness by utilising health communication strategies. It was found that all four district hospitals in Namibia experienced an insufficient supply of IEC materials for disseminating health information to HAART patients. That was evident in the following statements:

*“We don’t have any designed tools for giving health information”.*

*“We give patients health information through watching videos, and not sure whether it covers the patients’ needs”.*

While examining the nature of the phenomenon, it was found that majority of health care workers were lacking the standardised tools and IEC materials that were relevant to PLWHA, particularly those patients on treatment. They expressed that:

*“There were insufficient IEC materials in most of the hospitals during...”*

According to UNAIDS Global Progress Report (2012) the shortcomings were identified in Sub-Saharan African countries that faced insufficient resources and the development and distribution of IEC materials for PLWHA, particularly those patients who were residing in remote areas. Similar experiences were acknowledged in a study on nutrition done in Ethiopia, where IEC / BCC materials were in short supply while major materials were of an inadequate quality. The same perspectives were held in Ghana where IEC messages for

PLWHA were perceived as either gender biased or in-sensitive and stereotypical.

It was found that more than half of the health care workers took personal initiative by using the Internet as a source of information.

*“Sometimes, I search from the Internet, most health information that I give to my patients”.*

This is similar to the perceptions illustrated by Coiera (2013) on telemedicine technologies by pointing out that Internet technologies were conveniently utilised for health care services delivery in developed countries. This is in contrast with other studies about Internet technologies that indicate that information of such a nature is inconsistent and unreliable.

In this study, it was found that all district hospitals were utilising television as a mode of disseminating information. Participants indicated that:

*“HAART patients are entertained by watching television while waiting on [sic] the long queues”.*

In contrast with how the patients perceived television, some health care workers reported:

*“[The] majority [of] patients perceived television consequently as more entertaining than educative since they preferred watching African movies”.*

They further uttered that *“most recorded movies were more entertaining than educative, such as African movies”.*

The majority of health care workers at their facilities were utilising expert patients (EP) and support groups as sources of information.

*“Due to lack of time and resources we always refer our patient to EP where they received health education and counselling although we are all aware that they had no formal training”.*

At the time of the study, health care workers relied on EP who were attached to the hospital for assisting them in paediatric departments and at antenatal clinics where their responsibilities were to retrieve and fill in patients' files.

Some studies indicate that information should be perceived as important to PLWHA on HAART because it assists them with making decisions about treatment and specific support they need. Therefore, information is valuable and an important part of coping with illness. This includes communicative and cognitive activities like seeking, avoiding, providing, appraising, and interpretive information (Robinson, *et al.*, 2013). Similar views are shared by Edewor, (2010) who states that insufficient information can compromise the success of treatment and other HIV prevention interventions. Therefore, patients need to be provided with relevant, accurate, and timely information that addresses their health needs.

This study further found that health care workers expressed their concern about printed information:

*“Specifically patients come to the facilities to collect pamphlet, or posters and used them to make fire at their homes because they did not understand and read, since most of messages were written in [the] English language not in their vernacular languages”.*

In the context of Sub-Saharan Africa, IEC strategies are perceived as appropriate strategies for raising awareness and reducing HIV / AIDS in countries like Kenya, Tanzania, South Africa, Botswana, and Uganda (UNAIDS Progress Report, 2012).



## **Conclusion**

Participants expressed their concern about the shortage of IEC materials and tools for disseminating information to PLWHA on HAART at their facilities. Most pamphlets or posters were written in English which made it difficult for patients to read and understand. That led to patients using the posters for making fire at their homes. Insufficient IEC materials at all facilities resulted in health care workers rather using the Internet as a source of information. Television was used to entertain patients, not necessarily educating them, while they were waiting in long queues. Health care workers utilised expert patients' services for providing counselling and education to PLWHA on HAART due to a lack of time, resources, and infrastructure.

### **3.2.4 Main theme 2: Health care workers experiencing a lack of exposure to HIV /**

#### **AIDS management**

Exposure refers to advances of knowledge about the mechanisms and dynamics of an event, either causing or preventing adverse health outcomes (Lexicon dictionary, 2013). In this study, exposure indicates health care workers' ability to manage knowledge while dealing with HIV / AIDS aspects that lead to quality health care services to PLWHAs. Therefore, in order for health care workers to master the management of HIV / AIDS knowledge, they need to be guided by the existing collection of policies and frameworks that support their initiatives in interpersonal communication skills for exhibiting their performance and attitudes towards their patients. Moreover, Health care workers need to have knowledge about the disease itself, its progression, transmission, prevention, treatment, care, and support.

It was found that health care workers were experiencing a lack of exposure to HIV / AIDS management. This statement is supported by the following quotations:

*“Information about the epidemic is evolving and we want to be updated with new information about universal intervention strategies, care, and support for PLWHA”.*

*“We want more workshops to take place in our facilities HIV / AIDS management”.*

In addition, the study findings indicated that health care workers were not comfortable with operational policies because they lacked a clear definition of the scope of work and allocation of tasks that particularly addressed the health needs of PLWHA on HAART. This perception was illustrated:

*“In their facilities, there were no structures or uniformity orderly ways of operating day to day activities”.*

In the development of communication skills guidelines, communication theories are emphasised that assist in setting frameworks to guide health care workers during planning of and setting goals for their daily activities (Wouda & Van de Wiel, 2012). Examining the nature of the matter, the majority of participants indicated:

*“Health care workers expressed that they had limited knowledge on the epidemic despite the evolving information”.*

The attention of the researcher was also drawn to:

*“Health care workers indicated that the work that they do was delegated to them by the supervisors; there was no planning or any administration done”.*

Health care workers lost direction in providing quality care to patients because they had no knowledge about the organisation and analysis of information to make it understandable and applicable to problem solving or decision making. These skills are necessary for capturing knowledge to ensure the preparedness of public health services. Managing information is more effective and collaborative in a virtual environment, since it improves effectiveness in the face of dwindling resources (Malmberg, Harmon, Nauer, & Richard, (2012).

## **Conclusion**

Health care workers expressed their concerns with regard to insufficient knowledge in HIV / AIDS management, since it affected their daily operations at their facilities. According to them, they experienced a lack of uniformity when planning day-to-day activities. Most of their work was delegated to them by supervisors. There were no operational policies or curriculums to direct them.

### **□ Subtheme: Lack of support in developing knowledge through in-service training to manage HIV / AIDS**

Support means contributing or assuring success (Oxford dictionary, 2013). In this study, support means empowering health care workers with relevant skills and tools for enabling them to deliver quality health care services that improve the lives of HAART patients. It was found that health care workers experienced a lack of support in developing knowledge through in-service training to manage HIV / AIDS. This was evident in the response of participants:

*“At our hospitals, there are no structured curriculums or manuals that can guide us health information communication thus why we rely on own initiatives”.*

The majority of the respondents shared this opinion:

*“Health care workers were educating themselves through Internet technology, although struggling to pay for internet services at the cafes”.*

In examining the nature of the phenomenon, it emerged that Internet access was a major challenge at all hospitals, since they were trying to limit some costs of installing Internet access in every office; the only connections were in the managers’ offices.

A similar view is shared by Coiera (2013) that utilising the Internet and other technologies have evolved, particularly in most developed countries where the Internet improved communication and care of patients. Health providers communicate with their colleagues much easier and faster while sharing ideas on patients, diagnosing, accessing patients’ files, retrieving new health information, and accessing technologies.

The majority of health care workers at Hospitals A, B, C and D expressed their concerns about training:

*“Most of the trainings provided by the Ministry of Health targeted our managers only, but now the problem was they don’t even come and share or give use inhouse training”.*

*“We always hear about these on-going trainings but we have not reached us here in rural areas”.*

It was found that:

*“More than half [of the] participants work in district hospitals situated in remote areas of different Namibian regions; namely north, northeast and south, and not feasible for all HCWs to leave patients and to attend training”.*

Findings of other studies state that workshops and in-service training have an effect on communication skills, particularly of health care workers who are working directly with patients. Similar views are shared in a paper about patient education and counselling which indicates that training boosts self-perceptions of confidence and competence in caring for the patients (Malmberg, *et al.*, 2012).

A further notion of inadequate training was argued by a health care worker from Hospital D:

*“I only heard that NGOs are the ones giving HIV / AIDS training but to attend required some recommendations from your supervisor... In most cases, the manager attends alone”.*

However, the study found that:

*“Training health care workers at the facility level were through NGOs perceived as the most convenient strategies in most hospitals because it was cheaper and no travelling involved and accommodating participants”.*

Most organisations that were working with PLWHAs had offices at the facilities. The majority of participants argued:

*“Their dilemma was for them to attend these training required approval letters from supervisors”.*

Despite these shortcomings, some other studies emphasise that employers assist health care workers to acquire appropriate training at all levels of responsibilities in order to increase an understanding of HIV / AIDS and to help reduce negative and discriminatory attitudes toward colleagues and patients who are living with HIV / AIDS. World Health Organization Report

(2009) on: Towards universal access: Scaling up priority HIV/AIDS stated that this training needs to include the etiology of the disease and provide a platform for continuing learning, improving interpersonal skills, understanding the impact of HIV / AIDS and the burden of stigmatisation, as well as providing the tools to communicate with patients.

## **Conclusion**

Health care workers expressed their concerns about the lack of support for in-service training at their facilities that paralysed their efficiency and effectiveness in providing quality care to PLWHA on HAART. They further expressed that there were no structured curriculum or manuals that could guide them in health information communication. Therefore, they resorted to the Internet for guidance.

### **□ Subtheme: Lack of guidelines that clearly assist Health Care Workers to engage in the management of PLWHA on HAART**

A guideline refers to a principle or criterion that is guiding or directing action (Oxford dictionary, 2013). In this study, guidelines and frameworks describe operational directives (action plans) that guide health care workers in their day-to-day activities.

The study outcomes indicate that in Namibia there are no specific guidelines with regard to communication skills that clearly stipulate the roles of health care workers in HIV / AIDS management. This was evident in the following statement:

*“As far as I am concerned, here at our health facility, there are no guidelines that define our roles and how we can address PLWHA the needs”.*

The majority of participants from Hospitals A, B, C and D uttered their discomfort about the content of HIV Counselling and Testing (HCT) guidelines which they said contained limited information on their responsibilities in HIV / AIDS management.

*“HCT guidelines are not clear in how we can provide counselling to PLWHA on HAART. The content covers few issues in counselling not detailed health education”.*

In the context of Sub-Saharan Africa, a lack of urgency to develop guidelines that advance skills for health care workers who are caring and supporting HAART patients is a matter of concern. Consequently, the performance and work of health care workers are affected. A similar view is shared in other studies that state a lack of appropriate guidelines in most developing countries compromises quality health care services and performance of workers (Wouda, *et al.*, 2012). The same research report further emphasises the importance of empowering patients and physicians, during frequent discussions, to improve the effectiveness required for the development of guidelines to teach communication skills. However, the findings indicated that:

*“Health care workers need operational and programmatic guidelines that guide them in providing quality health care services, treatment, care, and support to PLWHA on HAART; particularly on these times where integration of HIV / AIDS health care services into primary health care, had took its drastic changes that affected the most health care departments with regards to staff rotation, task shifting and absenteeism of other HCWs due to illness”.*

These perceptions are illustrated in the WHO Report Global Summary Report (2009): Towards universal access: Scaling up priority HIV/AIDS which indicates that guidelines are essential to health sectors, since they assist with defining and planning HIV programmes

while linking them to the wider health policies, strategies and plans, as well as the wider multi-sectoral AIDS response. These guidelines need to emphasise the principles that focus on: The outcomes and maximising returns on investment; describing main components of a sectoral HIV plan, such as situation analysis, prioritisation, approach to service delivery, monitoring, and costing; as well as establishing a direct link between strategic, operational planning, and implementation.

### **Conclusion**

This study notes that all participants from Hospitals A, B C and D advocated for the development of a communication skills guideline that would guide and direct health care systems in developing frameworks that assisted health care workers with planning and implementing relevant programmes that addressed the health needs of expanding PLWHA treatment, care, and support of health care services.

### **□ Subtheme: Health Care Workers experience lack of supervision from the superiors to be able to manage HIV / AIDS**

Supervision is a process of guiding, helping, training and encouraging staff to improve their performance in order to provide high-quality health care services. Supervision is complex, especially in health care services, where there are different health care facilities, levels of care, types of care, services provided and ways to pay for those services where people still need such services and provide those services (Wouda, *et al.*, 2012) Therefore, in order for health care workers to provide quality health care services to HAART patients their performance need to be guided and supported on their day to day activities.



However, the study results illustrate that health care workers are experiencing a lack of supervision from their superiors that prevents them from managing HIV / AIDS. This was evident in the following statements of participants:

*“We don’t have sense of direction due to poor supervision”.*

*“We discovered that even supervisors have no clues on HIV / AIDS management”.*

*“No one from the management team or from the national offices concerned about what we do”.*

It was found that the majority of participants from Hospitals A, B, C and D expressed their discomfort with regard to poor supervision from their superiors at their facilities.

These perceptions were confirmed by another health care worker:

*“Disgruntled on the attitudes of supervisors referencing their behaviours as insensitive towards staff members, even if one had pressing personal issues found it difficult to approach supervisors”.*

The majority of health care workers from the four CHS hospitals disapproved of supervision methods and of being supervised:

*“Supervisors always made excuses not to supervise them due to workload they encountered at the facilities and not paying any attention to HCWs who working directly with PLWHA”.*

To elaborate further, the majority of health care workers agreed:

*“[At] their facilities, they had no open door policy where one can just walk in and be welcomed by the supervisor”.*

*“Most of the time they complain that they did not want to be disturbed sticking out a ‘Do not disturb’ warning sign”.*

Garrison in Wouda, et al., (2012) urges supervisors to abide by their obligation and responsibilities in supporting their members of staff and states that supervisors can help staff to acquire skills that are essential for completing any given tasks effectively (Wouda, et al., 2012). This could be made possible by improving communication, transferring knowledge / skills, in-service training, and building opportunities of targeted needs for particular members of staff in the context of day-to-day work (Pecora, Cherin, Bruce & De Jesus Arguello, 2010).

## **Conclusion**

Health care workers experienced a lack of supervision from their superiors which they perceived as affecting their performance and provision of high-quality care to PLWHA on HAART. Health care workers viewed supervisors as their mentors and expected them to guide, assist, train, and encourage them in their day-to-day activities.

### **3.2.5 Main theme 3: PLWHA on HAART experience insufficient information on HIV / AIDS aspects essential to their health**

Information refers to an abstract entity (Chmielecki, 2008). Various theorists define information as data, facts, intelligence, and advice. Information can be knowledge or wisdom. People acquire information through reading, studying, and practical experiences. Information can also be provided by telling, reading, or communicating facts that may be disorganised and unrelated. The concept of knowledge, however, is perceived as an organised body of information or as comprehension and understanding that are based on an acquired and

organised body of facts. Furthermore, wisdom is viewed as knowledge of people, life, and conduct with facts thoroughly assimilated to produce sagacity, judgement, and insight (Oxford dictionary, 2013).

Information is essential to PLWHA and cannot be ignored (Edewor, 2010), particularly to those patients who are on treatment. Information is seen as an important part of coping with their condition. Therefore, HIV / AIDS service providers should have tenacity in prescribing types of information they assume is relevant to the needs of PLWHA, including medical information and information about social services. The same report further indicated that, the nature of information required by PLWHA should be based on their needs and can be categorised in different stages of the epidemic; such as the period of infection, initiating HAART, prevention, care, and support.

Ever, since the age of the epidemic, information has been perceived as a critical requirement. Information is used for prevention of HIV, management of complications of the disease and prolonging of lives. Since PLWHAs are now leading productive, healthy lives and the morbidity and mortality rate has been reduced, the roles of information change, including information for the health care providers. Nowadays, information needs to focus on empowering PLWHAs in maintaining their new lifestyles. However, the challenges are whether the meaning of the information is being communicated accurately, clearly, and educationally as intended to improve the quality health of PLWHAs (Robinson, *et al.*, 2011).

#### □ **Subtheme: PLWHA ON HAART experience a lack of information**

The outcomes of the study identified that PLWHA on HAART experienced a lack of information in relation to: The prevention of HIV, adherence to treatment of HIV, blood results, sexual relationships, alcohol abuse, and nutrition.

## **HIV / AIDS Prevention**

In this study, the concept of HIV prevention refers to activities or information that stops negative actions or behaviour of PLHWA while promoting positive behaviour. The current study findings add substantially to our understanding that PLWHA on HAART experience insufficient information about HIV prevention. Moreover, the participants (HAART patients) expressed their discomfort with insufficient information on HIV prevention that they are provided with by health care workers each time when they visit the health care facilities. This was evidence in the following statements:

*“My partners say they enjoy sexual intercourse without protection”.*

*“I am discharging smelly fluid from my private part but still my partner still demand having sexual intercourse”.*

The majority of participants from the four hospitals A, B, C and D indicated:

*“They had immense information on using condoms for protection but they didn’t know how to convince their partners about the dangers of unprotected sex”.*

However, the study findings indicate that the health of the majority of PLWHA on HAART has improved ever since the ARVs intervention, therefore, their priorities have changed, since they now feel strong and physical fit and see no reason for not leading normal lives.

In examining the nature of the shortcomings:

*“Participants argued that condom use was not an option since their health has improved”.* Most participants reflected that the use of condoms was preventing them from conceiving while they were also chasing their partners away. Therefore, they preferred to use protection methods that were acceptable to their partners.

*“Participants further demanded more information on how to prevent re-infection and prevention interventions, including counselling and specific health care services”.*

Similar views are acknowledged in UNAIDS Report on Global AIDS Epidemic (2010) which states that since the antiretroviral interventions, many opportunities have been missed in addressing prevention in terms of treatment, care, and multiple points of contact between health services and PLWHA. The consequence were confirmed in UNAIDS Global AIDS Epidemic Update (2009) which indicated that the main focus of HIV prevention in SADC regions is on rolling out of ARV treatment in the absence of prevention activities; this vacuum contributes to new HIV infections.

### **Adherence to Treatment**

The term adherence is a process of being dedicated to do something (Oxford dictionary, 2013). In this study, adherence describes a patient’s commitment to carry out a prearranged plan of treatment, including food intake, in a sustainable fashion. The commitment of HAART patients to life saving treatment is determined by individual circumstances.

The study found that most of the participants were experiencing a lack of information on treatment and that was conveyed through the following statements:

*“How can I take my tablets everyday with no food?”*

*“Health care workers always shout at me if I miss my tablets”.*

*“Sometimes, I fail to go and get my tablets because the hospital is very far”.*

*“I feel strong now; think of stopping taking these tablets”.*

The findings indicated that the majority of participants also explained their emotional rollercoaster while they were taking their ARVs.

*“They further elaborated that in most occasions taking ARV drugs without eating food made them experience severe side effects; such as vomiting, diarrhoea dizziness, insomnia, and dementia”.*

According to the field notes, the majority of participants came from poverty stricken areas; most of them relied on harvesting crops to earn a living. For several years, they were experiencing persistent draught with the result that they neither had staple food, nor any source of food. Furthermore, some participants complained about travelling long distances from their rural villages to health care facilities to collect ARVs. Sometimes, they also missed appointments due to the distance from the health facilities.

In the interviews, most participants expressed their ignorance of information about the myths and misconceptions about HAART treatment.

This majority of participants raised the issues surrounding misconceptions about HAART treatment and a cure for AIDS by saying:

*“Having sex with a virgin, animal, or use crocodile fat when having sex cures HIV”.*

However, it was found that:

*“More participants indicated that these misunderstandings were circulated by their social networks and media”.*

Despite these misunderstandings, AIDS has no cure. Having sexual intercourse with a virgin, although it was prevalent in Sub-Saharan Africa, was considered a crime and having sex with

an uninfected virgin actually exposed that poor girl to HIV infection. Perpetrators were supposed to be incarcerated by the laws of the country, (UNAIDS Global AIDS Epidemic Update, 2009).

Furthermore, one of the participants witnessed the procession of men having sexual intercourse with an animal at their village in the northeast of the country where a cow gave birth to a humanlike animal.

Although sexual intercourse with animals was recorded in South Africa, Namibia, as well as in other countries, having sexual intercourse with animals was perceived as an act of cruelty. Furthermore, there was no documented evidence which suggested that sexual contact with an animal actually can cure AIDS (UNAIDS Global AIDS Epidemic Update, 2009).

*“Participants specifically indicated that their religious beliefs [do] not permit them [to] keep on using ARVs drugs”.*

This perception illustrated that these frequent misconceptions about AID treatment resulted from simple ignorance and misunderstandings with regard to the knowledge on HIV infection, the etiology of AIDS, and how ARV treatment worked. Contrary to various studies that indicate the factors that are associated with non-adherence originates from a lack of awareness about the treatment itself, public ignorance, and the misunderstanding of the etiology of the epidemic (Baltazary, Akarro & Mussa, 2011).

### **Blood Results**

In this study, blood results refer to the feedback given to HAART patients by HCWs on information about their CD4 count and the levels of the viral load in their blood. It is often said, “Life is in the blood!” It is important to note that there are various reasons why HAART patients need to know more about the condition of their blood. Therefore, health care workers

have an obligation to adequately empower HAART patients with information with regard to their blood in order for them to make the right decisions about their health (Edewor, 2010).

The majority of participants (PLWHA) were not given accurate information about their blood results. That was evident in the following statements:

*“I told one of the health care workers that I wanted to have a baby, she told me to come for my blood to be tested, but did not tell the reasons why?”*

*“How can I stay health with this virus eating me up?” “I was told that my blood was OK”.*

*“The health care workers told me that there was CD4 count and viral load in my blood, what does it mean, or does it mean I about to die or what?”*

*“Do I have to start my medication right away?”*

The findings of the study demonstrated that majority of participants were not knowledgeable of the medical terms that were used by health care workers. The most confusing terms, according to them, were normally used every time they were asking about their blood results. These terms included “CD4 count and viral load”.

In addition, it was found that:

[The] majority of participants complained a lot about the attitudes of health care workers with regards to feedback on their blood results.

Others were so disgruntled by the way they were treated by health care workers, after they had travelled for long distances and told that their blood results were not in from the laboratory.



Some expressed their emotions saying that their pregnancies were at the advanced stage but still told to wait for blood test for CD4 Count and viral load.

The other participant from D Hospital was too emotional when she explained how badly she and her husband waited for her blood result and wanted to conceive and have a baby. Unfortunately the husband died prematurely before the procedures were done.

The similar views were shared by one of the participants from A Hospital who claimed that the last time he received his blood results was in 2004 thus when he knew about his HIV status and told that he was OK.

That made the HIV positive patient to disappear from the system and by the time he visited the hospital, he was hospitalised with serious illness and was told that he experienced a CD4 count fall and his viral load was too high. He still did not understand what the information meant. He developed severe side effects because he was not on treatment for a long time.

The concepts of viral load (HIV-RNA) and CD4 count are perceived as the measure of the disease progression and survival as described by Akinsegum Akinbami (2012). The report further elaborates that this notion of CD4 count – although perceived as part of the immune system – is viewed as the strongest predictor of risking AIDS and death. This means that HIV over time destroys CD4 cells making the immune system weaker. Therefore, it is viewed as one of the determinants for measuring the strength and weakness of the immune system in the patients' bodies Akinsegum Akinbami (2012).

### **Sexual relationships**

The term sexual relationship refers to a relationship involving sexual intimacy (Oxford dictionary, 2013). Sexual relationships can be influenced by every culture, sub-cultures, or differences in individual values. It includes a positive and respectful approach to sexuality

and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences free of coercion, discrimination, and violence.

In this study, the sexual health of PLWHA refers to sexual relationships with respect to desires, concurrent sexual relationships, family planning, and childbirth. Due to ARV initiation, PLWHA are leading a healthy life and sexual perceptions of both men and women have changed, e.g. changes in numbers of partners; desire to start families, and desire to have babies (Degu, Yimer, Berhane & Melkamu, 2006). For PLWHA on HAART to live positively, they need to be provided with relevant information that addresses their health concerns without compromising their health. This information should not only focus on what they should be doing but also on what they should not be doing (Bell, Mtembu & O'Sullivan, 2007).

The study findings demonstrate that PLWHA on HAART experience a lack of information about their sexual needs. This was evident in the following statements:

*“Now, since I feel health [sic] my condition has improved, this is the right time for me to get married and have children”.*

*“I missed my period, but I was taking some family planning tablets”.*

The study found that:

[The] majority of participants (HAART patient) expressed their concerns with regard to treatment they received from health care workers as displeasing each time they ask specific questions about family planning and / or childbirth.

A variety of studies suggest that HIV positive women have the same rights as other women and also need access to HIV specific information and services (Gruskin, Ferguson, & O'Malley, 2007).

The majority of HAART participants uttered the similar concerns in relation to HIV specific information by saying:

*“I can have as many sexual partners as I want”.*

*“I am a driver and my work takes me away from home where my wife is, sometimes [I] engage in unprotected sex with different women”.*

*“My customers demand unprotected sex at a high cost”.*

These perceptions illustrated that participants (PLWHA) wanted to know how they could disclose their HIV status to sexual partners without compromising their business. Some participants mentioned that:

*“Sometimes using condoms makes them uncomfortable and time consuming, since they were long distance truck drivers”.*

In Namibia, the study done on the drivers and the HIV / AIDS epidemic under the auspices of the Ministry of Health and Social Services MoHSS, (2009) states that multiple concurrent partnerships (MCPs) are perceived as one of the main drivers of HIV transmission in Namibia which makes all people who are practising it vulnerable to contracting HIV. Moreover, the same report states that PLWHA on HAART experience inadequate education and / or relevant information about the dangers of MCPs to their health.

Some researchers suggest that there is a correlation between MCPs and HIV transmission among PLWHA on HAART that consequently is compromising prevention and treatment

efforts, is preventing ARVs to decrease viral loads to undetectable levels in the short to medium run, is causing the durability of first line treatment to be average, i.e. less than five years, while the first line treatment is weakening, viral loads are fluctuating, and the infectivity of individuals on HAART is increasing (Mah & Maughan-Brown, 2009).

### **Alcohol Abuse**

The Centre for Disease Control & Prevention (CDC) (2013) defines alcohol abuse as the pattern of drinking that results in harm to one's health, interpersonal relationships, or the ability to work. The manifestations of alcohol abuse include failure to fulfil major responsibilities, such as driving or operating heavy machinery.

In this study, alcohol abuse describes the general implications of alcohol that are associated with the health of PLWHAs which contribute to the interruption of ARVs treatment. This causes non-adherence; susceptibility to communicable diseases, such as STIs, TB, and reinfection that causes HIV stress and risk of the further spread of the virus; as well as exposure to certain types of behaviour, such as the prevalence of MCPs and its consequences. The outcomes of this study demonstrate that HAART patients on ARVs have insufficient information about the dangers of alcohol abuse. This was evident in the following statements:

*"Taking ARVs requires a full stomach, so I drink alcohol with my ARVs".*

*"In our villages, alcohol is part of socialisation, so yes. I do drink alcohol".*

*"As long as I don't forget taking my ARVs, I do drink alcohol because it helps me to sleep in the night".*

It was found that most participants strongly felt that there was nothing wrong with taking their ARVs with beer whereas some of them indicated that beer was one of their staple foods,

especially home brew beer, since it had been part of their lives for a long time and they could remember that by the elderly had normally used it for weaning babies.

*“Participants further reluctantly find it difficult to just stop drinking alcohol”.*

*“Other participants reiterated and said alcohol made them feel good about themselves and prevent insomnia problems. So, it was difficult for them to quit”.*

Contrary to the studies done in Sub-Saharan Africa that describe the implications of alcohol abuse among HAART patients as associated with various issues which result from the interference with ARVs treatment. These issues contribute to non-adherence, accelerating progression of the disease, increasing likelihood of having multiple concurrent partnerships and having unprotected sex, the effects of infectious diseases (STIs) on the immune system, diseases associated with neuropsychiatric disorders, related to cardiovascular ailments, and the effects on internal organs such as the liver and the pancreas as described by Baliunas, Pandrea, Hendershot, Corrao in (Rehm, 2012).

Despite these shortcomings, dealing with alcohol abuse and HIV requires policymakers and implementers to address alcohol related interventions that are aimed at increasing safer behaviour, such as condom use in conjunction with other issues like partner reduction and mutual monogamy. This includes the development and provision of education and training programmes for PLWHAs and the community. Therefore, the IEC educational materials should be a discussion point among PLWHA on HAART and health care workers (Habtemariam, Tameru, Nganwa, Beyene, Ayanwale, Robnett, & Wilson 2008).

### **Nutrition**

Nutrition, nourishment, or aliment refers to the supply of food required by organisms and cells to stay alive. In this study, patients’ nutrition refers to the food requirements of patients,

including nutritional solutions delivered via an IV (intravenous) or IG (intra-gastric) tube (Lexicon, 2013).

In this study, nutrition refers to knowledge and means of getting the right amounts good nutrients from local foods and in the right combination as a key to avoiding illness and many other chronic diseases.

The outcomes of the study demonstrate that PLWHA on HAART experience insufficient information about nutrition. This was evident in the following statements:

*“I cannot afford the type of food that is recommended by health care workers.”*

*“Every time when I mix my diet with milk, [it] makes me have a running stomach”.*

*“These ARVs increase my appetite and I have no idea which type of foods can make my stomach full”.*

*“I cannot afford fruits and vegetables that nurses always talk about”.*

In addition, the findings of the study indicated that the majority of participants displayed their ignorance with regard to the right diet for maintaining their health.

A similar view was shared:

*“Other PLWHA[s] on HAART [are] grumbling due to lack of proper foods in their areas because of some persistent draught”.*

*“Participants were confused on what they should or should not eat”.*

Participants further expressed their educational needs for maintaining their diet by eating their own local foods or for starting gardening projects to sustain themselves. The sustainability of

a nutritious diet is emphasised in many research studies. This requires the integration of healthy eating programmes that need to include local food recipes because local food is cheap and affordable for local people (UNAIDS Global Report, 2012).

A similar view is expressed by the WHO Global Report Global Summary of AIDS epidemic (2009) that considers ART as an essential component of care for PLWHAs. However, nutritional interventions need to be incorporated into HIV treatment programmes. On the other hand, health care providers need to acquaint themselves with new knowledge about nutrition, counselling, and management of limited resources.

However, it was found that most participants came from poverty stricken areas of Namibia and they had neither formal jobs nor any source of income, therefore, they were struggling to make ends meet. Furthermore, some of the participants went out of their way and pleaded with the Namibian Government to declare HIV / AIDS as a disability so that they might earn a living through disability grant. An example of such a view was:

*“[The] majority of participants further indicated their struggling in acquiring nutritional food”.*

Ashely, and Lush (2007) show the same results in their findings about treatment literature for PLWHA and state that the respondents were struggling to take their medication with an empty stomach because they could not afford three meals per day due to their lack of earning an income. The same concerns about the lack income among PLWHAs are acknowledged in Sub-Saharan Africa where socioeconomic and psychological factors are seen as challenges among PLWHAs that are contributing to non-adherence (UNAIDS Global Report, 2012).

## **Conclusion**

The study draws attention to the needs of health information by PLWHA on HAART that would improve their knowledge about their health. According to the outcomes of the study, PLWHA on HAART experience inadequate information with regard to: HIV prevention, adherence to ARVs, blood results, sexual health, alcohol, and nutrition.

□ **Subtheme: PLWHA on HAART indicated the need to be empowered to enable them to manage disclosure, stigmatisation, and discrimination**

Empowerment is a process of enhancing the capacity of individuals or groups to make choices and to transform those choices into desired actions and outcomes (Lexicon dictionary, 2013). In order for HAART patients to make informed choices about their health, they require to be empowered with appropriate and accurate information with regard to disclosure, stigma, and discrimination in their communities and workplaces. PLWHAs are reluctant to disclose their HIV positive status because they fear being stigmatised and discriminated against by partners, family members, colleagues, and the community in general (UNAIDS Global Report, 2012).

In this study, the findings demonstrate that PLWHAs on HAART are reluctant to disclose their HIV status because they are afraid of being stigmatised and discriminated.

## **HIV Disclosure**

With regard to disclosure, the study found that PLWHAs on HAART expressed their need to be empowered to disclose their HIV status without compromising their relationships with people whom they loved. This was evident in the following statements:



*“I am afraid to approach my partner about my HIV positive [status] because he will break up with me”.*

*“I don’t know how to tell my parents that I am HIV positive”.*

*“My body weight is failing [sic] but people at [my] workplace are suspecting that I might be ill but I don’t know how to break the news to them about my HIV positive status”.*

It was found that the majority of participants were single women who revealed that their reluctance to disclose resulted from fear of being victimised by their partners who might accuse them of infidelity and bringing the deadly disease into their relationship.

Similar views are supported in a study done in Ethiopia on reasons for non-disclosure; respondents were afraid of being victimised or fearing separation / divorce or even accusations of infidelity (Deribe, Woldemichael, Wondafrash, Haile, & Alemayehu, 2008). However, it contrasts with other participants who perceived disclosure as the right thing to do because it enabled partners make decisions together in relation to treatment, reduced sexual behaviour, reproductive choices, and access to further social support (Bradley, Remien & Dolezal, 2008).

### **Stigma and discrimination**

Stigma comprises two Greek words sigma ( $\Sigma$ ) and tau (T) and has two meanings: (1) In Christianity, stigma refers to body marks that resemble the crucifixion of Jesus Christ, and (2) in a secular context, stigma is used to describe marks of disgrace, discredit, or infamy. In a social context, the term stigma is more frequently applied to social disgrace than to body

signs or tattoos. It can be either internal or external. External stigma refers to actual experiences of discrimination. Internal stigma refers to imagined or perceived stigma (Ngozi, Mbonu, Nanne, De Vries, 2009). Discrimination is the actions or treatment of stigmatisation (Chirawu, 2009).

In this study, stigma and discrimination have three meanings: (1) Self-directed stigma, i.e. PLWHAs are being judged by others which results in self-hatred, shame, and isolation; (2) perceived stigma, i.e. the reality of being singled out, stigmatised, and discriminated against; and (3) enacted stigma that leads to active discrimination and negative behaviour towards PLWHAs (Chirawu, 2009).

Extensive studies were done on stigma and discrimination which concluded that stigma and discrimination was linked to disclosure and prevented PLWHAs from seeking treatment and access to quality health care services. After many decades with AIDS in our midst, PLWHAs are still victimised, burnt alive in some countries, or even killed because of their HIV positive status. This is a clear indication that society is not yet prepared to condone the epidemic (put a face to the disease).

In this study, it was found that PLWHA on HAART need to be empowered to deal with HIV / AIDS related stigma and discrimination. This was evident in the following statements:

*“Each time we visit [the] HAART Centre for ARVs re-fill, health care workers shout and call us names about our HIV status”.*

*“I have no friends anymore, even my treatment supporter. She was victimised by the community because she befriending [sic] me”.*

*“I prefer to be on my own, since I was told I was HIV positive”.*

*“When I told my employer that I was HIV positive, he / she changed my work*

*shift*".

It was found that the majority of participants in this study were stigmatised and being discriminated against in one way or another, since their status was known to a second or even the third person. According to them:

*"The manifestation of stigma and discrimination comes only when they want to engage with the society or community they live in"*.

Stigma has negative connotations as seen by many, because it enhances secrecy and denial, which can be a catalyst for HIV transmission (Ngozi, *et al.*, 2009).

Moreover, the majority of participants were assertive enough to express their negative attitudes towards the policies and legislations of the country that did not protect them completely while they were being victimised by the system.

*"One of the participants who was awarded with [a] scholarship to study abroad, failed to pass HIV test and her future was tarnished"*.

*"Their children born with the virus were being stigmatised and discriminated at school where they go to"*.

*"At the workplace, her husband was demoted due to his status"*.

In order to understand stigma and discrimination, one has to know the root causes that are attributed to culture, sexuality, gender, race and ethnicity, class, and how it affects PLWHA (Mahajan, Sayles, Vishal, Robert, Daniel, & Coates, 2008).

The findings further reveal the distress facing participants (HAART patients) who took part in this study.

*“They said stigma and discrimination was [sic] experienced in the health care systems, where [the] majority of participants mentioned that they were being victimised by the system itself and health care workers who always shout at them whenever they felt like [it]”.*

*“The other elderly person among the participants even pointed [out] where [the] HAART clinic was located, saying thus the reasons why these people stigmatise us because even the hospital has isolated us too”.*

These challenges of stigma and discrimination were expressed:

*“Participates said seem as [sic] people thought they were sticking or rotten because even at church, they experienced stigma and discrimination where they were supposedly being loved, still vulnerable of being stigmatised and discriminated [against] by the community, families, and people who just look at you as if you had done something wrong”.*

Researchers have identified various leverages or interventions for reducing HIV / AIDS related stigma and discrimination. Most of them encourage educational interventions that aim at providing of factual information about HIV / AIDS, interventions focusing on the willingness of health care providers to empower PLWHA with coping skills, mass media campaigns that are providing HIV / AIDS knowledge by targeting attitudes and behaviour, policies, and legislation targeting important structures; such as churches, the workplace, health sectors, and judicial institutions (Chirawu, 2009).

## **Conclusion**

The study outcomes reveal that PLWHA on HAART are being stigmatised and discriminated against. It starts with the affected person, families, societies, the workplace, as well as in

health care systems, government policies, and legislation that are supposedly protecting them from the ills of being stigmatised and discriminated against.

### **3.3 SUMMARY**

Chapter 2 has covered design and methodologies of the study. This chapter presents the data analysis and reviewed literature, the objectives of the study, and responses of the study participants. The study draws attention to and concluded that health care workers have neither knowledge, nor the interpersonal communication and counselling skills to facilitate communication with PLWHA on HAART, affecting their self-efficiency with regard to managing HIV / AIDS activities; absence of communication skills guidelines; inadequate audience targeted IEC material, counselling curriculum, and manuals; training; and poor supervision from their supervisors. Consequentially, it is compromising the quality of life for PLWHA by depriving them of necessary knowledge that is accurate, timely, and relevant to their health needs. HAART patients, furthermore, requested health information with regard to HIV prevention, adherence to HIV treatment, blood results feedback, sexual health, alcohol abuse, nutrition, disclosure, as well as stigmatisation and discrimination. Chapter 4 covers the conceptual framework of the study.

## **CHAPTER 4**

### **CONCEPTUAL FRAMEWORK OF THE STUDY**

#### **4.1 INTRODUCTION**

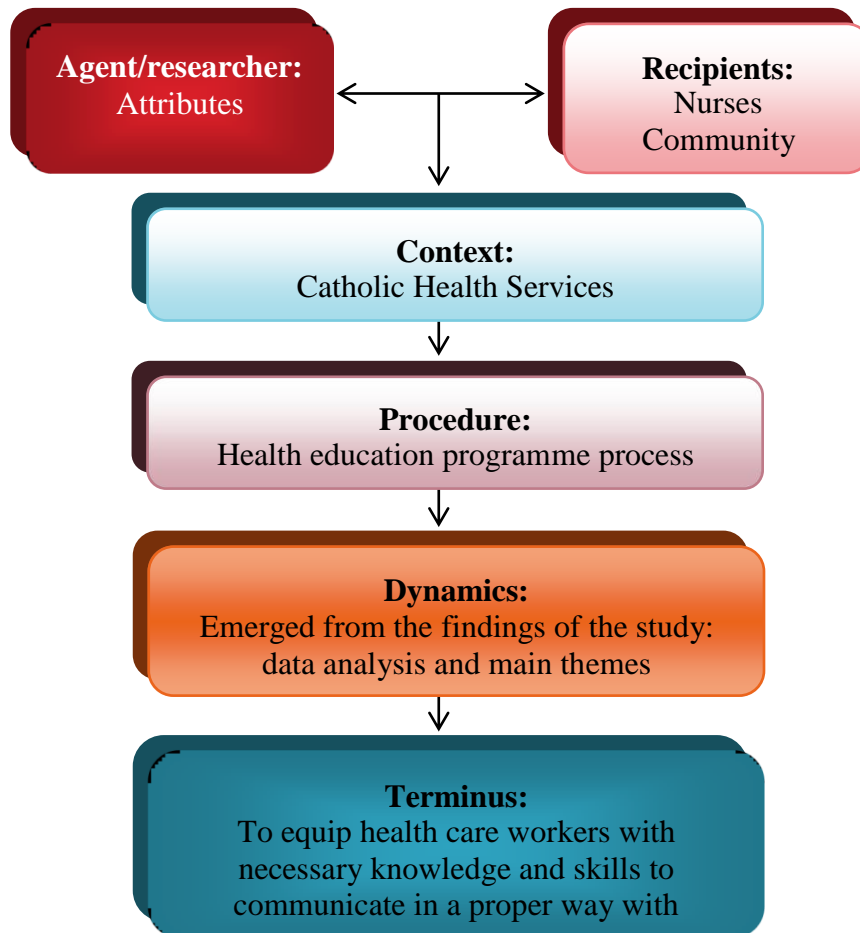
The study findings were presented in Chapter 3. Chapter 4 focuses on the conceptual framework that seeks to synchronise the study findings with the objectives and themes of health care workers' skills deficiencies in addressing health issues for PLWHA on HAART at their respective health care facilities. Chinn and Kramer (2011) describe a conceptual framework is an essential process for creating a rigorous way of structuring ideas while

purposefully and systematically viewing the phenomena. The researcher had the imagination and coherent vision that was important for rigorously ordering these ideas to support the outcomes Fawcett, (2012). This imagination utilised a reasoning map, which referred to a structure for a specific domain that is related through cause-effect relations and that aims at stimulating behaviour of a dynamic system (Alejandro, Humberto, & Agustino, 2012). In this study, a reasoning map is used as a guide for connecting roles to the activities of the programme.

## **4.2 DEVELOPING THE CONCEPTUAL FRAMEWORK**

The emergence of the conceptual framework was associated with the objectives, Themes and study findings. A conceptual framework is defined by Dickoff *et al.* (1968) in Chinn and Kramer (2011) as a structured set of broad ideas and theories that assist researchers to properly identify the problem of inquiry, frame their questions, and find suitable literature. In this study, the conceptual framework utilised the six aspects of activity as an organizing principle. The six aspects refer to agent, recipients, context, dynamics / challenges, and outcome / terminus or destiny. These aspects seek to answer the following “who”, “what”, “where”, and “how” questions:

1. What roles and activities does the agent perform?
2. Who are the recipients of the activities?
3. Where and what is the context of the activities?
4. How and what are the procedures of the activities?
5. Where and what are the challenges?
6. How and what are the outcomes / terminus of the activities?



**Figure 4.1:** Conceptual framework

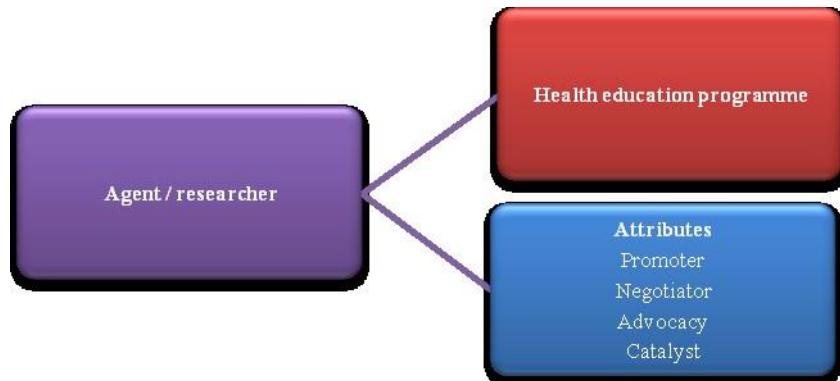
*Source: Adapted by author from Dickoff, James, and Wiedenbach (1968) in*

Principles and descriptions were adopted from Dickoff et al (1968) and utilised to select responsibilities that were consolidated and navigated during the facilitation and accomplishment of the health education programme activity; namely the agent / researcher and recipients; including the context, procedures, challenges / dynamics, and terminus.

#### **4.2.1 Agent / Researcher**

It refers to an individual who performs research independently or systematically. In this study, the researcher / agent was responsible for developing the health education programme

and actualization of the outcome of the activity. The researcher / agent model is depicted in Figure 4.2:



**Figure 4.2: Agent activity model**

*Source: Chipare (2012)*

The attributes and roles of the researcher in this study were to develop a health education programme that assisted health care workers to facilitate communication which would reinforce positive behaviour of PLWHA on HAART. Apart from this initial role, the agent was also responsible for a range of other roles.

### **Good communicator**

The researcher needed to have good communication and interpersonal skills and knowledgeable in providing and collecting information from recipients in relation to the processes, as well as the development and facilitation of a health education programme.

Furthermore, the agent managed to:

- influence the attitudes and behaviour of health care workers during the adoption of the new programme;



- establish and maintain relationships with potential partners;
- express personal needs, understand the needs of other people, and provide emotional support to health care workers;
- make decisions and solve problems;
- anticipate and predict behaviour; and
- regulate power struggles among the potential users (recipients)
- Act as a promoter

The agent encouraged the promotion of the health education programme. Firstly, the researcher wrote letters to the responsible ministries, policymakers and implementers, as well as potential donors to fund HIV / AIDS activities and programmes. Secondly, the researcher scheduled various meetings with the stakeholders and partners to promote the concept.

Thirdly, during a training workshop, the researcher motivated and encouraged the recipients (health care workers) to become part of the concept; adopt the programme; and, more importantly, to send out mass health messages to HAART patients and the public in general through talk shows and campaigns.

### **Negotiator**

The agent accomplished this task by providing a structural platform for inviting parties involved in order to reach a mutual understanding of the expectations of the programme in such a way that did not hinder productivity (Lexicon dictionary, 2013). The agent negotiated with the four CHS health care facilities to utilise IVR - as an integral tool for promoting health.

**Advocacy**

It describes the display of active support (Lexicon dictionary, 2013). The agent resumed a supportive role by reaching out to some of the most marginalised and disadvantaged people who were living with HIV / AIDS in the surrounding villages, remote, rural, and urban areas who had lost faith in health systems and who were unaware that services and support still existed. This role included the lobbying for support from the Ministry of Health and Social Services to seek permission for utilising the programme while not infringing on the ethical and fundamental rights of the subjects in question. Most importantly, the agent sought funding and other resources from potential local and international donors who were willing to contribute towards the successful implementation of the health education programme.

**Catalyst**

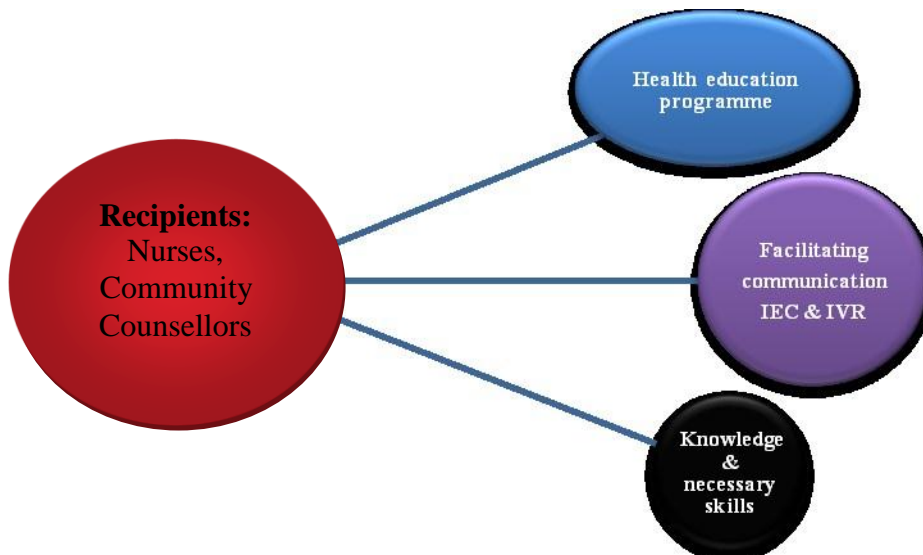
It refers to speeding up things with the purpose of making it happen (Oxford dictionary, 2013). The agent used her interpersonal communication skills as a vehicle / mechanism to spearhead the successful delivery of the health education programme as part of health communication services. It included asking influential people relevant questions for ensuring the availability of human and financial resources, as well as the infrastructure to support the smooth implementation and success of the health education programme. This included volunteering to monitor and evaluate the programme outcomes and impact.

These abovementioned attributes of good communication skills, interpersonal skills, knowledge, promoter, negotiator, advocacy, and catalyst supported the role of the agent in promoting the utilisation and application of the health education programme as a vehicle to disseminate health information to PLWHA. Therefore, the agent planned appropriately regarding on the adaptation of the programme by the recipients (health care workers) and the

logistics around it, encouraging also the recipients to effectively communicate with PLWHA on HAART to improve their health needs.

#### 4.2.2 Recipient / Health care workers

Recipient refers to someone who receives something (Oxford dictionary, 2013). In this study, the recipients were nurses and community counsellors who were regarded as the helpers and facilitators of the health education programme. Figure 4.3 represents the recipient activity model.



**Figure 4.3:** Recipient activity model

*Source: Chipare (2012)*

The recipients' (health care workers') responsibilities were to adopt and facilitate the new programme while having receptive attitudes and appropriate knowledge. They needed knowledge, interpersonal communication, and counselling skills in order to facilitate and reinforce the positive behaviour of PLWHA on HAART, particularly the ones in remote areas. Their counselling skills needed to include appropriate non-verbal communication and attentive listening, expert technical knowledge, maintaining professionalism, being

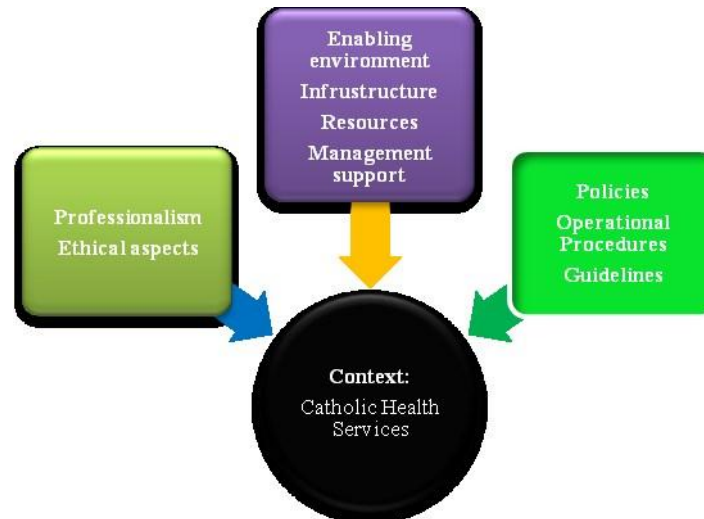
innovative and resourceful, being versed in effective writing, building rapport, and communicating factual information.

**Counselling skills** are another important tool for effective communication, particularly when dealing with PLWHA on HAART. Recipients resumed their formal roles to assist patients with managing the distressing problems of life (Chinn, *et al.*, 2011). To determine what help comprised, recipients needed to consider the reasons why patients sought help and the principal goal of the helping process. Health promotion is a process directed at enabling people to take action. Health promotion cannot be feasible without health education. Thus, health promotion is not something that is done on or to people; it is done by, with, and for people either as individuals or as groups (Schiavo, 2007). Therefore, recipients promote health by educating patients and utilising IEC material and IVR tools during counselling, support groups, and awareness campaigns to empower individuals with knowledge or information to take action and the communities to act collectively to exert control over the determinants of health in order to achieve positive change. The health education programme, therefore, can be facilitated as an integral tool for communicating with PLWHA on HAART.

#### **4.2.3 Context / Catholic Health Services in Namibia**

This research study took place in the context (environment) of the Catholic Health Services (CHS) in Namibia. The health education programme was implemented in the context of health care workers at the facilities of Catholic Health Services (CHS) as described by Dickoff *et al.* (1968) who perceives context as the environment where an activity takes place.

The CHS context is illustrated in Figure 4.4:



**Figure 4.4:** Context of the programme

*Source: Chipare (2012)*

The health education programme operated within the structures and hospital departments of the Catholic Health Services in Namibia. The context was also informed by the HIV / AIDS policies, frameworks, operational procedures, and guidelines that were influencing professionalism and ethical measures set for health care workers. The context, moreover, according to Dickoff et al (1968), practice theories permit an enabling environment for the activity to take place and describe the provision of infrastructure (counselling rooms, time), allocation of resources, and management support. Management support includes the skills development and education of recipients (Baltazary, *et al.*, 2011).

### **Professionalism and ethical aspects**

The CHS, like any other faith-based organisation, is bound by laws, regulations, and conduct that govern operational procedures overseen by the Health Professional Council of Namibia (HPCNA) that reports to the Ministry of Health and Social Services who then reports to CHS. Hence, this collection of laws is depicted in the organisational culture and behaviour of professionalism and enforcement of ethical aspects in relation to staff members.

- **Professionalism:** It describes the attitudes health care workers towards their work; including planning, administration, and day-to-day activities. Characteristics of professionalism entail the building of relationships and caring for patients, respect, empathy, as well as the knowledge and skills that are necessary for providing professional services (WHO Towards Universal Access Report, 2009).
- **Ethical aspects** include maintaining confidentiality among caregivers and, most importantly, respecting civil and health information rights of PLWHA on HAART that are enshrined in the Namibian constitution and fundamental rights that make provision for increasing patients' access to quality health care and for reducing HIV-related stigma and discrimination (Center for Disease Control & Prevention 2012).

### **Policies, operational procedures, and guidelines**

The existing HIV / AIDS policies, frameworks, guidelines, and operational procedures in association with the strategic plan validated the successful outcomes of the implementation of the health education programme. This required the organisational culture to invest in proper planning; interpersonal skills; and accountability, including supervision, efficiency, efficacy, trust, motivational, appraisal, and negotiating skills.

In this study, the context was the CHS health care facilities in Namibia where the health education programme was to be facilitated by recipients. In addition, this platform also permitted an enabling environment for the activity to take place; including the provision of appropriate infrastructure, allocation of resources and management support, enabling recipients to maintain professionalism, and observing the ethical aspects as described in the policies, operational procedures, guidelines, and frameworks of the organisation.

#### 4.2.4 Procedures / processes

Procedure refers to processes or series of acts, especially of a practical nature, that involve standard operating procedures, i.e. the step-by-step instructions for achieving desired results (Lexicon dictionary, 2013). A procedure begins and ends with activity when the desired results are achieved as mentioned in Dickoff et al (1968). In this study, procedure included both the processes and steps that were needed to be performed in order to achieve the outcomes of facilitating a health education programme. The programme procedures are indicated in Figure 4.5.



**Figure 4.5:** Programme procedures

*Source: Chipare (2012)*

The procedure included the outcome processes of facilitating a health education programme according to the practical theories of project development (Dickoff et al, 1968). The health

education programme addressed the needs raised by the recipients in the study findings; i.e. facilitating communication with PLWHA on HAART that required the enhancement of knowledge in HIV / AIDS, interpersonal communication skills, relevant IEC materials, infrastructure (counselling rooms), resources, and management support. According to the UNAIDS Global AIDS Response Progress Report (2012) minimising the incidence of HIV in Sub-Saharan African countries requires empowering health providers with relevant skills and resources to intensify programmes for PLWHA.

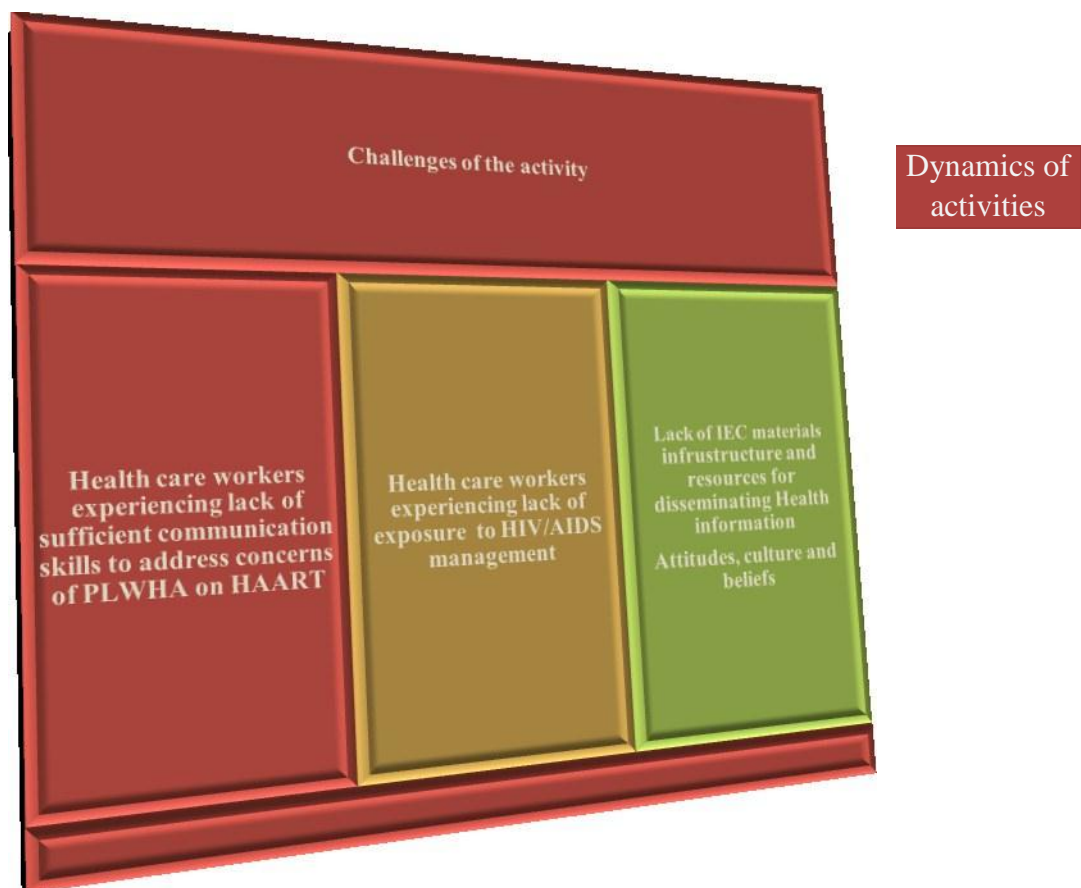
The processes of the procedure, therefore, had to be congruent to the needs of health care workers by focusing on the goals of health education programme. Evaluation of the programme resumed one month after its implementation during which the progress assessment template of the organisation was used.

The procedure ignited the effectiveness of facilitating the health education programme. The facilitation process was based on Dickoff's (1968) practical theories of activity that emphasised steps which needed to be performed in order to achieve the goals of an activity. The evaluation of the activity was conducted one month after the implementation of programme.

#### **4.2.5 Dynamics / experiences**

According to the Oxford dictionary (2013), a challenge is defined as a task or situation that tests someone abilities. In this study, challenges were those obstacles that hindered the accomplishment or facilitation of the health education programme that had emerged from the findings of the study. The programme dynamics are depicted in Figure 4.6.





**Figure 4.6: Programme dynamics**

*Source: Chipare (2012)*

The recipients (health care workers) experienced the following dynamics:

- Recipients (health care workers) experienced a lack of knowledge and necessary skills to facilitate communication with PLWHA on HAART. They also experienced inadequate space for counselling patients, a lack of resources, and insufficient IEC material for conveying relevant health information.
- Patients' attitude towards the new programme, religion, culture, and values.
- Recipients (health care workers) experienced a lack of exposure to HIV / AIDS management, a lack of clearly defined guidelines, and inadequate supervision from

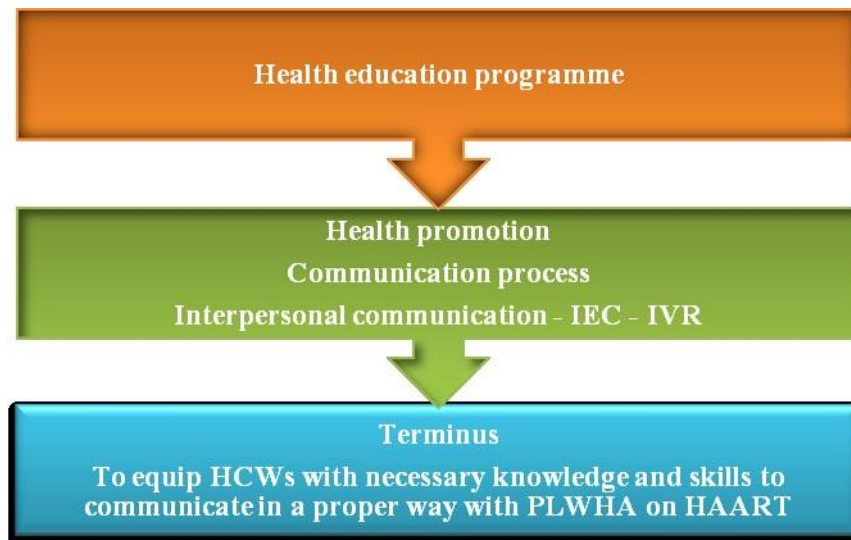
their superiors. It was compromising the essential health needs of PLWHA on HAART.

In conclusion, the outcomes of the study found that health care workers were experiencing dynamics that hindered them to effectively communicate with PLWHA on HAART.

Consequently, the health care workers were infringing on civil and information rights of PLWHA essential for their health as enshrined in the Namibian Constitution.

#### 4.2.6 Terminus / end of an activity

The terminus / destiny or accomplishment of the activity was the adoption of the health education programme at Namibian Health Institutions and the SADC region. The health education programme equipped health care workers with the necessary knowledge and skills to initiate and facilitate communication that reinforced the positive behaviour of PLWHA on HAART. Figure 4.7 illustrates the terminus of the activity.



**Figure 4.7:** Health Education Programme terminus

*Source: Chipare (2012)*

In this study, the terminus of the activity referred to the contextual adoption and utilisation of a health education programme. The health education programme produced well equipped recipients with the necessary skills and knowledge to communicate in a proper way with PLWHA on HAART. Ultimately, recipients were perceived to have abilities to effectively communicate and facilitate change in PLWHA on HAART.

Accomplishment of the health education programme was to support and assist recipients' abilities to effectively communicate with patients despite their heavy workload, time constraints, and their experiences in relation to a shortage of resources and space for delivering counselling services to PLWHA on HAART.

In this study, the terminus of the activity also highlighted steps for using the health promotion protocols and demonstrating methods for disseminating mass health information to patients and the public by utilising counselling, support groups, and awareness campaigns.

**Effective communication:** as a successful outcome according to Hogan & Palme, (2012) note that effective communication is a learned skill that, with practice, enables a person to become a good communicator. Also, it is more than exchanging information; it includes an understanding of the emotions behind the information that can improve relationships at home, work, and in social situations by deepening one's connections to other people and by improving teamwork, decision-making, and problem solving.

The communication process validates an individual's abilities to convey information accurately, clearly, and as intended. It is part of vital life skills and goes hand in hand with counselling skills that empower patient / clients to understand their options upon which to base informed choices about their health.

**Knowledge:** in this study, refers to exposing health care workers' knowledge of HIV / AIDS management while dealing with PLWHA HAART. However, in this final phase, health care workers need to be empowered in the field of management of HIV/AIDS in order to gain confidence in dissemination accurate health information through health promotion strategies.

**Health promotion:** on the other hand is a process directed at enabling people to take action. Thus, health promotion is not something that is done on or to people; it is done by, with, and for people either as individuals or as groups (Schiavo, 2007). Health promotion strategies are utilised by using various types of tools, including IVR.

In conclusion, the accomplishment of the activity means the contextual demonstration of the adoption and facilitation of health education programme, as well as the proper use of IEC material and IVR. The terminus activity illustrated the importance of producing a well equipped health care system with workers who had knowledge and the necessary skills to facilitate communication with PLWHA on HAART. Ultimately, recipients were presumed to have capabilities to effectively communicate and facilitate change in PLWHA on HAART.

### **4.3 SUMMARY**

Chapter 4 presents a conceptual framework of the study findings while synchronizing the objectives and themes (Chapter 3) that exhibit the skill deficiencies of health care workers in addressing health issues of PLWHA on HAART at their respective health care facilities. The chapter, furthermore, covered the conceptual framework based on theories of Dickoff et al (1968), in (Chinn & Kramer 2011), that guided the development of the health education programme and reasoning map that were required for achieving the outcomes of the activity. The reasoning map includes the agent, recipients, context, procedure, challenges, and terminus / accomplishment of the activity as captured in Figure 4.1. The chapter also

illustrates the agent's attributes and roles that were necessary for developing and promoting the health education programme, i.e. good communicator, negotiator, advocate, and catalyst. Additionally, the chapter covers the responsibilities of recipients (nurses and community counsellors), the context (Catholic Health Services), procedure, and challenges. Context refers to the environment where the health education programme was implemented. The procedure encompasses the process / steps of application of the health education programme that utilized health promotion strategies, such as IVR and IEC. The study findings contain challenges associated with health care workers who are not addressing the health needs of PLWHA on HAART. Lastly, the chapter describes the accomplishment/terminus of the adoption and utilisation of a health education programme at health care services in Namibia that equipped health care workers with communication skills and the necessary knowledge to communicate properly with PLWHA on HAART. The health education programme development and implementation are described more extensively in Chapter 5.

## **CHAPTER 5**

### **DEVELOPMENT, AND IMPLEMENTATION OF A HEALTH EDUCATION PROGRAMME (PHASE III)**

#### **5.1 INTRODUCTION**

Chapter 5 presents the development, and implementation of a health education programme with the purpose of enhancing the knowledge and communication skills of health care workers serving PLWHA on HAART in Namibia. This phase follows on Chapter 4 that illustrates the construction of the conceptual framework based on the study findings that guided the development of a health education programme according to the organising principles of Dickoff et al. (1968); namely agent, recipient, context, procedure, challenges, and terminus. The study found that at four CHS district hospitals health care workers (recipients) had no:

- Sufficient communication skills to address concerns of PLWHA on HAART. They experienced inadequate interpersonal and communication skills and a severe shortage of IEC materials for disseminating health information to PLWHA on HAART.
- Exposure to HIV / AIDS management. They did not acquire knowledge through inservice training. Guidelines that enabled them to engage in the management of PLWHA on HAART were not available. Their superiors did not supervise them adequately to manage HIV / AIDS.
- Means to assist PLWHA on HAART (patients) who did not have sufficient information about aspects of HIV / AIDS that were essential to their health. HAART patients had no information about: Prevention of HIV, adherence to treatment of HIV, blood results, sexual relationships, alcohol abuse, and nutrition. HAART patients also needed to be empowered in relation to disclosure, stigmatisation, and discrimination.

Furthermore, the study also found that health care workers (recipients) could not cope with the heavy workload, lack of space, time constraints, and insufficient resources for providing quality health care to PLWHA on HAART. Moreover, other studies found that health care workers without the basic knowledge and skills required for diagnosing and treatment might not be able or willing to attend to the needs of patients with HIV (Lule, 2009).

## **5.2 PURPOSE OF THE HEALTH EDUCATION PROGRAMME**

The purpose of this health education programme is to enhance knowledge and communication skills of health care workers (recipients) serving PLWHA on HAART in Namibia. The health education programme was developed at a time when the Catholic Health Services district hospitals (context) were integrating all their HAART clinics into primary health care services. This proposed strategy was congruent with the development and implementation of this health education programme.

## **5.3 PHILOSOPHICAL APPROACH**

The humanistic assumption based on Mezirow (2007) philosophical approach in transformation learning and education, health care workers (recipients) as humans need to rethink their actions deeply in order for them to act with more insight and effectiveness. Health care workers can be innovative and critically rethink and reflect on those obstacles that are deterring them from not being effective in communicating with PLWHA on HAART and that are preventing them to learn from their past experiences. The humanistic approach presupposes that health care workers as care givers have an opportunity to play a significant role in fostering transformational learning by effectively communicating with PLWHA on HAART and providing them with relevant health information that would improve their health.

This transformation process has become critical when human beings are aware of how and why their assumptions restrict their way of observing, appreciating, and experiencing the world around them; reformulating of these assumptions permit them to develop a more inclusive, discriminating, permeable, and integrative point of view (Mezirow, 2007).

Mezirow's (2007) philosophical approach of transformation and education was used in this study as a guide in the development and implementation of the health education programme. Health care workers as care givers have an opportunity to foster transformation learning and education by effectively communicating with PLWHA on HAART about the importance of their health.

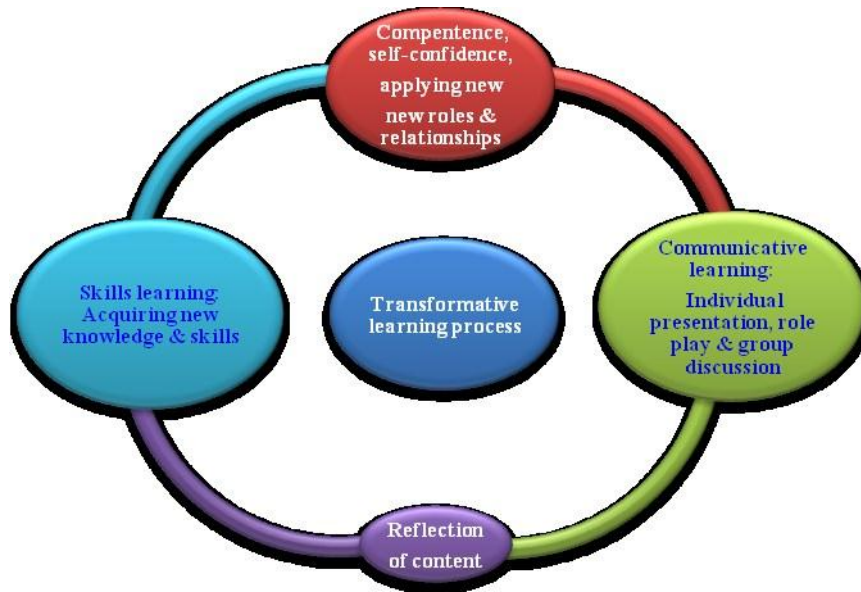
#### **5.4 EDUCATION APPROACH**

In this study, the human assumption refers to health care workers (recipients) who have the potential to be transformed and to acquire the relevant knowledge and necessary skills that can effect change in the lives of PLWHA on HAART. Transformative learning theories (Mezirow, 2007) were used as the educational method for equipping health care workers (recipients) with new knowledge and skills to better facilitate communication with PLWHA on HAART.

#### **5.5 METHODS OF TRANSFORMATION LEARNING**

According to Mezirow (2007), learning can be defined as the process of making a new or revised interpretation of the meaning of an experience that guides subsequent understanding, appreciation, and action. In this study, the researcher adopted transformative learning processes were in order to transform health care workers (recipients) in adopting new communication concepts that enabled them to integrate these concepts into practice while, at the same time, enhancing their knowledge and skills (Figure 5.1).





**Figure5.1: Transformative learning approach**

*Source: Chipare, (2012)*

The learning processes encompass transformative learning, skills learning, and communicative learning.

### **5.5.1 Transformative learning**

The researcher (agent) encouraged health care workers (recipients) to examine their motives and rethink issues on the basis of supposition. Transformative learning permitted health care workers (recipients) an opportunity to think as individuals, develop a sense of meaning, and to question accepted purpose, beliefs, judgments, values, and feelings that were received from their cultures, religions, family values, personalities, and life experiences. Transformative learning also allows for moral decision making and for building genuine relationships between the researcher (agent) and health care workers (recipients) in effecting a change of behaviour in their lives (Mezirow, 2007). Through transformative learning, health care workers (recipients) were taught to refrain from internal and external factors that deterred them from not effectively communicating with HAART patients during every interaction.

Acquiring that knowledge and skills required health care workers to reflect and self-examine their emotions and feelings in order to build competence and self-confidence when assuming new roles and relationships that effected change in people around them, particularly those PLWHA on HAART (Mezirow, 2007).

### **5.5.2 Skills learning**

In this study, the skills learning as part of transformative learning was applied and achieved by health care workers (recipients) to acquire knowledge and the communication skills necessary that enabled them to facilitate communication with PLWHA on HAART. Health care workers, therefore, could only acquire these skills by utilising their interpersonal communication and counselling skills when they communicated with HAART patients. These skills included verbal, nonverbal, and listening skills. Also health care workers needed to provide health information to PLWHA on HAART strategically and integrate health promotion strategies into education through utilising a health education programme, design message content, as well as IEC and IVR tools for disseminating health information to PLWHA on HAART and to the public.

### **5.5.3 Communicative learning**

Communication is an unavoidable skill acquired since birth. As human beings, we find ourselves communicating in one way or another to convey messages, even when we are silent. It is human, therefore, for health care workers (recipients) to initiate communication with PLWHA on HAART. In this study, communicative learning was applied and achieved by health care workers (recipients) during workshop training where they were urged to utilise their knowledge and interpersonal skills to engage with their peers and the facilitator (agent) during the learning process.

## **5.6 THE PROCESS OF DEVELOPING OF HEALTH EDUCATION PROGRAMME**

The development process of the health education programme was based on the themes of the study:

**Theme 1**– Interpersonal communication and counselling skills: The communication process was essential in this study, since it played a big role in restructuring the health education programme. In this process, health care workers were perceived as “senders” of messages and PLWHA on HAART as the “receivers” of those messages. Feedback from both parties completed the whole communication process.

With regard to counselling skills, the health care workers’ role was to educate and provide counselling to PLWHA on HAART in terms of relevant information about their health.

**Theme 1.1** – IEC material and other modes of disseminating health information: IEC materials were considered to be the most essential and convenient method for promoting health or disseminating health education to PLWHA on HAART and the public in general.

**Theme 2** – Exposure to HIV / AIDS Management: Empowering health care workers through training in HIV / AIDS aspects and management of the disease in relation to PLWHA on HAART.

**Theme 3:** PLWHA on HAART information about aspects of HIV / AIDS that is essential to their health: Empowering health care workers with relevant HIV / AIDS information required by PLWHA on HAART. The development and content of the health education programme summary is presented in Table 5.2:

**Figure 5.2: Health education programme summary**

Themes	Programme content to address the theme	Main approach Summary
1. Interpersonal communication and counselling skills	<p><b>Communication:</b> Channels of communication</p> <p><b>Good communicator:</b> Self awareness, communicating with other people, and self actualisation</p>	Communication process: Health care worker (sender) and HAART patient (receiver) and feedback from both parties. Verbal and nonverbal communication, active listening
	<p>Individual / face-to-face counselling steps:</p> <p><b>Current scenario:</b> Health care workers assisting HAART patients to understanding their problem</p> <p><b>Preferred scenario:</b> Health care workers assisting HAART patients make choices</p> <p><b>Strategies:</b> Health care workers (recipients) assisting HAART patients have resources and information to accomplish action</p> <p><b>Action:</b> Health care workers assisting (recipients) HAART patients to achieve their goals</p>	<p>Methods of counselling:</p> <ul style="list-style-type: none"> <li>• Individual / face-to-face counselling</li> <li>• Group counselling</li> </ul>
2. IEC materials and other modes of disseminating health information	<p>Steps of developing IEC materials:</p> <p>2.1 Communication: objectives should be based on audience's feelings, emotions, thoughts, reasons, and advice.</p> <p>2.2 Obstacles: Health care workers (recipients) consider PLWHA on HAART beliefs, religion, cultural practices, pressures, and misconceptions</p> <p>2.3 Key messages / advice: messages that promote health education</p> <p>2.4 Support statement /</p>	Training health care workers to develop IEC materials

Themes	Programme content to address the theme	Main approach Summary
	<p>reasons why: health care workers (recipients) assure HAART patients reasons of the message</p> <p>2.5 Tone of message: messages need to be sensitive to the feelings of HAART patients</p> <p>2.6 Creative considerations: IEC developer / health care workers (recipients) messages need to be persuasive to PLWHA on HAART</p>	
3. Other modes of communication	<p>IVR operating steps:</p> <p>3.1 Health care worker (recipients): prepare the target messages for HAART patients</p> <p>3.2 Health care worker (recipients) pre-record messages using voice / verbal language</p> <p>3.3 Health care worker (recipient) send mass messages to service provider</p> <p>3.4 Health care worker (recipient) dials principal client using short code then follow steps of automated response</p>	Training health care workers to operate IVR tool by using a mobile phone
4. Health care workers exposed to HIV / AIDS management	<p>Health care workers knowledge about:</p> <p>4.1 Etiology of AIDS</p> <p>4.2 HIV / AIDS transmission</p> <p>4.3 HIV / AIDS treatment</p> <p>4.4 HIV / AIDS prevention</p>	Training health care workers to familiarise them with existing policies, frameworks, and guidelines

5. PLWHA on HAART insufficient information about the aspect on HIV / AIDS essential to their health	Health care workers (recipients) provide health information required by PLWHA on HAART. information: 5.1 HIV prevention 5.2 Adherence to HIV treatment	Training health care workers to provide HAART patients with relevant health information pertaining their health
Themes	Programme content to address the theme	Main approach Summary
	5.3 Feedback on blood results, Information on CD4 count / t-cell, viral load and types of blood tests 5.4 Sexual relationships 5.5 Alcohol use 5.6 Nutrition 5.7 HIV disclosure 5.8 HIV / AIDS related stigma and discrimination	

Review Annexure I for the content of health education programme.

## 5.7 IMPLEMENTATION OF THE HEALTH EDUCATION PROGRAMME

A six-day training workshop was conducted with health care workers (recipients) at four CHS district hospitals in Namibia.

### 5.7.1 Health care workers (recipients) matrix

The training workshop catered for a total of 23 health care workers (recipients) from four CHS district hospitals.

**Figure 5.3: Cadre composition**

Health care facility A	Health care facility B	Health care facility C	Health care facility D
Participants: five (two nurses and three community counsellors).	Participants: six participants (two nurses and four community counsellors).	Participants: six participants (two nurses and four community counsellors).	Participants: six participants (one nurse and five community counsellors).

### 5.7.2 Training workshop venue

The training workshop was held at four individual CHS health care facilities. This was convenient to health care workers (recipients), since their movement away from the respective facilities was limited, due to a shortage of staff members. The first two training workshops were held in the northeast of the region at Hospital A and Hospital B. The third training workshop was conducted at Hospital C in the northwest region while the last one was conducted at Hospital D in the southern region.

### 5.7.3 Training workshop goal

The purpose of the training workshop was to implement the health education programme to health care workers (recipients) while equipping them with knowledge and skills to facilitate communication with PLWHA on HAART.

The training workshop was conducted by applying a transformative learning approach that utilised various learning methods during facilitation, i.e. PowerPoint presentations, individual presentations, role-play, and group discussions.

#### **5.7.4 Workshop training teaching strategies**

In this study, active learning was essential and perceived as part and parcel of transformative learning processes. Active learning permitted health care workers (participants) to undergo training during a workshop and to have open discussion activities while utilising various teaching strategies, such as: Facilitation, PowerPoint presentations, individual presentations, role play, and group discussions. These teaching strategies are discussed in more detail below.

In this study, during the workshop training, health care workers (recipients) who were directly working with PLWHA on HAART were encouraged to attend in-service training that provided them with opportunities to learn new information, re-learn, and reinforce existing knowledge and skills. Most importantly, it gave them the opportunity to think about and consider what new options could assist them with improving their effectiveness (Mezirow, 2007).

##### **□ Facilitation**

Facilitate means to make easy or less difficult or more easily achieved (Oxford dictionary, 2013). In this study facilitation was applied and achieved during the workshop training was regarded as an appropriate method to be utilised by the researcher (agent). The researcher (agent) resumed her facilitation role by assisting health care workers (recipients) in understanding the common objectives and to achieve those objectives without being biased. Beside this, the researcher (agent) had other responsibilities: Creating a conducive environment for all participants to feel comfortable and welcomed, building and enforcing group dynamics, and cohesion.



### 5.7.5 Facilitation techniques

During workshop training facilitation techniques applied and achieved as described by Sajjad (2005) were used by the researcher (agent):

- Help the participants to be comfortable with one another;
- Create a fun and interesting learning environment;
- Boost the energy levels of workshop participants;
- Organise interesting and productive group work activities;
- Use participatory activities that enable dynamic reviews of what has been learnt; and
- Increase group activity in order to expose workshop participants to new knowledge and to localise that knowledge.
- PowerPoint presentations

The PowerPoint program is regarded as appropriate in conducting in-service training. PowerPoint was designed specifically to teach participants to be effective in a most convenient way (Gallian, 2012). It is a computer program that allows one to present brief and short messages where information is easy to follow and purposely displayed for everyone to view.

- **Individual presentation:** Health care workers (recipients) were taught by the researcher (agent) through presentation of individual tasks that was assigned to them as part of a practical learning intervention, for example developing and presentation of IEC materials. This method of learning intended to encourage self-efficiency and selfrealisation in relation to a particular approach to a given task (Sajjad, 2005). In this case, health care workers (recipients) were motivated to grasp new subjects, tools, and an opportunity to apply them.

- **Role play:** Role play is an active way of learning. It means to assuming the attitude, actions, and discourse of another – especially in a make-believe situation – in an effort to understand a different point of view or social interaction (Sajjad, 2005). Learning topics such as Johari’s window activity (self actualisation) were presented in conjunction with exercise examples where participants were allowed to act upon them as part of the learning process. This type of learning process allowed health care workers to apply creative thinking that was beyond their knowledge (Sajjad, 2005).

This learning method was utilised as an ice breaker activity, since it displayed the real attitudes, personalities, and values of participants while trying to overcome the obstacles that might have deterred them from learning.

- **Group discussions:** A group discussion is perceived as an effective learning process because it allows participants to be engaged directly with the facilitator (agent). Group discussions were applied and achieved by health care workers (participants) during the workshop training where the researcher (agent) encouraged communication among participants by creating a learning platform where information and opinions were shared and expressed. At the same time, it gave the facilitator an opportunity to rectify and correct mistakes or misconceptions about the topics under discussion (Corey, 2010).

#### □ **Resources required for the training workshops**

The following resources were essential for the accomplishment of the in-service training workshop: A computer for PowerPoint presentations, a multimedia projector, viewing screen, pens and writing-pads, flip charts, markers, mobile phone for practical exercises of counselling skills, sticky stuff, and the health education programme for health communication.

### **5.7.6 Training workshop**

The main aim of the training workshop was to enhance communication skills and knowledge of health care workers (recipients) who served PLWHA on HAART each time when they were consulting at their respective health institutions. The training workshop included:

#### **□ Programme implementation context**

The health education programme was to be utilised by health care workers (recipients) in the context of the CHS district hospitals in Namibia through primary health care, since it was the entry point of VCT where patients were referred from other health departments or health facilities for further treatment, care, and support.

#### **□ The logistics of the training**

Dickoff's (1968) practical activity theory guided the context of health institutions where the health education programme was implemented, including the logistics of the programme. The researcher (agent) as the facilitator visited all four hospitals respectively, where the meetings were held with the principal medical doctor (medical officer in charge) prior the training. The logistics included setting up of the training hall and the training materials; i.e. flipcharts, markers, pre-stick, laptop and multimedia projector, refreshments, and lunch. The question / answer box was also provided for the purpose of collecting all the responses from participants during the training.

#### **□ Workshop training facilitation overview**

The workshop training was facilitated in six days: Two days per health care facility at all four CHS hospitals. During the first two days, the training workshop was held at hospital A in the Northeast of the Okavango region. Five participants attended the training workshop: Two

nurses and three community counsellors. The venue of the workshop training was the boardroom adjacent to the hospital OPD unit.

The second two-day training workshop was also conducted in the same Northeast Okavango region at Hospital B. A total of six participants (health care workers) attended the workshop training: Two nurses and four community counsellors. The venue was located at the boardroom adjacent to the main hall at the hospital.

The third workshop training was held in the Omusati region, in the north western part of the country at Hospital C. A total of six participants attended the workshop training: Two nurses and four community counsellors. The venue was in the therapy room at the main hospital.

The fourth training workshop was held in the Hardap region at Hospital D. Six health care workers attended the workshop training: One nurse and five community counsellors. The training workshop was conducted in the boardroom. The health care matrix is presented in Figure 5.1.

The researcher (agent) facilitated all four training workshops, since the number of participants who attended were manageable and the time intervals between training workshops were favourable to her because it allowed her to travel from one health facility to the other without any difficulty.

All workshops were conducted in English, therefore, there were no challenges in terms of language. All health care workers who attended the training workshops were proficient in spoken and written English Language.

## **PROCEDURE FOR CONDUCTING TRAINING**

## **Day 1**

### **Session 1: Training welcome and introduction**

The registration of participants was done prior to commencement of the training. All participants were welcomed by the facilitator. The purpose of the training was briefly introduced, as well as the ground rules and set of objectives. A flip chart and marker pen was accessible for all participants in the front of the hall where the training was held to record their expectations. A questions / comments box was provided and participants were encouraged to post their pressing questions or comments about the programme during the training sessions. These questions were compared with the objectives and expectations of participants at end of each day of the training.

After the facilitator (agent) had finished with the welcoming remarks, all participants (recipients) were encouraged to introduce themselves to the large group. It was essential for the participants to include the following in their introduction: Stating his / her name and surname (preferred name was used throughout the training), profession, department, as well as writing his / her own expectations on the provided flip. The name of the organisation was not recorded.

#### **□ Learning objectives**

The programme objectives were to:

- enhance knowledge and interpersonal communication skills of health care workers (recipients) with the purpose of facilitating communication with PLWHA on HAART;
- obtain training in HIV / AIDS management and feedback to patients;
- communicate health information with PLWHA on HAART and provide feedback;

## □ **Study findings overview**

The overview of the findings was derived from the themes and objectives of the study. The study found that at four CHS district hospitals the health care workers (recipients) did not have sufficient communication skills to address concerns of PLWHA on HAART. They also experienced inadequate interpersonal and communication skills and a severe shortage of IEC materials for disseminating health information to PLWHA on HAART.

- were not exposed to HIV / AIDS management and knowledge during in-service training. There were no guidelines that clearly assisted them to engage with the management of PLWHA on HAART. Supervision by their superiors was lacking with the result that they could not manage HIV / AIDS;
- provide PLWHA on HAART (patients) with sufficient information about HIV / AIDS aspects that were essential to their health. HAART patients had no information about: prevention of HIV, adherence to HIV treatment, blood results, sexual relationships, alcohol abuse, and nutrition. HAART patients also needed to be empowered to manage disclosure, stigma and discrimination; and
- could not cope with providing quality health care to PLWHA on HAART due to the heavy workload, space and time constraints, and resources. Moreover, other studies found that health care workers without the basic knowledge and skills required for diagnosing and treatment might not be able or willing to attend to the needs of patients with HIV (Lule, 2009).

### **Session 2:** Facilitating interpersonal communication and counselling skills

**Communication process exercise:** Before the workshop began, the question was posed to participants: “Why was communication important to human species?” For this exercise, a flip

chart was provided for all participants (recipients) to write their answers individually for discussion by the group.

The objectives of this exercise were to provide participants (recipients) with an understanding of effectively conveying information to another person during the communication process. This session also covered the process of communication: The process was illustrated through a role play during which the sender / health care worker (recipients) encoded (decided what type of message to convey) to the receiver / patient (PLWHA on HAART) who then decoded (interpreted the message while trying to find its meaning). Thereafter, the sender received feedback which completed the process of communication. During this session, participants (recipients) were urged to communicate appropriately by utilising communication skills that cemented the process of communication. These identified skills included verbal, nonverbal, and active listening, as well as the elements of communication (top 7Cs): clear, concise, concrete, correct, coherent, complete, and courteous.

### **Session 3: Facilitating interpersonal communication and counselling skills exercises**

#### **□ Interpersonal communication exercise: Self-awareness**

The objective of this session was to assist participants (recipients) to know themselves before communicating with other people. They have to be genuine and honest about their feelings, thoughts, desires, and needs because without self-examining they might find themselves projecting their feelings and emotions to their patients. The other exercises covered in the self-awareness exercise were the identification of beliefs and the of interpretation Johari's window.

## □ **Facilitation of counselling skills practice**

The main objective of this exercise was to allow the participants (recipients) an opportunity to master individual and group counselling activities at their respective health institutions. Health care workers (recipients) had to role-play or practise individual and group counselling that covered core counselling skills, phases (initial, transition, working, and final / termination), and various techniques; including empathy, congruence, affirmation, listening, paraphrasing, and open-ended questions. The practice was open structured and directed by the needs of enhancing health care workers (recipients) to have a positive attitude and better abilities in counselling skills to effect change in the lives of PLWHA on HAART. It enabled them to transfer newly acquired skills and behaviour learned during the workshop to their day-to-day activities (Corey, 2010).

### **Session 4: Facilitation development of IEC materials and introduction of IVR**

The objective of this session was to provide participants (recipients) with the insight that would enable them to develop their own IEC materials at their health institutions. The training introduced the creative brief guidelines for developing and designing messages for PLWHA on HAART. To cement this session, the facilitator (agent) used a PowerPoint presentation to expose the group existing evident-based IEC materials messages that had been developed in other countries with the aim of expanding their understanding in order to develop their own.

### **Session 5: Facilitation of IEC development and IVR practice**

During this session, the objective was to provide the participants (recipients) with an opportunity to gain some experience in practising the development of IEC, design their own messages of relevance to their patients, and record IVR messages. During the workshop, each



and every participant (recipient) was given a blank flip chart page and a koki pen to practise developing IEC messages. On the other hand, the IVR demonstrations took place where participants were given a voice recorder and opportunities to pre-record their voice messages. All participants were cautioned to be sensitive to culture, since they were dealing with multicultural patients and should refrain from messages that were defamatory to their patients; i.e. stereotyping, gender biased, and those messages that would instigate chaos among their audience.

**Session 6:** Facilitation of end of the day session

Day 1 ended by evaluating the session and encouraging participants to raise some questions or some comments about the session. Feedback was then given by the facilitator (agent) to health care workers (recipients) and they were satisfied with the outcomes of the session.

**Day 2**

**Session 1:** Facilitation re-cap the sessions from the previous day

This session was started with a prayer by one of the participants (recipients). The purpose of this session was to re-cap sessions that were conducted the previous day. In completing this task, every participant (recipient) was encouraged to get involved. A flip chart board and koki pens were provided at the front of the training room where all participants (recipients) were given a chance to write down three new points that they had learnt and two points that they did not understand which needed clarification from the group. Issues about the in-house logistics were also addressed.

**Session 2:** Facilitation in relation to management of HIV / AIDS

The objective of this session was to empower participants (recipients) with regard to the management of HIV / AIDS and the policies that governed the health needs of PLWHA on

HAART. In order to complete this task, participants (recipients) were urged to have knowledge and an understanding of the etiology or origin of HIV / AIDS, its transmission, prevention, treatment, care, and support. All the participants (recipients) were provided with information about the latest HIV / AIDS prevalence rate in Namibia; accumulating number of PLWHA on HAART; reviews of the existing HIV / AIDS policies, frameworks, guidelines (if any), and programmes in comparison with other countries in the region and elsewhere in the world.

**Session 3:** Facilitation of health information for PLWHA on HAART

The objective of this session was to provide all participants (recipients) with knowledge and the necessary skills for facilitating health information to PLWHA on HAART. All participants (recipients) were encouraged to initiate a conversation with their patients each time they visited the health care facilities. This information needed to be structured according to the international standards of HIV / AIDS prevention, treatment, care, and support. The training workshop identified health information that was in short supply: HIV prevention, adherence to HIV / AIDS treatment, blood results, sexual relationships, alcohol usage, nutrition, disclosure and HIV / AIDS related stigma and discrimination.

**Session 4:** Facilitation of blood results feedback practice

The objective of this session was to provide participants with opportunities to practise giving feedback to their patients' about their blood results. The participants (recipients) were informed about the importance of blood results and how it contributed to decision making between the physicians and patients, specifically in relation to monitoring the immune system, when to start treatment, and whether the treatment is working or not. The process of feedback was covered during this training session. "Sandwich feedback" was used during the role-play exercise. This exercise encouraged participants (recipients) to start with "bun part"

when giving feedback to patients, i.e. to provide the positive information first and to explain its impact to patients (benefits or advantages). Secondly, the “meat part” should be given, i.e. to acknowledge the patients’ behaviour when they were consistently taking their medication (adherence to treatment) or when they were maintaining their CD4 count. Thirdly, the second half of the “bun part” reminded the patients about the implications of not taking care of their health (consequences or disadvantages). The participants (recipients) were warned that if they were hesitant to give feedback or when they had no knowledge of the health information requested by patients, they should refer them to other health professionals or physicians.

**Session 5: Facilitating types of HIV testing**

The objective of this session was to explore the available types of HIV tests. Participants (recipients) as health professionals managed to identify different types of HIV tests that were available at their health institutions; such as rapid test, ELISA, western blot, and infant HIV. The latter test was normally done 3 to 15 months after the baby had been born. This session covered the advantages and disadvantages of testing while encouraging couple testing and counselling.

**Session 6: Facilitation on providing health information to PLWHA on HAART**

The objective of this session was to assist participants (recipients) to provide relevant health information to their patients (PLWHA on HAART) each time they visited their health care facilities. The training covered HIV aspects in relation to sexual relationships, alcohol usage, nutrition, disclosure, and HIV / AIDS related stigma and discrimination.

### □ **Assessment of the two-day training workshop**

The two-days training workshop assessment covered a total of 13 sessions. The goal of this evaluation was to determine the level of knowledge, understanding, and skills adopted by participants / health care workers (recipients) during and after the training workshop during which new theories and concepts were introduced while responding to the questions of the participants and clearing the emerging confusions. Two assessment processes were used during this training workshop.

The first process happened verbally at the end of each session and the second process was conducted at the end of the second day of the workshop when participants were given an opportunity to completed assessment forms. The assessment templates comprised four questions. This template is displayed in Table 5.3 and is followed by the comments / remarks gathered from the participants

**Figure 5.4: Training workshop assessment form**

**TWO-DAY TRAINING WORKSHOP  
ASSESSMENT FORM**

Your feedback is important to us, since it provides valuable information to help us continually improve future workshops. Completing this evaluation provides you with an opportunity to communicate your thoughts and experiences during the training workshop.

1. What information have you learnt from this training workshop?

.....  
.....  
.....  
.....

2. What new information have you learnt from this training workshop that improves your work?

.....  
.....  
.....  
.....

3. What other information do you want to know about that has not been covered during this training workshop?



**Figure 5.6: Training workshop programme**

	<b>Title</b>	<b>Content</b>	<b>Strategy</b>	<b>Education theory</b>	<b>Philosophy</b>
Day 1	<b>Session 1</b> <ul style="list-style-type: none"> <li>• Welcome</li> <li>• Introductions</li> <li>• Workshop norms</li> <li>• In-house logistics</li> </ul>	<input type="checkbox"/> Purpose of the training <input type="checkbox"/> Expectations <input type="checkbox"/> Objectives <input type="checkbox"/> Study overview <input type="checkbox"/> Findings of the study	<input type="checkbox"/> PowerPoint presentation <input type="checkbox"/> Facilitation	Communicative learning theory	Respect
	<b>Session 2</b> <b>Theme 1:</b> <input type="checkbox"/> Interpersonal communication and counselling skills	<input type="checkbox"/> Communication process <input type="checkbox"/> Verbal and nonverbal communication <input type="checkbox"/> Active listening <input type="checkbox"/> Counselling methods: Individual and group	<input type="checkbox"/> PowerPoint presentation <input type="checkbox"/> Facilitation <input type="checkbox"/> Individual presentations <input type="checkbox"/> Group discussion	Skills learning and communicative theory	Humanistic approach
	<b>Session 3</b> <input type="checkbox"/> Interpersonal communication & Counselling skills practice	<input type="checkbox"/> Self-awareness <input type="checkbox"/> Communication with ourselves <input type="checkbox"/> Communicating with other people	<input type="checkbox"/> PowerPoint presentation <input type="checkbox"/> Facilitation <input type="checkbox"/> Demonstration <input type="checkbox"/> Role-play <input type="checkbox"/> Individual presentations <input type="checkbox"/> Group discussion	<ul style="list-style-type: none"> <li>• Skills learning</li> <li>• Communicative theories</li> </ul>	<ul style="list-style-type: none"> <li>• Humanistic</li> <li>• Reasoning</li> <li>• Reflective</li> </ul>
	<b>Session 4</b> <b>Theme 2:</b>	<input type="checkbox"/> Developing IEC materials <input type="checkbox"/> Creative brief guidelines	<input type="checkbox"/> PowerPoint presentation	<input type="checkbox"/> Skills learning <input type="checkbox"/> Communicative	<ul style="list-style-type: none"> <li>• Humanistic</li> <li>• Reasoning</li> </ul>

	<b>Title</b>	<b>Content</b>	<b>Strategy</b>	<b>Education theory</b>	<b>Philosophy</b>
	☐ IEC Materials	for developing IEC materials <ul style="list-style-type: none"> <li>• Communication objectives</li> <li>• Message designs</li> </ul>	☐ Facilitation ☐ Demonstrations ☐ Individual presentations ☐ Group discussion	☐ Learning	
	<b>Session 5 Part 1</b> ☐ IEC Practice	☐ IEC message designing	☐ PowerPoint presentation ☐ Facilitation ☐ Demonstrations ☐ Individual presentations ☐ Role-play ☐ Group discussion	Skills learning and communicative learning	<ul style="list-style-type: none"> <li>• Humanistic</li> <li>• Reasoning</li> </ul>
	<b>Session 5 Part 2</b>	☐ IVR introduction	☐ Demonstrations and practice	Skills learning and communicative learning	Humanistic reasoning
End of Day 1	<b>Session 6</b> ☐ Wrap up	☐ Summarising all sessions of Day 1	☐ PowerPoint presentation ☐ Facilitation	Communicative learning	<ul style="list-style-type: none"> <li>• Respect</li> <li>• Reflective</li> </ul>
Day 2	<b>Session 1</b> <ul style="list-style-type: none"> <li>• Recap on the sessions of the previous day</li> <li>• In-house logistics</li> </ul>	<b>Raise questions on:</b> <ul style="list-style-type: none"> <li>• Communication process</li> <li>• Interpersonal communication</li> <li>• Counselling methods</li> <li>• IEC development</li> </ul>	☐ PowerPoint presentation ☐ Facilitation ☐ Demonstrations ☐ Individual presentations	Communicative learning	<ul style="list-style-type: none"> <li>• Humanistic</li> <li>• Reasoning</li> <li>• Reflective</li> </ul>



	Title	Content	Strategy	Education theory	Philosophy
			<input type="checkbox"/> Role-play <input type="checkbox"/> Group discussion		
	<b>Session 2</b> <b>Theme 3</b> <input type="checkbox"/> HIV / AIDS Management	<ul style="list-style-type: none"> <li>• Etiology of HIV / AIDS</li> <li>• Transmission</li> <li>• Prevention</li> <li>• Treatment, care, and support</li> </ul>	<input type="checkbox"/> PowerPoint presentation <input type="checkbox"/> Facilitation <input type="checkbox"/> Demonstrations <input type="checkbox"/> Individual presentations <input type="checkbox"/> Role-play <input type="checkbox"/> Group discussion	Knowledge, skill & communicative Learning	<input type="checkbox"/> Humanistic <input type="checkbox"/> Reasoning <input type="checkbox"/> Reflective
	<b>Session 3</b> <b>Theme 4</b> <input type="checkbox"/> Health information for PLWHA on HAART	Provide feedback to patient about the following: <ul style="list-style-type: none"> <li>• HIV prevention</li> <li>• Adherence to HIV treatment</li> <li>• Blood results feedback</li> <li>• CD4 count</li> <li>• Viral load</li> </ul>	<input type="checkbox"/> PowerPoint presentation <input type="checkbox"/> Facilitation <input type="checkbox"/> Individual presentations <input type="checkbox"/> Group discussion	Knowledge, skills & communicative learning	<input type="checkbox"/> Humanistic <input type="checkbox"/> Reasoning <input type="checkbox"/> Reflective
	<b>Session 4</b> <input type="checkbox"/> Blood results feedback practice	<ul style="list-style-type: none"> <li>• Blood tests</li> <li>• ELISA</li> <li>• Western blot</li> <li>• HIV testing infants</li> </ul>	<input type="checkbox"/> PowerPoint presentation <input type="checkbox"/> Facilitation <input type="checkbox"/> Individual presentation Role-play <input type="checkbox"/>	Knowledge, skills & communicative learning	<input type="checkbox"/> Humanistic <input type="checkbox"/> Reasoning <input type="checkbox"/> Respect

	Title	Content	Strategy	Education theory	Philosophy
			<input type="checkbox"/> Group discussion		
	<b>Session 5</b> <input type="checkbox"/> Health information for PLWHA on HAART	<input type="checkbox"/> Sexual relationships <input type="checkbox"/> Alcohol usage <input type="checkbox"/> Nutrition	<ul style="list-style-type: none"> <li>• PowerPoint presentation</li> <li>• Facilitation</li> <li>• Individual presentations</li> <li>• Role-play</li> <li>• Group discussion</li> </ul>	Knowledge, skills & communicative learning	<input type="checkbox"/> Humanistic <input type="checkbox"/> Reasoning <input type="checkbox"/> Reflective
	<b>Session 6</b> <input type="checkbox"/> Health information for PLWHA on HAART practice	<input type="checkbox"/> Alcohol screening for heavy drinkers	<ul style="list-style-type: none"> <li>• PowerPoint presentation</li> <li>• Facilitation</li> <li>• Role-play</li> <li>• Individual presentations</li> <li>• Group discussion</li> </ul>	Knowledge, skills & communicative learning	<input type="checkbox"/> Humanistic
	<b>Session 7</b> <input type="checkbox"/> Health information for PLWHA on HAART practice	<input type="checkbox"/> Disclosure <input type="checkbox"/> HIV / AIDS stigma & discrimination	<ul style="list-style-type: none"> <li>• PowerPoint presentation</li> <li>• Facilitation</li> <li>• Individual presentations</li> <li>• Group discussion</li> </ul>	Knowledge, skills & communicative learning	<input type="checkbox"/> Humanistic
End of Day 2	<b>Wrap-up session</b>	<input type="checkbox"/> Evaluation of the workshop	Facilitation	Communicative learning	<input type="checkbox"/> Humanistic <input type="checkbox"/> Reflection

					<input type="checkbox"/> Respect
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## **5.8 SUMMARY**

This chapter presented the planning, development, and implementation of the health education programme for communication in reference to the conceptual framework of the findings in Chapter 4. The development of the health education programme synthesises with the main themes and objectives of the study which are categorised according to interpersonal communication, counselling skills, IEC materials, management of HIV / AIDS, and health information for PLWHA on HAART. Chapter 5 also describes the purpose of the health education programme, the philosophical approaches of the study, and transformative learning theories. These theories use an education approach of structured learning methods; such as skills learning, communicative learning, and reflective learning that uses the learning methods of facilitation, presentations, role play, and group discussions. The chapter showcases the processes that include all workshop training activities; i.e. development, and implementation of health education programme. Chapter 6 contains an evaluation of the health education programme.

## **CHAPTER 6**

### **EVALUATION OF THE HEALTH EDUCATION PROGRAMME**

## **6.1 INTRODUCTION**

In the previous chapter, the development and implementation of the health education programme are discussed. Participants were allowed one month to implement the knowledge and skills that had been offered to them at their respective facilities. After one month, the groups gathered to evaluate the health education programme. The programme assessment was conducted with health care workers during focus group discussions.

The goal of the evaluation was to get feedback from the participants (health care workers) one month after implementation of the health education programme and to assess their levels of understanding, knowledge, skills, attitude towards the adoption of new knowledge and roles in serving PLWHA on HAART.

Quinn (2011) describes the evaluation process as human efforts to increase effectiveness through systematic inquiry. In preparation of the evaluation process, the researcher created a supportive environment to protect both parties (researcher and participants) from unforeseen problems, prejudices, and biases. Most importantly, the evaluation process protected the validity of the assessment tool and process used for evaluating the whole process and its final outcome.

Evaluation of the health education programme was employed to measure the progress or outcomes of the health education programme one month after implementation.

## **6.2 HEALTH EDUCATION PROGRAMME EVALUATION AFTER IMPLEMENTATION**

Evaluation of the health education programme (HEP) included the assessment of all activities that took place, i.e. the planning, development, and implementation of the health education programme.

### **6.2.1 Evaluation objectives**

The objective for this evaluation was to determine the extent of changes that had occurred in one month after the health education programme implementation. The assessment of the process mostly focused on the changes that occurred with regard to quality health care service delivery to PLWHA on HAART. Most attention was paid to the changes that had occurred in terms of the participants' attitude, knowledge, and skills in serving these particular patients. Other interests included their interpersonal communication and counselling skills, HIV/AIDS management, development of IEC materials, use of IVR messages, and assessing whether there was any improvement in communication between health care workers and PLWHA on HAART. Also, the evaluation interrogated the types of information provided to patients that improved their knowledge about HIV / AIDS aspects.

### **6.2.2 Evaluation methods**

In order to determine the outcome and the effectiveness of the HEP, the researcher utilised a focus group discussion as a method of gathering information and feedback during assessing the effect of the implementation of the health education programme. Onwuegbuzie (2009) describes focus groups as small structured groups with selected participants who are normally led by a skilful moderator.

### **6.2.3 Focus group composition**

The focus group had 10 members: Four nurses and six community counsellors were purposely selected from four health institutions in Namibia. These health care workers were part of the group in the study who underwent the HEP training workshop and who were responsible for the implementation of the health education programme. The invitation to this focus group discussion was extended through the principal medical officer at their respective health care institutions.

### **6.2.4 Designing evaluation questions**

The evaluation process guided the development of the questions with the interest of describing what happened as a result of the delivery of the health education programme. It assessed whether the activity had achieved the outcomes and determined the general impact of the effected change (Trochim, 2006). Focus group discussions were guided by five questions.

1. What are your experiences in utilising the health education programme at your health care facilities?
2. What are your experiences in communicating with your colleagues and patients?
3. What are your experiences with regard to counselling skills?
4. What are your experiences in relation to developing IEC and IVR messages?
5. What types of health information or feedback are you communicating to PLWHA on HAART?

### **6.2.5 Focus group discussions enforcement**

The focus group discussions were held at a venue that was convenient for every participant. Ten participants attended. A large spacious conference room was prepared prior to the discussions. The room had 11 chairs arranged in a semi-circle to allow free movement between the moderator and participants. The facilitator (researcher) was introduced, the length of each session was communicated, and the participants were informed about the purpose of the discussions and the application of information gathered.

The objectives of the discussions were displayed on the flip chart at the front of the room where the discussions were held for everyone to read and inspect. The discussion questions were prepared beforehand. One question was written on one page and neatly printed out and displayed on the flip chart. This sequence was intended for reporting the responses to each question respectively. The standard ground rules were laid beforehand and modified by the focus group. The focus group discussion lasted for two hours. After the discussions were concluded, the facilitator / researcher thanked the group for attending, their effort, as well as their contribution to the discussions.

## **6.3 EVALUATION OUTCOMES**

Focus group discussion questions were displayed on the flip chart and were read aloud by the facilitator / researcher before commencing the discussions. That approach allowed the participants to respond appropriately during the evaluation session. The facilitator / researcher assured the participants that there were no right and wrong responses and that they should respect the answers of other participants.



The facilitator / researcher read the questions sequentially, allowing her time to write down the responses from the participants. During the discussions, the facilitator / researcher utilised interpersonal communication skills and active listening techniques, inclusive of body language and open-ended questions, while attending to the responses of the group members. Participants were cautioned not to use discriminatory remarks and senseless jargon. At same time, the facilitator / moderator dealt with dysfunctional behaviour.

### **6.3.1 The responses of the focus group discussions**

Focus group responses were validated before and after discussions, especially when they related to changes that took place over time (Marczak, & Sewell, (2012). In this case, the facilitator / researcher gathered relevant group interactions that contained valid information which was required for evaluation. The responses from the field notes were retrieved and coded according to the questions asked and reported sequentially. Experiences in relation to utilising the health education programme at their respective health care facilities

All four health care facilities were represented this focus group evaluation and it was very interesting to note that all participants reverberated similar responses that the health education programme could be used as a guide for delivering of health care services at their respective facilities.

The participants alluded that the health education programme was implemented at a time of need and was an eye opener because ever since they had adopted and implemented the health education programme, their skills and knowledge about HIV

/ AIDS management were improving. The health education programme enhanced their communication skills with their patients and colleagues. Retention of PLWHA on HAART was improving. Most health care facilities had initiated action plans for the way forward, particularly to execute HIV / AIDS activities by introducing international standards or uniformity when engaging and giving feedback to address the health needs of patients in general and particularly those PLWHA on HAART.

These action plans were to expand the implementation of the health education programme in primary health care that is responsible for other HIV / AIDS activities like VCT, ANC, PMTCT, MC, PEP and OPD, as well as the communities where outreach and mobilisation already existed.

The following are some of the remarks retrieved from the focus group discussions:

*“This health education programme was an eye opener because I have gained knowledge and skills to do my work confidently with regards to planning of my day to day activities beforehand”.*

*“I am happy that I can listen to my colleagues and patients without being frustrated and annoyed by what they are trying to communicate to me”.*

### **6.3.2 Health care workers’ experiences of communicating with their colleagues and patients**

Participants indicated their gratitude towards the health education programme and how they were exposed to communication processes that were consistently encouraged in the programme. Some participants commented:

*“The implementation of the health education programme enhanced my knowledge and abilities to communicate with others, since I was experiencing some difficulties in expressing myself during the staff meetings and or when attending to patients”.*

*“Implementing the health education programme had enlightened me because it made me to be aware of my cultural beliefs when initiating communication with others particularly patients, in some cases I used to impose my emotions and thoughts upon patients ignoring their health needs”.*

*“I am happy to say that since I practised communication process, enabled me to address patients regardless of their age difference, sex, gender, race, and any health concern that they might have”.*

### **6.3.3 Experiences in relation to counselling skills**

According to the participants, counselling / education was part of their training but it was not as comprehensive as this health education programme. Moreover, the use of the references from the health education programme made it much easier to engage patients with counselling services, since the steps and phases of counselling were stipulated clearly.

*“I really enjoyed group counselling practice as entailed in the health education programme, since it was one of my weakest points and it has improved my interpersonal communication skills”.*

*“Counselling has enhanced abilities in communicating feedback to my patients in a sense that it created a platform for me to get engaged with patients, particularly those PLWHA on HAART”.*

#### **6.3.4 Experiences in relation to the development of IEC materials and IVR demonstrations**

The participants acknowledged that at their health care institutions they were faced with a shortage of IEC material for specific audiences. In addition, IEC material was part of resources allocated to them and they had no control over them and had to work with what they had at that particular time. Therefore, it benefited their health care facilities by developing their own IEC material, since it allowed them to design messages that were relevant and suitable for their target groups. During training, they learned how to develop and design motivational and cautioning messages for their audience plus pilot testing of their own IEC material. Therefore, that enabled them to disseminate accurate and clear health messages to their patients. The same process was repeated when demonstrating IVR and the participants were very interested in learning more about how IVR worked.

*IEC: “Implementation of my own designed IEC materials was very encouraging”.*

*IVR: “I have never heard my voice in the tape recorder before”.*

#### **6.3.5 Types of health information provided to PLWHA on HAART**

Participants acknowledged that health information was important to patients, particularly those PLWHA on HAART. After implementation, participants were

using the health education programme as a guide in directing them to provide relevant health information required by patients and PLWHA on HAART. Furthermore, patients were encouraged to ask for any information about their health each time they visited health care facilities:

*“The health education programme enhanced my knowledge and skills in initiating communication with patients”.*

*“Giving feedback to patients was one of my weakest points because I did not know what to say to them”.*

*“I used to communicate to patients not with patients. Now I respect and listen to other people when talking with me”.*

*“I thought as a qualified professional individual I had the whole world rapped on my fingers, I thought listening to other people when talking was [a] weakness, but now I have realised that I was wrong. This programme has taught me a lot with regards to communication that it is reciprocal (give and take) not one sided”.*

*“In some cases, I felt challenged or provoked by patients because of my low self-esteem. I didn't know the reasons why but through practising this programme, all my questions were answered. The main reasons were I had insufficient information to share or to give them accurate information on their health concerns”.*

These above-mentioned comments were expressed by the participants freely without being pressured or coaxed.

## **6.4 SUMMARY**

This chapter presents the evaluation results of the health education programme that were obtained during focus group discussions with the participants. The evaluation process guided the researcher and participants to refrain from unforeseen prejudices and biases with the aim of protecting the validity of the evaluation. Evaluation was a crucial process in providing “useful feedback” that influenced the outcomes of the health education programme, since it simultaneously assessed health care workers’ knowledge, communication skills, and attitude towards adoption of essential new roles in delivering of quality health care services to ordinary patients, particularly PLWHA on HAART. The next chapter presents the conclusions, recommendations, and limitations of the study.

## **CHAPTER 7**

### **CONCLUSIONS, LIMITATIONS, UNIQUE CONTRIBUTIONS, AND RECOMMENDATIONS OF THE STUDY**

#### **7.1 INTRODUCTION**

The previous chapter presents Phase VI that comprises the evaluation of the health education programme. All the purpose of this chapter is to summarise the findings that are supported by the study objectives as mentioned in chapter 1. Conclusions are drawn and recommendations are suggested to establish the gaps and the limitations of the study findings.

The aim of the study was to develop a health education programme to enhance knowledge and communication skills of Health Care Workers serving People Living with HIV/AIDS on HAART in Namibia. Conclusions are discussed with reference to each objective.

#### **7.2 CONCLUSIONS**

The unique objective of the study was to develop a health education programme to enhance the knowledge and communication skills of health care workers serving PLWHA on HAART in Namibia. The goal, therefore, was to equip health care workers with knowledge, as well as interpersonal communication and counselling skills that would enable them to effectively communicate with HAART patients by increasing their knowledge concerning their health. To achieve this task, the following objectives were essential:

### **7.2.1 Objective 1**

**To assess the knowledge and interpersonal communication skills of health care workers in facilitating communication with PLWHA on HAART at health care services of Catholic Health Services in Namibia**

To meet this objective, focus group discussions were held with health care workers to determine how they experience communication with their patients. Patients living with HIV / AIDS on HAART were interviewed to determine how they experienced communication with health care workers.

It was concluded that both groups (health care workers and PLWHA on HAART) experienced challenges with communication. Health care workers experienced lack of interpersonal communication and counselling skills when addressing different HIV / AIDS aspects due to lack of exposure (training) in HIV / AIDS management and supporting guidelines.

On the other hand, PLWHA on HAART had no knowledge about what to ask health care workers in relation to their condition due to fear of being victimised or asking embarrassing questions. The other contributing factors that hindered communication in both groups were: cultural diversity, language barriers, opposite sex, age difference, misconceptions attached to the disease, time factors, and resources.

### **7.2.2 Objective 2**

**To determine types of information provided by health care workers to**

**PLWHA on HAART at health care services in Catholic Health Service**



**Namibia**

This objective was attained through focus group discussions with health care workers to establish what types of information they were giving to HAART patients. People living with HIV / AIDS on HAART treatment were interviewed to determine the types of information that were given to them by health care workers. The conclusions were that health care workers were giving their patients information that was not relevant to their illness and HAART patients were not getting any information of relevance from health care workers. In most cases HAART patients did not understand the medical terminology used by health care workers when communicating to them.

**7.2.3 Objective 3****To develop a conceptual framework from the study findings**

From the study results gathered during the needs assessment, the conceptual framework was developed. The conceptual framework of a health education programme for health care workers was developed by making use of a survey list as described by Dickoff, *et al.* (1968). The aspects of the list that were used in the creation of the conceptual framework were agent (Researcher), recipients (Health care workers: Nurses and Community Counsellors), context (Catholic Health Services), procedure (activity), challenges (Health care workers experiences), and terminus (Health Education programme).

A major concept that was identified during data analysis and the coding process was the real challenges of communication and counselling. The objective of the

development of the conceptual framework had been achieved through the description of the conceptual framework presented in Chapter 4 of the study.

#### **7.2.4 Objective 4**

**Develop and implement a health education programme that enhance the knowledge and communication skills of health care workers who serve PLWHA on HAART in Namibia**

The educational programme for health education development was achieved through amalgamating the themes and results in conjunction with the objectives of the study that were within the reach of the conceptual framework. The health education programme was successfully developed and supported by an educational and philosophical approach. Operationalization of the health education programme for health care workers was based on Mezirow's (2007) transformation learning theories by training health care workers who served people living with HIV / AIDS on HAART treatment. The aim was to enhance the knowledge and communication skills of health care workers. The implementation of the programme was done by health care workers at their respective facilities.

At the CHS district hospitals in Namibia there were no communication guidelines that clearly guided and directed the development of programmes to serve PLWHA on HAART. Health care workers who served HIV / AIDS patients were operating without guidelines, sufficient skills, motivation, and support. PLWHA on HAART were not receiving quality health care services. It was against this background that this health education programme was developed.

**It is concluded that:** Health education programme can meaningfully contribute to the health promotion goals in the absence of guidelines, since health institutions have expressed the need for more defined roles and updated skills in addressing the health needs of PLWHA on HAART. The health education programme accomplishment, therefore, equips health care workers with the necessary knowledge, and interpersonal communication and counselling skills in order to facilitate communication with PLWHA on HAART. Most importantly, the programme can be useful for health promotion strategies, such as IEC resources and IVR communication through cellular phones, training of health care workers in HIV / AIDS management and a baseline for developing universal standards of disseminating health information to HAART patients. Furthermore, the health education programme can create good communication behaviour in the health fraternity and build a conducive culture in health systems.

#### **7.2.5 Objective 5**

##### **Evaluate the effectiveness and feasibility of the health education programme after implementation**

This objective was achieved by conducting focus group discussions with health care workers at various CHS district hospitals, particularly the ones who participated in the training process of the health education programme. The purpose of the evaluation process was to validate the efficiency of the health education programme one month after implementation. Evaluation aimed at assessing health care workers' knowledge, communication skills, and attitudes while adopting the new roles.

**It is concluded that:** the outcomes of the health education programme were positively welcomed by both the CHS management and health care workers. The health education programme for health care workers was perceived by the management as the much needed component that closed the gap between HIV / AIDS policies and existing guidelines for health care services. The health care workers welcomed the health education programme and viewed it as resourceful.

### **7.3 RECOMMENDATIONS**

The recommendations emanated from this study and the health education programme based on:

- Nursing and Public Health practice;
- Education;
- Policymakers and other HIV / AIDS coordinating bodies; and □ Research.

#### **7.3.1 Practice**

The health education programme evidently enhanced the knowledge, the interpersonal communication and counselling skills of health care workers, as well as their attitude towards work and their relationship with patients, particularly the ones who were on HAART. It also created a good communication culture in the health care fraternity and health system. The health education programme has the potential to have a positive impact on patient outcomes.

Therefore, operationalization of this health education programme relies on the policy implementers / health care workers specifically nurses and community counsellors to effectively utilise it each time in consultation with HAART patients. It can be

utilised as a guide / training manual in the absence of guidelines and for planning of HIV / AIDS activities.

Operationalization of the health education programme can start at the district hospitals departments; i.e. primary health (PH), outpatient departments (OPD), wards, VCT, and HAART clinics. At a later stage, it can be decentralised and utilised by both public and private health institutions, as well as the AIDS coordinating bodies. The health education programme can be useful with the support of the following:

- Resources and infrastructure (private rooms for counselling patients). Comprehensive counselling services can cater for individual, couple, family, and group counselling. Aftercare services can include psychosocial education groups and alcohol consumption support groups.
- Health promotion in vernacular languages using IEC materials and IVR mass messages by using cellular phones.
- Time provision for health care workers to provide counselling to patients.

### **7.3.2 Education**

The health education programme can be utilised for the promotion of health at Namibian health care institutions, in the SADC region and elsewhere in the world. The researcher resumes the role of an advocate and / or promoter which includes lobbying the Ministry of Health and Social Services to introduce the health education

programme at all health care facilities in Namibia without infringing on the ethical and fundamental rights of the subjects in question.

The researcher needs to seek funding and other resources from potential local and international donors to contribute towards the training of health care workers in all regions of Namibia.

The health education programme should also be promoted by NGOs, CBOs, FBOs and other AIDS bodies that are providing care to HAART patients in Namibia.

In addition, the researcher could also conduct in-service training with health care workers at CHS health facilities, including 17 other health care centres and HIV / AIDS clinics in 13 regions that have not been included in the study. Moreover, this health education programme could also be recommended to curriculum designers in the Faculty of Health Sciences, School of Nursing and Public Health for inclusion as part of a communication awareness module in core training courses for health sciences students. An additional faculty for External Studies could be established to reach out to the hard-to-reach health care workers in the remote areas of the country.

These courses could be designed in such a way that it could be included at all levels of health sciences training.

The health education programme could be used as a tool for promoting health education to the public through community mobilisation, outreach, and awareness campaigns.

The health education programme should be published internally and internationally in order to attract more professionals worldwide while it could be used as a baseline for other health education programmes.

### **7.3.3 Policymakers**

Recommendations are forwarded to the Policymakers in the Ministry of Health and Social Services and other HIV / AIDS coordinating bodies.

There is a need for all stakeholders of health care institutions, specifically the Catholic Health Services, to take the lead in advocating guidelines that promote health communication skills by fostering good communication behaviour at health institutions.

should be promoted to The policymakers at the Ministry of Health and Social Services should be encouraged to implement the health education programme by creating social and health policies that are favourable to health care workers who specialises in HIV / AIDS management, interpersonal communication skills, and PLWHA empowerment.

Moreover, this should entail the desired communication behaviour and intended requirements that create rapport between both parties. These guidelines should guide implementers / facilitators to effect change by using patient-centred frameworks each time in consultation with patients by means of the communication process (sender – message – receiver – feedback to the sender). At the same time, it would enforce interpersonal communication skills; including verbal, nonverbal, and active listening when dealing with patients. The objectives of the guidelines should be based on:

- Goal-orientated communication that requires the collection of sufficient information about patients' health and the assurance that they understand the nature of their illness by conveying relevant information, developing a treatment action plan, and ensuring implementation.
- Implementers / facilitators also need to be guided to deal with health, psychological, and socioeconomic needs of patients.
- Guidelines should have instructions to handle or deal with patients' health needs in consultation with them, such as collecting relevant information about the health needs of patients. This may include discussing issues of disclosure when caregivers assist patients throughout the process of disclosing and provide an action plan that subsequently gets achieved by the patients.
- The guidelines should set provisions for training health care workers in effective communication by fostering confidence and abilities to successfully initiate communication with patients.
- In consultation with patients, health care workers each time should take charge of the conversation by building a professional relationship with patients.
- Health care workers should obtain and synthesise information before conveying it to patients and providing feedback.
- Training provision should be made for health promotion strategies, such as IEC and IVR.
- Infrastructure (create space / rooms for providing counselling to patients).
- Allocated time should be provided for caregivers to counsel patients.
- The guidelines should make provision for in-service training and



administration of HIV / AIDS management to cope with the evolving trends of the epidemic, supervision, and planning of day-to-day tasks.

- In-service training for new cadres should be provided due to the rotation of staff members.

#### **7.3.4 Research**

Recommendations for future research topics:

- Development of a health education programme that assists health care workers to identify the needs analysis of HAART patients.
- A health promotion programme for health care workers who utilises Interactive Voice Responses (IVR) for PLWHA on HAART.

#### **7.4 STUDY LIMITATIONS**

The study focused on collecting information through focus group discussions with health care workers and in-depth interviews with HAART patients. All the research protocols were observed, inclusive of ethical measures, the diverse cultural and religious backgrounds, as well as human rights.

One big limitation in the study was identified among both the health care workers and HAART patients who were so uncomfortable and reluctant to talk about sex issues to strangers, since it was considered as a private matter and a taboo in most African cultures. Even though there is a worldwide cry to formalise HIV / AIDS as a common disease; such as diabetes, cancer, and other chronic diseases; the epidemic still remained a private and sensitive issue in our societies due to the ways it got acquired (sexually).

During focus discussions with health care workers, the icebreaker group method was applied to put participants at ease in order for them to comfortably talk about sex topics. Before the interviews commenced, HAART patients had to consent after everything had been explained to them, including the sex topics discussed.

Yet another limitation of the study was identified when the researcher was interviewing HAART patients. Information was translated from English to vernacular languages with the assistance of a fieldworker. Some important information could not exactly be translated into English due to lack of meaning in the vernacular languages. This outcome did not attenuate the meaning and rich information required for the study because most words in the sentence were simplified to the appropriate level of the HAART patients' understanding.

A significant limitation of the study was the researcher's struggled to assemble health care workers / participants in focus group discussions due to staff shortages at most health care institutions that resulted from staff rotation (movement). Each time the researcher visited the facilities for data collection, she found new staff members who had no knowledge about the research, and therefore, she had to wait for more days until the same health care workers appeared or were reassigned to the HAART department.

The locality of the health care institutions where the research was conducted presented another limitation. Most HAART patients (potential participants) came from remote rural villages and travelled long distances to reach the health care facilities. This resulted in limited time of interviewing them. Most of these patients were pregnant women and mothers with babies. During interviews, some of them

and their babies were feeling so hungry that it was difficult for the researcher to interview them. Catering for these mothers who had babies was perceived as a challenge but the researcher reached an agreement with CHS management who allowed these mothers to be served first and at the soup kitchen provided by the hospital before their interviews commenced.

## **7.5 STUDY CONTRIBUTIONS**

### **7.5.1 The unique contributions of the study**

The study contributed to the body of scientific knowledge as follows:

- In the development and amending operational policies within Catholic Health Services.
- A health education programme was designed and implemented to address the as explained above.
- The researcher identified the gap in the practice because there were no specific guidelines/programmes for health care workers in respect of communication with PLWHA on HAART.
- The health education programme that enhances communication with HIV positive patients is unique in a sense that the implementation activities of the programme are comprehensive, affordable, and implementable.
- Since a qualitative approach was adopted, information was obtained through focus group discussion with health care workers and in-depth interviews with HAART patients where participants' verbal, active listen skills and non-verbal expressions found a meaningful and honest expression.

- This research study should enable policymakers and managers in the health care services to gain a wider understanding of what is required to communicate effectively with HIV patients. It could persuade policymakers to create conditions and practices for achieving targeted strategies that involve PLWHA on HAART and for promoting health communication frameworks and intervention programmes.

A conceptual framework was considered to be a unique contribution to the body of knowledge in public health, since it could be utilised by health professional as references or baseline for developing health professional models for designing activities and programmes.

The health education programme makes several noteworthy contributions to Namibia as a country, the SADC region and elsewhere in the world by equipping health care workers with knowledge and the necessary skills that assist with improved dialogue by facilitating communication with PLWHA on HAART. At the same time, it serves as a baseline for future studies about the psychosocial and health needs of patients, specifically of PLWHA on HAART.

It also contributes to the existing body of knowledge in public health that can be utilised by both the health professionals and the PLWHA to promote patient-centred frameworks that would improve health care workers' performance and communication behaviour. Narrowing the gap between HIV / AIDS policies and guidelines, as well as improving the performance standards of individual health care workers would also enhance their knowledge and abilities in relation to desirable communication, the consultation process, and building rapport with their patients.

Health care workers as senders convey messages to patients as receivers (PLWHA on HAART). This health training programme enhances their capabilities to communicate on a level where ordinary / lay patients could grasp or comprehend the messages / health information they are receiving.

## **7.6 CONCLUSIONS**

The study findings are validated by the conclusions, recommendations, limitations, and contributions that demonstrate the feasibility of methods and evaluation of the content of the programme that are significant to the general goal of the study. The discussions in this chapter centres on the importance of the health education programme at the Namibian health institutions and elsewhere in the world. The unique attribute of this training intervention for health care workers is found in the application of their knowledge and abilities in effectively communicating health information with PLWHA on HAART. The health education programme encourages good communication behaviour between health care workers and HAART patients. It also increases self-efficacy and confidence among health care workers in respect of effective communication with PLWHA on HAART. The programme enhances the promotion of health by utilising IEC resources and IVR interactive pre-recorded mass messages for disseminating health information to the individuals and the public during self-awareness, community mobilization, and outreach campaigns.

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#### **ANNEXURE A**

#### **CHS PERMISSION LETTER**



## CATHOLIC HEALTH SERVICES

17 Jan Jonker Road, PO Box 11525, Windhoek, Namibia  
Tel: (061) 224799/225265/259554/259847. Fax: (061) 248126. e-mail: health@ncbc.com.na

ASSOCIATION INCORPORATED UNDER SECTION 21

Enquiry: Sr. A. Bock

Date: 22-10-2010

OFFICE OF THE DIRECTOR OF HEALTH

SHALOM!

DEAR ABIGAIL,


RE: PROJECT FOR DOCTORATE DEGREE

AT THIS POINT IN TIME, WE FIND NO OBJECTIONS WITH YOUR PROPOSED PROJECT FOR YOUR DOCTORATE DEGREE. THE TOPIC BEING "DEVELOPING AND EVALUATION OF A HEALTH EDUCATION PROGRAMME FOR HEALTH CARE WORKERS THAT FACILITATES AND REINFORCES RESPONSIBLE BEHAVIOURAL CHANGE IN PATIENTS ON HIGHLY ACTIVE ANTIRETROVIRAL THERAPY IN CATHOLIC HEALTH SERVICES FACILITIES IN NAMIBIA", WITH THE FOLLOWING OBJECTIVES:

- DETERMINE THE INFORMATION PROVIDED BY HEALTH CARE WORKERS TO HIV PATIENTS ON HAART AT CATHOLIC HEALTH SERVICES IN NAMIBIA
- TO DEVELOP A HEALTH EDUCATION PROGRAMME FOR HEALTH CARE WORKERS THAT WOULD FACILITATE AND REINFORCE RESPONSIBLE SEXUAL BEHAVIOURAL CHANGE IN HIV-POSITIVE PATIENTS ON HAART
- TO IMPLEMENT THE HEALTH EDUCATION PROGRAMME IN AREAS OF THE COUNTRY WHERE CATHOLIC HEALTH SERVICES ARE ACTIVE
- TO EVALUATE THE EFFECTIVENESS AND FEASIBILITY OF THE PROGRAMME.

WE WISH YOU ALL THE BEST WITH YOUR PROJECT.

SINCERELY YOURS,

  
SISTER ANGELA BOCK, O.S.B.  
DIRECTOR OF HEALTH  
CATHOLIC HEALTH SERVICES

Directors: Archbishop L. Nashenda, Bishop J. Shikongo, Bishop P. Pöllitzer, Sister A. Donadilla,  
Sister S. Endjala, Sister M. Shetunjenga, Sister Dr. I. Iita, Sr. A. Bock

District Hospitals: Andara, Nyangana, Oshikuku, Rehoboth  
Health Centres: Aroab, Bunya, Okatana, Sambyu, Tondoro  
Clinics: Anamulenge, Ilyateko, Mayara, Mbambi, Old Bagani, Oshitutuma, Shinungwe

## ANNEXURE B MOHSS ETHICAL CLEARANCE

9 - 0/0001



## REPUBLIC OF NAMIBIA

## Ministry of Health and Social Services

Private Bag 13198	Ministerial Building	Tel: (061) 2032562
Windhoek	Harvey Street	Fax: (061) 272286
Namibia	Windhoek	E-mail: <a href="mailto:amuhcua@mhss.gov.na">amuhcua@mhss.gov.na</a>
Enquiries: Mr. A. Muheua	Ref.: 17/3/3/AP	Date: 15 November 2010

## OFFICE OF THE PERMANENT SECRETARY

Miss. M. A. Chipare  
P. O. Box 23124  
Windhoek  
Namibia

Dear Ms. Chipare,

**RE: Study - Development a health education program that facilitate and reinforce positive behavioural changes in patients on highly active antiretroviral therapy in Namibia**

1. Reference is made to your application to conduct the above-mentioned study.
2. The proposal has been evaluated and found to have merit.
3. Kindly be informed that approval has been granted under the following conditions:
  - 3.1 The data collected is only to be used for academic purpose;
  - 3.2 A quarterly progress report is to be submitted to the Ministry's Research Unit;
  - 3.3 Preliminary findings are to be submitted to the Ministry before the final report;
  - 3.4 Final report to be submitted upon completion of the study;
  - 3.5 Separate permission to be sought from the Ministry for the publication of the findings.

Yours sincerely,

  
MR. K. KAHURE  
PERMANENT SECRETARY



"Health for All"

**ANNEXURE C UNAM LETTER OF PERMISSION**

**UNIVERSITY OF NAMIBIA**

Private Bag 13301, 340 Mandume Ndemufayo Avenue, Pionierspark, Windhoek, Namibia



**FACULTY OF HEALTH SCIENCES  
SCHOOL OF NURSING AND PUBLIC HEALTH  
UNIVERSITY OF NAMIBIA**

**Letter of permission:  
Post graduate students**

Date: 24 AUG 2010

Dear Student: M N Chipare

The post graduate studies committee has approved your research proposal.

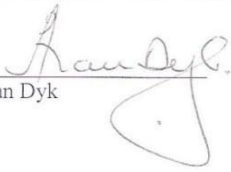
**Developing and evaluating of a health education programme for health care workers that facilitate and reinforce positive behavioral change in patients on highly active antiretroviral therapy in Catholic Health Services Facilities in Namibia**

You may now proceed with your study and data collection and formal registration for the degree.

It may be required that you need to apply for additional permission to utilize your target population. If so, please submit this letter to the relevant organizations involved. It is stressed that you should not proceed with data collection and fieldwork before you have received this letter and got permission from the other institutions to conduct the study. It may also be expected that these organizations may require additional information from you.

Please contact your supervisors on a regular basis.

Faculty Representative Post Graduate Studies Committee

  
Prof A van Dyk

## ANNEXURE D HAART PATIENTS' INFORMED CONSENT

PATIENTS' INFORMED



CONSENT FORM

Participants' information leaflet

and informed consent form

**Title:** Developing a health education programme to enhance communication skills and knowledge of HCWs who serve patients on highly active antiretroviral therapy at Catholic Health Services facilities in Namibia

### INTRODUCTION

You are invited to participate in this research project. This leaflet will help you make an informed decision about whether or not to participate. It is good for you to fully understand why the research is being done and what it involves before you agree to participate. However, should you have any unanswered questions do not hesitate to contact the researcher directly.

### THE PURPOSE OF THE STUDY

The purpose of the study is to develop a health education programme for health care workers that will enhance communication skills and knowledge of health care workers who serve patients on highly active antiretroviral therapy at Catholic Health Services district hospitals in Namibia.

The objectives of this study are to:

- determine the information provided by health care workers to HIV patients on HAART at Catholic Health Services in Namibia;
- develop a conceptual framework from the findings of the study;
- develop and implement a health education programme for health care workers;  
and
- evaluate the effectiveness and feasibility of the programme.

#### WHAT IS EXPECTED OF YOU?

You need to respond to the research questions from the researcher.

#### ETHICAL APPROVAL OF THE RESEARCH PROJECT

The research protocol was submitted to the postgraduate committee of the University of Namibia and was approved and authorised.

#### YOUR RIGHTS AS A PARTICIPANT

You are at liberty to participate or not and you can stop at any time without providing a reason. Your withdrawal will have no effect on the outcome of the study.

The implication of completing the questionnaire is that informed consent has been obtained from you. The information given by you will not be traceable and you will not be able to recall your consent.

#### CONFIDENTIALITY

All information obtained during the study is strictly confidential. Data might be

reported in scientific journals but will never include information that identifies you as a participant of this study.

Consent: May I continue to ask you some questions?

Yes.....1. (Begin the questionnaire)

Respondent's thumb print / signature

No.....2. (Do NOT continue with the questionnaire)

\*\* Any information needed, please contact

Researcher: Ms ABIGAIL CHIPARE

Thank you for giving of your time in this study!

**ANNEXURE E HCWS FOCUS GROUP DISCUSSION GUIDE**





**HEALTH CARE WORKERS FOCUS GROUP DISCUSSION GUIDE**

Developing a health education programme to enhance communication skills and knowledge of HCWs who serve patients on highly active antiretroviral therapy at Catholic Health Services facilities in Namibia.

Name of the Hospital:

.....

Facilitator:

.....

Date:

.....

Question guideline for focus group discussion with HCW:

1. Tell me about your experiences while serving PLWHA on HAART here at your health care facility?

2. How do you intend to address all these challenges that you are concerned about?

3. How often do you talk or communicate with HAART patients each time they visit your facility and what do you talk to them about?

4. How to you promote health to PLWHA on HAART at your health care facility?
5. Who supply these materials to your health care facility?

## **ANNEXURE F FOCUS GROUP DISCUSSIONS**

Researcher: *“Thank you for coming this morning. I want to briefly share with you the purpose of this study and how it is important for you to contribute to the discussions as much as you can, since you have more information on the subject than I do. Information gathered from these discussions will be confidential and no names or personal information will be mentioned without your informed consent. This information is going to be used to improve our health care services. Those are the reasons why you were chosen to participant. No information is right or wrong, therefore, respecting other people’s opinions without any criticism is important. All protocols are observed. We can start with our discussions by introducing ourselves to the members of the group.”*

Researcher: *“I want to welcome you once again. In front of us in this room we have provided you with two flip chart boards. One is for you to write on one or two expectations about these discussions and two; is a questions guide provided for our discussions. Make sure you can see clearly on the chart or if you need us to make some adjustments, do not hesitate to say so. For my conveniences [sic], all information that we are going to discuss will be recorded. Therefore, don’t get distracted by my movements.”*

Researcher: *“Tell me about your experiences serving PLWHA on HAART here at your health care facility?”*

FG: *“We treat these patients (HAART patient) the same way as with other patients with general conditions only that their needs are completely different. They need (HAART patients) expertises [sic] who are trained to deal them.”*

FG: *“The other challenge is that these patients (HAART patients) do not say much about how they feel about this disease (HIV / AIDS) and they are uncomfortable to discuss it with us. So, sometimes we run out of options on how best we can assist them (HAART patients).”*

FG: *“In our culture, in this region, a young person as I am is not allowed to talk to elderly persons about sexual issues. Sex issues are considered a taboo, I think in all African cultures and this disease is acquired through sexual contact, thus why it becomes tough to help them.”*

FG: *“If the truth can be told, we have no formal training on how to care for these patients (HAART patients). Sometimes, I feel uncomfortable to give information that I am not quite sure of.”*

FG: *“The other issues that cripple our efforts in serving these special patients (HAART patient) are that we lack clear guidance support from our management. In some instance[s], we felt being de-motivated. We all know that these patients need a comprehensive health care intervention. The diagnosis can be a patient need psychological intervention, and willing to talk and confide in us about what is bothering her / him but you find that there is no room to even a place to sit and have [a] private conversation with that patient.”*

FG: *“Really how can you give counselling in the waiting area? The main challenges facing our health care facility is infrastructure and resources for HAART patients. Besides these patients (HAART patients), you must know that we serve other general patients who need our attention as well. Our region is boarded [sic] to three other countries who seek health care services from our facility causing us not to pay more*

*attention to these (HAART patients). Most of these patients are pregnant women and mothers with babies who pass through us (health care workers). Where would we have that time to give counselling to these patients (HAART patients)? The waiting area will be full to the capacity leaving us with limited space to allow movements.”*

*FG: “It is very clear that some of us who went through professional training, HIV / AIDS management were [sic] not part of it, therefore, it complicates our efforts to do our work in the right way. This disease, furthermore, is not even making it any easier for us to understand more about it, since it is evolving every time. The other pressing issue is that here in our facility we have nothing to guide us in the management and caring of HAART patients.”*

*Researcher: “How do you intend to address all these challenges that you are concerned about?”*

*FG: “I think your question should be directed on what do we have that can help us dealing with these challenges. Frankly speaking, currently we do not have any remedies or intervention strategies in place to deal with to these problems.”*

*FG: “We need clear guidelines that are in line with HIV / AIDS policies and frameworks of the country. These guidelines should guide us in programmes that focus on the health needs of PLWHA on HAART. Yes, we have ARVs guidelines but it does not cover programmes and training of health care workers.”*

*FG: “The most important thing is the lack of resources and shortage of space in our facilities in addressing the health needs of PLWHA on HAART.”*

*Researcher: "How often do you talk or communicate with HAART patients each time they visit your facility and what do you talk to them about?"*

*FG: "In most cases, we just respond to their (HAART patients) questions if they have any but to tell the truth we don't have any structured information or guidelines that direct us in giving information to HAART patients at the moment."*

*FG: "Sometimes, if I have time, normally I get information from the Internet that I give to my patients. This makes me feel as easy [sic] because at least I will be quite certain about that information."*

*FG: "With regards to talking to patients, I think one of my colleagues mentioned that earlier on that we just don't have enough time to talk to all patients because of time constraints. We should make it clear for the record that these patients (HAART patients) come from remote villages inland, very far from the hospital and they travel long distance[s] to come here (health care facility). Some [of] them, if not all, they will be hungry and exhausted that they won't even bother to listen to what I will be talking to them about. These patients, some of them are pregnant women and mothers with babies."*

*Researcher: "How do you promote health to PLWHA on HAART at your health care facility?"*

*FG: "Currently, we have health care workers who once a week (Thursdays) go for outreach and do mobilisation in the community. They (health care workers) promote VCT mostly and testing of new patients and dispense ARVs in the remote villages."*

Researcher: *“So, do you think this health promotion covers also people who are living with HIV on HAART health needs?”*

FG: *“Not at all, a lot needs to be done with regards to promoting health, particularly to these patients (HAART patients) regarding IEC materials, for instance. All what [sic] we have covers information that was meant for general public, not necessarily HAART patients.”*

FG: *“In our facility, we have shortage of IEC materials for all patients.”*

Researcher: *“Who supplies you with these materials to your health care facility?”*

FG: *“Sometimes, the Ministry of Health but we heard now they have opened a new place where every health care institution should place an order once or twice a year. The challenge with these arrangements was if we don’t order in time, [it] means that for the whole six months we operate without any IEC material.”*

Researcher: *“I want to thank you all for your productive contributions towards this research study. The final report will be shared with you in the near future!”*

Researcher: *“I thank you.”*

#### **ANNEXURE G HAART PATIENTS’ INTERVIEWING TOOL**



Developing a health education programme to enhance communication skills and knowledge of HCWs who serve patients on highly active antiretroviral therapy at Catholic Health Services facilities in Namibia

Name of the Facility:.....

Name of the Facilitator:.....

Date:.....

Time of interview:.....

**Interview instructions:**

The interview is designed strictly for HIV positive patients who are on HAART. Ask for patient's consent, then proceed with the interview and thank participant for her / his responses and move on to the next potential patient. No individual names should be asked in the interview.



Confidentiality should be guaranteed!!!

Please discuss with the patient using the listed questions below!!!

#### PART I: PATIENT'S DEMOGRAPHIC INFORMATION

1. Age:.....
2. Sex: Male / Female:.....
3. Married / Single:.....

#### PART II: INTERVIEW QUESTIONS

“Tell me about your experiences when dealing with health care workers with regard to your health condition?”

“Tell me, when you discuss with health care workers what do you talk about?” “What type of information would you want to know about your health condition?” a.

HIV prevention

- b. Treatment adherence
- c. Blood results
- d. Viral load
- e. CD4 count
- f. Sexual relationships

- g. Nutrition
- h. The dangers of alcohol abuse
- i. Disclosure
- j. HIV / AIDS stigma and discrimination

**Thank you for your time!**

**ANNEXURE H HAART PATIENTS' INTERVIEW EXAMPLE**

**Researcher:** *“Good morning? My name is Abigail Chipare and I am busy with a research [study] at this hospital to improve our health care services. I would like to talk to you about these services that you get from the health care workers. Is it OK with you?”*

**Participant:** *“Good morning too. Yes, it OK to ask me questions.”*

**Researcher:** *“Then if it is fine with you, I would like you to complete this informed consent form before we proceed with the interview. This form is all about informing you about [your] rights and gives you the instructions about the interview. All information will be confidential. No name or personal information will appear or mentioned in this study without your consent. You have all the rights to pull out from this interview is [sic] you feel uncomfortable with some of the questions asked.”*

**Participant:** *“Thank you. I do understand and I would want to continue with this interview.”*

**Researcher:** *“What brings you to visit the health care facility today?”*

**Participant:** *“I came to get my tablets refill, since this is my scheduled date for follow-up.”*

**Researcher:** *“Tell me about your experiences when dealing or talking with health care workers about your health conditions?”*

**Participants:** *“There is nothing much that they (health care workers) talk to me about really, unless if I am not feeling well.”*

**Researcher:** *“If you are not feeling well and you tell them (health care workers), what do they say?”*

**Participant:** *“They (health care workers) just refer me to the sister (nurse) for examination.”*

**Researcher:** *“If you go to the nurse, what does the nurse talk to you about?”*

**Participant:** *“The nurse just tells me to take off my shoes and go on the weighing scale and then sit on the examining table. And ask me some questions about where the pain was and when I started feeling that pain.”*

**Researcher:** *“Then what else does the nurse say?”*

**Participants:** *“Nothing much, but only to go and get my tablets on my prescription and to take them regularly and on time with food.”*

**Researcher:** *“What other information does the nurse talk about with you when you are in that examining room?”*

**Participant:** *“As I said, they (health care workers) don’t talk to me about anything unless if I ask them questions. Sometimes, they (health care workers) are so difficult to approach.”*

**Researcher:** *“Why do you say that?”*

**Participant:** *“Your [sic] can be so lucky is [sic] they (health care workers) don’t shout or embarrass you even in front of other people (patients). Their (health care workers) reaction sometimes makes me feel afraid to even ask any questions although I know that it is the right thing to do.”*

**Researcher:** *“What would you want to know about your condition?”*

**Participant:** *“I tell you, if they (health care workers) permit me, I would want to know more about how I can live and cope with this disease (HIV / AIDS), because in my village where I come from, I hear a lot of things that confuse me about this disease. My brother was told that he was HIV positive in 2004. When he came for check-up he was told that by (health care workers) that his blood was OK and it was good news to the family. He stopped coming to the hospital and taking these tablets (ARVs). His problem was he liked drinking alcohol (Tombo) too much. What surprised me was he did not last for a long time. He came to the hospital after a year and he was very sick that he was admitted and died the following morning of chest pains because he was coughing a lot. My brother left behind a wife and five children that my husband and I have to take care of them, since my sister-law is not formal employed. Now back to your question. I would like to know more about how I can cope with this disease and prevent it not to kill me faster. If my brother’s blood was or [sic] OK, what killed him? Is it that that disease (HIV / AIDS) came to him again? Why did the machines at the hospital catch this disease (HIV) before it killed my brother?”*

**Researcher:** “Thank you very much for your contribution to this research. You should be rest assured you [sic] that we will share with you this report after the research have finished.”

**Participant:** “Thank you for listening to me because this disease (HIV / AIDS) is very tricky. So, I really wanted to share with someone how I felt about it.”

**Researcher:** “Thank you, once again!”

## **ANNEXURE I HEALTH EDUCATION PROGRAMME FOR HEALTH CARE WORKERS SERVING PLWHA ON HAART IN NAMIBIA**

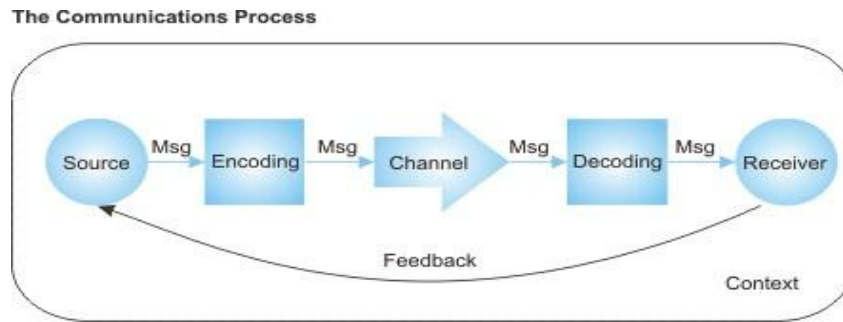
The content of the health education programme was planned, developed, and implemented according to the themes of the study.

### **Interpersonal communication and counselling skills (Theme 1)**

Interpersonal communication is a process between two people exchanging information, feelings, and meaning by using verbal and non-verbal signs and gestures. During this process, other skills are acquired such as counselling skills which augments the roles that people play in providing social or personal advice, especially professionally.

#### **Communication**

The communication process involves at least two people: **The sender and the receiver**. Communication begins when the sender wants to convey messages to the receiver. The messages are displayed in the form of mental images that include ideas, thoughts, pictures, and emotions. In order for the sender to transmit these messages to the receiver, the sender first should transpose or translate these mental images into symbols in order for the receiver to understand them. These symbols were often words, pictures, sound, or senses (touch or smell) that makes sense or have meaning to the receiver. The process of translating images into symbols is called encoding and decoding (Figure 7.1).



**Figure 7.1: Communication process**

*Source: Williams (2013)*

The sender (source) can transmit or communicate the messages to the receiver in many ways; such as verbal, nonverbal, written, or in the form of picture. During the coding or communication process, the sender should have the ability to listen actively to receiver's responses (feedback). Therefore, in order to accomplish the communication process between two persons, one of them has to be the sender will another person is the receiver. In this study, the health care worker was the sender (encoded) who conveys the messages and the receiver (decoded), were the PLWHA on HAART. To our benefit, this process is repeated below:

□ **Sender: Health care worker (recipients)**

Health care workers (senders) should have the ability to convey (encode) messages to the patients (receivers) through verbal or nonverbal communication. These messages should be constructed in such a way that the receiver is able to understand and decode the message with the purpose of giving appropriate feedback to the sender. The sender / source as the encoder decides what type of messages are needed to be

encoded to the receiver (Williams, 2013). The senders (recipient) who are encoding messages need to:

- know their audiences (to whom are the communication directed);
- know the purpose of the communication;
- know the topic;
- anticipate the objectives;
- present the complete picture;
- develop a practical, useful way to get feedback; and
- use multiple communication techniques (Williams, 2013).

According to Rowe, (2013) the sender (recipient) should consider the following aspects when conveying messages:

- **Authenticity** is to be direct, honest, straightforward when communicating information and feelings that are relevant and legitimate to the subject under discussion.
- **Empathy** is the understanding of another person's point of view without giving up one's own position or sense of self. Comments; such as "I see your point", or "I'm beginning to understand why you feel that way" demonstrate empathy.
- **Confirmation** is demonstrated by non-possessive expressions of warmth for other people that affirm them as unique persons without necessarily approving of their behaviour or views. An example would be: "I'd still prefer that you didn't consume alcohol while taking your ARVs, but you probably have carefully thought about its ramifications."



- **Presentness** is demonstrated by listening actively to another person while avoiding all distractions.
- **Messages:** According to Williams (2013), messages are a form of conversation that is constructed and conveyed through verbal examples, face-to-face dialogue and / or nonverbal-gestures, facial expressions, signs, vocalisation (including pitch and tone), speech, and the written word.
- Verbal / spoken messages

The sender (recipient) who is encoding verbal messages needs to articulate its meaning in a non-judgemental manner to enable the receiver to understand the information being conveyed.

### **Consider the elements of conveying messages**

Messages should be: Clear (not uncertain), concise message should be straight to the point (not misleading), concrete messages that are based on facts (evidence based) and not assumption, correct and truthful based (not lies), coherent and consistent (not sluggish), complete and holistic (not incomplete), and courteous (not rude).

### **Conversation example**

Conversation can be simply use of words, phrases or actions that edify communication, e.g. words like “Really”, “Uh-huh”, “Hmm”, or phrases like: “What did you want to know about your blood results?”, “How many times a day do you take your tablets?”, and using gestures like smiling, flinching, nodding, and frowning.

*Rowe Doug,(2013)*

Messages can be conveyed and expressed in many ways, including verbal and nonverbal (Figure 7.2):

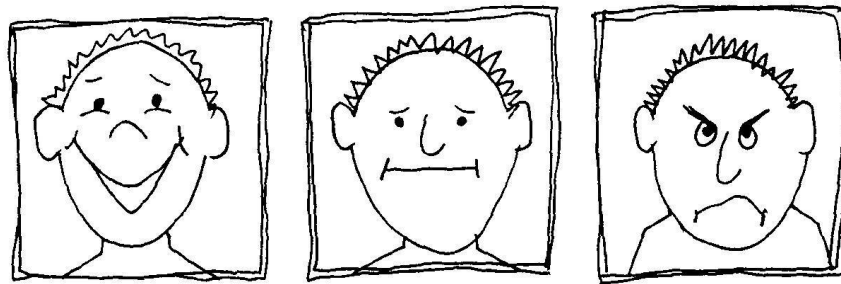


**Figure 7.2:** Verbal / spoken messages

*Adapted from Warren & Windle (2010)*

### **Non verbal messages**

Nonverbal messages include silent messages or communicating emotions; for example facial expressions, body movement and gestures, eye contact, posture, tone of voice, muscle tension, and breathing. The way you look, listen, move, and react to other people tells them more about your feelings than words can ever tell (Warren & Windle, 2010). Figure 7.3 demonstrates communicating emotions, e.g. facial expressions.



**Figure 7.3: Communicating emotions**

*Warren & Windle (2010)*

### **Channels of communication**

These messages can be conveyed to the receiver through various channels of communication. Mass media channels include television, radio, newspapers, books, and magazines. IEC includes posters, pamphlets, and drama. Health promotion tools, such as IVRs and campaigns.

### **Receiver: patients (PLWHA ON HAART)**

according to Williams (2013), the receiver / decoder is responsible for extracting / decoding the meaning from the messages and also for giving feedback to the sender. this gives the sender an indication whether the messages to the receiver were successfully conveyed or not. the sender (recipient) is obliged to interpret the messages accurately so as to respond to the feedback from the receiver in an appropriately manner. this required the sender (recipient) to actively listen to the messages conveyed. (see image below):

### **Active Listener / sender (recipient)**

Successful listening does not simply mean an understanding of the words or information that is being communicated, but also includes an understanding of how the receiver comprehends messages that are being communicated to them (Sid, 2011). Figure 7.4 illustrates successful listening.



**Figure 7.4: Successful listening**

*Adapted from Warren & Windle (2010)*

### **Feedback to the Sender**

Feedback is essential to the sender / encoder, since it determines whether or not the receiver / decoder has grasped the intended meaning and whether the communication has been successful (Williams, 2013). Messages should not be conveyed in such way that the terminologies hinder the receiver to comprehend information meaningfully, with the consequence that it hinders or interferes with the outcome / feedback of the communication.

### **Context / Environment**

According to Williams (2013), the context / environment referred to the place where communication takes place. Therefore, it is essential to take note of the place or environment where these messages are being communicated by the sender / encoder (recipients) and being received by the receiver / decoder (PLWHA on HAART). The context does not represent the health institution only but also included time, place, events, and the attitude of the sender (recipient) and receiver (PLWHA on HAART). For example, timing is very important when conveying sensitive information to the

patients; it requires the health care worker (recipient) and PLWHA on HAART (patient) to be in a conducive atmosphere, where there are no interruptions.

### **Noise / Deterrence of Messages**

When giving information / feedback, one has to avoid places where there is lots of noise. Noises / deterrence are emanating from internal or external factors hinder the conveyance of messages. This can be anything that gets in the way of messages being accurately received, interpreted, and responded to. For example, communicating confidential information to a patient in the waiting room area where other patients in that place could overhear the conversation (Williams, 2013).

## **GOOD COMMUNICATORS: HCWS HAVE TO COMMUNICATE WITH THEMSELVES / HEALTH CARE WORKERS / RECIPIENTS**

### **Communication with ourselves (self-awareness)**

According to Sid (2011), in order to communicate with other people, we have to know ourselves. Moreover, we have to be genuine and honest about our feelings, thoughts, desire, and needs. Consequently and without this self-knowledge, we might find ourselves projecting onto other people our feelings, thoughts, desire, and needs. The exercise below serves as an example.

We start by trying to identify our beliefs in a role play exercise:

Identify and reflect on your own beliefs with regard to the following emotions and feelings and how they influence your communication with other people. Some of the common emotions and feelings are: Fear, anger, grief, and despair.

If our perceptions seem to be negative towards other people, we should turn them into positive (**Affirmation**).

### **Communicating with other people**

As health care workers (recipients), we should become aware of our feelings when we are communicating with other people; the messages that we convey can be verbal and/or nonverbal. Furthermore, there are some circumstances in which patients need to hear or understand beyond the message that we are trying to convey to them. We can briefly say that other people say more about us than what we are saying and we sometimes are not listening to what people are trying to say to us (Sid, 2011).

### **Self-Actualisation**

Sender (recipients) view themselves through Johari's window and visualise what they have seen (Figure 7.5).

1. Blind area	3. Open free area
2. Hidden / secret area	4. Unconscious area

**Figure 7.5: Interpretation of Johari's window**

- The interpretation of windowpane number 1 indicates what is known or unknown to oneself and other people.
- Windowpane number 2 shows what is known to others but not to oneself.

- Windowpane number 3 illustrates what is known to oneself but not to other people.
- Windowpane number 4 indicates what is unknown to both self and others.

If people need their communication to be transparent, they should move away from the unknown area (4) to the public area (1) by giving feedback, i.e. allowing other people tell them things that they do not know about them without disclosing their secrets).

## **COUNSELLING / EDUCATION SKILLS**

- Counselling / education refers to providing general information (Sid, 2011) and all the aspects about HIV / AIDS that are required by patients, particularly PLWHA on HAART. These patients who need counselling services can be from primary health care departments, such as OPD / VCT / ANC / PMTCT /FP / ART / clinics and TB wards.

**Counselling can be done through different methods namely:**

□ **Individual / face-to-face counselling**

The main goal is assisting patients to help themselves. The individual counselling process as described by Corey (2010) involves the following phases:

- **Current scenario:** Patients should understand what problems they are experiencing or information they need to have, issues, concerns, or

undeveloped opportunities, e.g. patients who are seeking information that would improve their knowledge about aspects of HIV / AIDS.

- **Preferred scenario:** Patients should be assisted to understand what they need or want instead of what they have, for example making choices or inquiring about CD4 count with the intention to conceive a baby.
- **Strategies:** Assist patients to have all the resources and information they need to accomplish their action goal.
- **Action:** Assist patients to focus on and achieve their goals. This phase helps patients to shift from planning to acting, e.g. helping patients who are heavy drinkers to propose a feasible treatment plan, enforcement, and management.

#### □ **Group counselling**

Groups are either structured or unstructured.

The composition of a group, according to Corey (2010), is determined by various factors; such as the age of patients, the experience of health care workers (recipients), the type of group, and the problems to be explored. For example, one can have a group of six to eight adult patients for continual weekly group interaction. The size of a group gives an opportunity for interaction and should be small enough for all participants to be involved and to have a sense of belonging.

Group counselling stages are the initial stage, transition stage, working stage, and termination stage.

- **Initial stage:** This stage focuses on the orientation and exploration of the group. During this stage, members are encouraged to get acquainted with one



another, learn the functioning of the group, developing spoken and unspoken rules that govern the group behaviour, exploring their fears and hopes pertaining the clarification of group expectations, identifying personal goals, and determining whether the group is regarded as safe.

- **Transition stage:** During the transition stage, normally group members are characterised by anxiety, defensiveness, resistance, a struggle for control, member conflicts, challenges to or conflicts with the leader, and various patterns of problem behaviour. In this stage, the group leader is required to work with members by intensely dealing with the identified challenges in order to proceed to the working stage.
- **Working stage:** The transition stage is overlapping with the working stage because all the group members' characteristics identified during the transition stage are being dealt with in the working stage for the purpose of proceeding to the final stage. The group leader facilitates the movement of a group from both the initial and transition stages to the working stage. This focuses on the leader's self-disclosure while encouraging and motivating members to work towards identified goals.
- **Final stage:** During this stage, members of the group have evolved and have the opportunity to clarify the meaning of their experiences in the group, consolidate the gains they have made, and share their decisions about newly acquired behaviour that they could transfer to their everyday lives. In final stage, the group is dissolved or terminated and / or referred to psychosocial support groups for continual support.

## **Lack of IEC materials and other modes of disseminating health information**

### **(Theme 1.1)**

#### **Development of IEC materials**

According to Swann (2010), before developing IEC materials, it is essential for the developer to collect relevant information about that particular group to determine what would be the best IEC materials to use. At this point, a creative brief is created.

This creative brief serves as a guide that is assisting the IEC developers with carrying out the real design and production of the IEC materials.

The creative brief also assists with defining objectives that are based on formative research done on the target audience to identify the foreseen obstacles, develop the draft messages or advice and support statement, define the tone of messages, and list any other necessary creative considerations, such as different language versions or social conditions.

#### **□ The steps of developing IEC materials**

Target audience: It includes all the people who are intended to be reached with the IEC, as well as their characteristics (be prepared that the audience can resist by not accepting these IEC materials). Therefore, it is essential to compose a secondary group who can utilise the same materials. For instance, you can combine your original group (PLWHA on HAART) and other patients who have chronic or communicable diseases; such as diabetes, high blood pressure, and cancer.

- **Communication objectives:** These objectives should be based on the audience's feelings, emotions, thoughts, and the reasons why they should follow the advice stated in IEC materials. For instance, one of the objectives is to educate PLWHA on HAART about the dangers of having multiple concurrent partnerships. Then, one has to justify why one thinks it is important for members of the target audience to follow that advice.
- **Obstacles:** This is very important for the IEC developers (recipients) to consider the beliefs, religion, cultural practices, pressures, and misconceptions that stand between the target audience and the objectives.
- **Key messages / advice:** The message content should promote the benefits of doing, thinking or feeling, and reasons why the audience should follow this advice, for instance promoting the benefits of using condoms effectively. The benefits would be usage of condoms to minimise the chances of contracting STIs, unplanned pregnancies, re-infection, and improves CD4 count and immune system. These messages should be gender sensitive and should neither stereotype nor be biased to the people who are at risk the most.
- **Support statement / reasons why:** One has to support one's statements or assure the audience about the reasons why they should follow the message or advice.
- **Tone of messages:** The tone of the messages that are being communicated should be sensitive to the feelings and emotions of the targeted audience while, at the same time, respecting the religious values. Avoid using offensive, defamatory, racist, and hateful words or remarks that can cause the audience

discomfort. Also, the messages should be gender sensitive and tuned in such a way that it suits the different age groups, sexual roles, and classes.

- **Creative considerations:** The IEC developers / health care workers (recipients) need to be innovative enough to assemble other messages or connotations that are exciting, persuasive, and eye-catching to the audience.

### **Recording IVR messages**

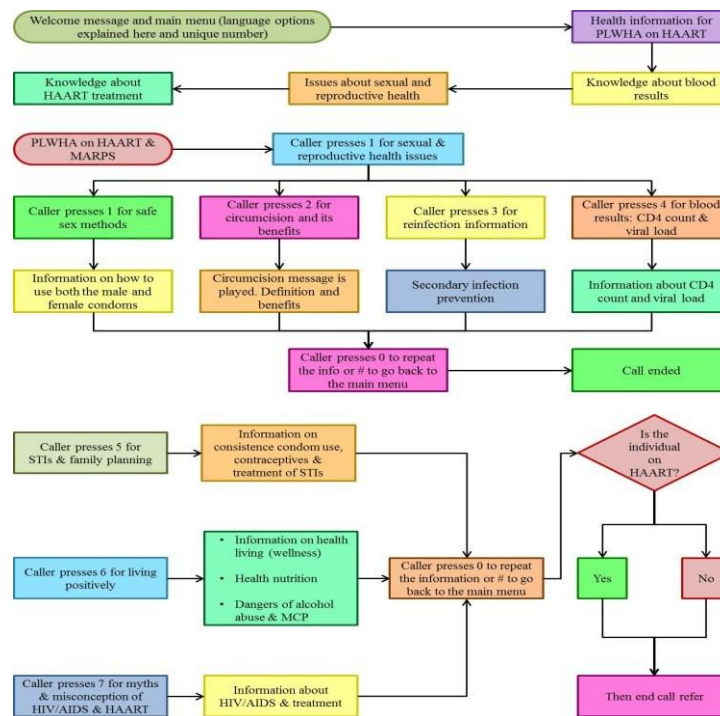
The facilitator / researcher (agent) conducted IVR tool demonstration aiming at assisting health care workers (recipients) with operating the tool on a mobile phone.

The IVR flowchart that includes the operating steps is illustrated in Fig 5.7.

### **IVR operating steps**

- **Step 1:** Prepare or develop messages for required health needs of PLWHA on HAART.
- **Step 2:** Pre-record these health messages (using your voice and / or verbal language) on a voice recorder.
- **Step 3:** Send these mass messages to the mobile service provider, e.g. MTC in Namibia who records these automated verbal messages in their database / system with the purpose of enabling individuals (PLWHA on HAART) and / or members of the public to access them at a later stage.
- **Step 4:** Principal clients dial a short code, e.g. 111, and gets directed to the main menu where they listen to the voice prompt. The automated response then starts giving a list of options from which one should select by pressing that particular option number.

- Step 5:** Once one responds by pressing a corresponding number, he / she gets redirected to a submenu where they can either find the information they want or are given another list of options that leads them to a specific submenu where he / she would find a solution to a particular problem. This process can be repeated until patients acquire the desired information before they are referred to health care workers (recipients) for individual and / or group counselling. All participants had an equal chance or opportunity to practise utilising the tool (Figure 7.6).



**Figure 7.6: Interactive Voice Response (IVR) tool**

**HEALTH CARE WORKERS EXPERIENCE LACK OF EXPOSURE TO HIV / AIDS MANAGEMENT (THEME 2)**

In order for health care workers (recipients) to manage HIV / AIDS, they need to familiarise themselves with the existing policies, frameworks, and guidelines that

provide information about HIV / AIDS programmes, resources, and daily activities for addressing the health needs of PLWHA on HAART (UNAIDS, 2009). It is essential for health care workers (recipients) to be well informed about the etiology of HIV / AIDS epidemic; including the progression of the disease, transmission, prevention and control, treatment, care, and support.

### **Etiology of AIDS**

No one knows the origins of AIDS. Some reports suggest that AIDS originated from the United States of America where the first case was reported in 1981 (NIAIDS, 2010). In Namibia, the first case was reported in 1983 and ever since HIV / AIDS has been a matter of concern in the country and other countries worldwide (MoHSS, 2010). The human immunodeficiency virus (HIV) causes the acquired immune deficiency syndrome (AIDS) by damaging the CD4 count or T-cells that protect the immune system of the body. HIV progressively destroys the ability of the body to fight infections and other opportunistic diseases.

### **HIV transmission**

According to NIAIDS (2010), HIV cannot survive for a long time outside its host (human beings). It can be transmitted from one person to another through contact of some blood fluids, semen or vaginal fluids, mother-to-child transmission, amongst people who are using the same syringes, and having unprotected sex with patients who are taking ARVs. HIV cannot be transmitted by shaking hands, sharing food and utensils, and using the same toilets.

Apart from occupational exposure, people who are at high risk of HIV transmission, are the ones who have unprotected sex, MSM, MCP, drug users who are sharing the same syringes, who are abusing alcohol and not consistently using a condom, who have a sexually transmitted infection; such as syphilis, genital herpes, chlamydia, gonorrhoea, bacterial vaginosis, or trichomoniasis, who have been diagnosed with hepatitis, tuberculosis, or malaria, and who have transactional, and inter-generational sex.

### **HIV / AIDS treatment**

With regard to HIV / AIDS treatment, health care workers (recipients) are required to have knowledge about the benefits of HIV treatment, as well as about the importance of adherence. Most importantly, health care workers (recipients) should put mechanisms in place to retain PLWHA on HAART and to investigate the causes of defaulters (MoHSS, 2010).

Furthermore, they should familiarise themselves with the most current ARV treatment guidelines and the latest drugs on the market. The NIAIDS (2010) identifies six major types of drugs that are used for treating HIV / AIDS; they are called “antiretroviral” because they act against the retrovirus HIV. The role of these drugs is to interfere with the HIV replication process. These drugs are: (1) Entry inhibitors, (2) Fusion inhibitors (3), Reverse Transcriptase inhibitors, (4) Integrate inhibitors, (5) Protease inhibitors, and (6) Multi-class combination products.

## **HIV / AIDS prevention**

There is no cure for HIV therefore, prevention is one of the options to curb the further spread of HIV / AIDS. Health care workers (recipients) are urged to start programmes and activities that are targeting individuals, particularly the PLWHA on HAART to reduce the risks of being infected or infecting others with HIV (NIAIDS, 2010).

### **PLWHA ON HAART EXPERIENCE INSUFFICIENT INFORMATION ABOUT THE ASPECTS OF HIV / AIDS ESSENTIAL TO THEIR HEALTH (THEME 3)**

Accessing quality health information and knowledge by PLWHA on HAART is essential to getting acquainted with the etiology of the disease (Edewor, 2010).

Therefore, informing or educating patients about preventing the further spread of HIV to their sexual partners is crucial. It was found that PLWHA on HAART each time that they visited health care facilities required information on the following aspects of HIV / AIDS: HIV prevention, adherence to HIV treatment, blood results, sexual relationships, alcohol usage, nutrition, disclosure, and HIV / AIDS related stigma and discrimination.

## **HIV prevention**

HIV / AIDS has no cure. Scientists and researchers are working tirelessly trying to find a vaccine that can prevent HIV infection. Therefore, to reduce the risk of becoming infected or re-infected by HIV or further spreading the virus to other people, individuals (including PLWHA on HAART) need to be informed about the



modes of HIV transmission, the implications, and how to prevent the further spread. That will encourage them to be tested regularly, practice abstinence, remain faithful to their spouses or partners, consistently use male and female condoms, and refraining from sharing needles (NIAIDS, 2010). HIV prevention is important for protecting those people who are not infected with HIV and STIs, as well as for preventing risky sexual behaviour, re-infection, TB, and co-infection.

### **Adherence to HIV treatment**

Adherence is essential for the success of HAART. It is defined as patients' abilities to adhere to prescribed treatment plans by taking ARVs daily and frequently as planned, as well as eating nutritious food. In addition, patients are required to take at least 95% of the prescribed drugs to suppress the replication of the HIV virus (MoHSS, 2010).

Health care workers (recipients), when communicating with PLWHA on HAART, should emphasise the importance of ARVs, the benefits and dangers of not adhering to treatment, symptoms of AIDS, clearing the misconceptions of treatment, encouraging patients to take care of themselves by taking their medication daily, refraining from risky sexual behaviour, good nutrition, safe drinking water, basic hygiene, physical exercised, and maintaining good adherence to treatment with the purpose of slowing down the progression of HIV (MoHSS, 2010).

NIAIDS (2010) indicates that patients need to be informed about classes of ARVs that they are taking, the reasons why they should keep on taking them, how ARVs control HIV reproduction in the body, and the implication of drug resistance. Drug

resistance happens when the HIV replicates itself, called mutation, that creates new forms of the virus. Mutation may not respond to existing HIV drugs.

### **Feedback on blood results**

Akinsegum Akinbami (2012) is of the opinion that the CD4 cell count and viral load tests provide PLWHA on HAART and physicians with important information about a person's HIV infection and immune system strength. Moreover, these tests also determine whether the patient is in need of taking medication for opportunistic infections, and / or medicine to fight HIV (HAART), and whether HAART was working effectively.

#### **□ The importance of cd4 count / t-cells**

NIAIDS (2010) report CD4 count is perceived as the “General” of the human immune system. It sends signals to activate the immune response of the body when it detects any intruders like viruses or bacteria. When health care workers give feedback to patients by saying their blood was “OK”, they should be clear and explain what that statement means to them and to patients.

The same report further indicates that health care workers (recipients) who are working directly with PLWHA on HAART should not only consider the CD4 count but also should base their decision on the best way and time to treat the HIV disease. According to CDC recommendations, a normal CD4 count should range from 500cell / mm<sup>3</sup> to 1 000cell / mm<sup>3</sup>, but that does not necessarily mean that patients should start with their treatment when it lower, unless there are pressing issues; such

as pregnancy, young age, constitutional symptoms, and / or acute retroviral syndrome.

#### □ **Viral load**

There is a relationship between viral load and the CD4 count in the blood. Therefore, it is imperative for health care workers to discuss with patients the levels of their viral load. Viral load refers to the levels of HIV in the blood (Akinsegun Akinbami (2012). Knowing their viral load assists patients and physicians to monitor the HIV disease, decide when to commence treatment, and determine whether or not the ARVs taken by patients are working. The main objective of treatment is to suppress the viral load up to undetectable levels. The “undetectable” levels could be under 4075 copies in a sample of the blood. It is advisable that the viral load test should be taken every 3-6 months, however, it should be adjusted according to changes in the updated guidelines (NIAID, 2010).

#### □ **Types of blood tests**

Patients need to be informed and educated about the types of tests available at the health care facility, how it works, as well as about their advantages and disadvantages. The three types of tests provided at most health care facilities are: The **enzyme linked immunosorbent assay (ELISA)** test, where the sample of blood is taken from a patient to determine whether it contains human antibodies (disease fighting proteins) unique to HIV; the **Western Blot** test, normally done when people have been recently infected with HIV (1-3 months of infection); and lastly, the **HIV testing in infants** which is based on the CDC recommendations that all pregnant

women get tested for HIV before or during delivery. This allows physicians to prevent mother-to-child HIV transmission by providing ARVs to both mothers and babies. A further test on babies is done when the baby is between the ages of 3 and 15 months (NIAIDS, 2010).

### **Sexual relationships**

The term sexual relationship refers to a relationship that involves sexual intimacy (Oxford dictionary, 2013). Sexual relationships can be influenced by every culture, sub-cultures, or different individual values. With regard to PLWHA on HAART, education about sexual relationships needs to happen in the context of health. Since the ARV intervention has started, the lives of people living with HIV have changed for the better. Currently, they are leading healthy lives and their priorities have changed, including their preferences in terms of sexual relationships. Some of them desire to get married and have babies, some feel that using condoms deprives them of enjoying sexual intercourse fully while some remain engaged in promiscuous relationships (Desert Soul, 2011). Therefore, it is the duty of the health care workers (recipients) to empower PLWHA on HAART about the implications of exposing themselves to high risk sexual behaviour that is subsequently disadvantaging their health. Patients need to be educated about sex, sexual intercourse, safe sex, family planning and suitable contraceptives, improving couple communication in dealing with sexual problems, sexually transmitted diseases and the importance of getting treatment, and the importance of using condoms consistently.

**Alcohol use**

Many patients relate HIV related risk to heavy use of alcohol. As a result of heavy drinking, patients often make dangerous decisions about either sexual practices, or about their health behaviour (UNAIDS, 2009). Consequently, they are more likely to engage in high risk sexual behaviour and thus be more likely to either be re-infected or transmit infection to their sexual partners, or to fail to adhere to their medication schedule. Therefore, alcohol abuse is regarded by many health care workers (recipients) as the primary reason for medication non-adherence.

According to Giuliano (2012), health care workers are required to educate PLWHA on HAART about the implications and / or dangers of alcohol that interfere with their ability to adhere to their antiretroviral treatment regimen, resulting in resistance.

These implications cause inflammatory reactions of patients, resulting in being at a higher risk of neurological and cardiovascular problems, aggravating depression, causing severe depression, being a driver of new infection by clouding judgement of sexual practice in choices of partners at a time, contributing to a lack of adherence. Defaulting on treatment, furthermore, affect newly infected patients due to limited treatment options and diminishing support structures. It also contributes to complex relationships between problematic alcohol use and other psychosocial factors like HIV stigma, homophobia, and a lack of social support. Figure 7.7 explains alcohol consumptions limits in Namibia.

According to MoHSS (2009), maximum drinking limits are:
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- For healthy men: Not more than three drinks a day and should not drink two days in a row.
- For healthy women: Not more than two drinks a day and should not drink two days in a row.

**Figure0.1: Namibian alcohol consumption limits**

## **Nutrition**

According to World Health Organization (WHO) (2010), nutrition is regarded as essential for preventing of disease, as well as treating and caring for PLWHA on HAART. However, when health care workers (recipients) are discussing nutrition with their patients, information should be based on sound scientific evidence and the acquisition of local resources; programmatic and clinical experience with the prevention, treatment, and management of the disease; and on related infections.

PLWHA on HAART should be encouraged to adopt good and healthy eating behaviour, eat balanced diet, use their local foods and to seek advice whenever they are visiting the health facilities (UNAIDS, 2010). Most importantly, health care workers (recipients) have a responsibility to refer malnourished patients and children for soup at the kitchen corner provided at most health care facilities.

The purpose of kitchen corners is to provide food demonstrations that are targeting pregnant and lactating HIV positive women, ANC and PMTCT, adolescents and

other adults living with HIV, and HIV exposed infants and children born to HIV positive mothers. The body mass index (BMI), as recommended by the guidelines, needs to be established for adults and children who show the need for such services and to properly explain feedback to them.

### **HIV disclosure**

Health care workers (recipients) need to empower their patients with strategies to disclose their HIV positive status to their sexual partners, family members, employers, and peers. According to Deribe, *et al.* (2008), disclosing one's HIV positive status is emphasised in both internal and international organisations; including UNAIDS, WHO, and CDC. Disclosure is important for preventing and controlling the further spread of HIV, preventing new infections, and treating the currently infected individuals.

The benefits of disclosure should be emphasised when patients present for testing and counselling (VCT), since it is the entry point for treatment, care, and support of patients. However, patients should not be pressured to disclose; they should rather be empowered and prepared for continual counselling support.

Disclosure empowerment entails providing patients with strategies to come to terms with the predicament they are in, assisting them to understand and accept the facts about HIV, providing patients with basic steps that can help them to reduce the risk of infecting their partners, putting patients at ease in order for them to be comfortable

and knowledgeable before disclosing their status to their partners, and empowering them to use their own words when telling their partners about their.

Health care workers may empower HAART patients to disclose their HIV status to partners their conversation by stating that e.g. “I want to talk with you about something that is important to me” or “I really feel I can trust you and I want to tell you something very personal! Last year I found out that I have HIV. Can I tell you about it?”

### **HIV / AIDS related stigma and discrimination**

Ngozi, Mbonu, Nanne, & De Vries, (2009) describes stigma as an act of identifying, labelling, or attributing undesirable qualities to those people who are perceived as being “shamefully different” and deviant from the social ideal. HIV related stigma originates from the pre-existing stigma in the form of social marginalisation and vulnerable groups; such as injecting drug users, men having sex with men, commercial sex workers, women, and children. On the other hand, discrimination is perceived as “enacted stigma”.

Gonzalez (2009) describes HIV / AIDS stigma in Sub-Saharan Africa as common and of concern to everyone. Some studies suggest that culture is perceived as the base of stigma; since it influences our beliefs, norms, and values that predetermine HIV / AIDS as a negative and immoral act that is not accepted in the society.

PLWHA on HAART need to be empowered by health care workers (recipients) to deal with stigma and discrimination. Health care workers (recipients) need to implement programmes that allow patients / people to discuss sexuality in the



context of their cultural norms and values with the purposes of dispelling myths about HIV / AIDS. Furthermore, patients need to be empowered and educated about the sources of HIV / AIDS stigma and discrimination, the manner in which individual and societal values impact on HIV / AIDS stigma, and the manifestation on HIV / AIDS stigma and discrimination.

**ANNEXURE K TRAINING WORKSHOP ASSESSMENT FORM**

<p style="text-align: center;"><b>TWO-DAY TRAINING WORKSHOP</b></p> <p style="text-align: center;"><b>ASSESSMENT FORM</b></p> <p>Your feedback is important to us, since it provides valuable information to help us continually improve future workshops. Completing this evaluation provides you with an opportunity to communicate your thoughts and experiences during the training workshop.</p> <p>What information have you learnt from this training workshop?</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>What new information have you learnt from this training workshop that improves your work?</p> <p>.....</p>
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What other information do you want to know about that has not been covered during this training workshop?

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What other information do you want to add to the questions asked above?

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Thank you!!

**Comments gathered from the participants (recipients) by the end of training assessment**

- This workshop was an eye opener to me, specifically because I did not know how to express myself even when attending meetings and when providing feedback to patients.

I learned a lot in this training workshop on how to communicate with PLWHA and on the management of HIV / AIDS.

I have learnt a lot on how to develop IEC material and designing of messages that were good for my patients.

This workshop has improved my abilities to deal with my feelings and emotions before communicating with others and most importantly my patients.

This workshop has improved my counselling skills, specifically the group counselling that was my weakest point.

My interpersonal communication skills had been polished up during this workshop that benefited my work.

Recommendations to the workshop:

The training workshop should be extended to other health departments.

More training needed for developing IEC materials and designing messages.