A MODEL FOR NURSES TO FACILITATE SUPPORTIVE CARE TO MEN DIAGNOSED WITH PROSTATE CANCER AND THEIR FAMILIES IN THE INTERMEDIATE HOSPITAL OSHAKATI: A HOSPITAL BASED APPROACH

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DECLARATION

I, Salomo, hereby declare that "**A model for nurses to facilitate supportive care to men diagnosed with prostate cancer and their families in the Intermediate Hospital Oshakati: A hospital based approach**", is a true reflection of my own work, and all the sources used have been acknowledged in the text and the bibliography. The version of this work is an original work, and has not previously been submitted in whole or in part for the degree at any other university.

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Salomo Salomo Date: October 2022

DEDICATION

To my lovely daughter, **Ehalolye-Nalitye**. The baton is over to you!

"There is no elevator to success. You have to take the stairs." ~ Anonymous

"If you run after two hares you will catch neither."~ African proverb

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ABSTRACT

Namibia appears to have no existing guidelines to facilitate supportive care for men diagnosed with prostate cancer (PCa) in the oncology departments at the Intermediate Hospital Oshakati (IHO). In King et al.'s (2015) opinion it is crucial for healthcare workers involved in delivering care for men diagnosed with PCa and their families to maximise their quality of life through supportive care. The purpose of this study was to develop a model for nurses to facilitate supportive care for men diagnosed with PCa and their families at the IHO. The study adopted a pragmatic worldview to achieve its objectives. In applying a pragmatic paradigm, the researcher adopted a convergent, parallel, mixed methods study, employing both a quantitative, descriptive, cross-sectional and a qualitative, exploratory, descriptive and contextual design. The study was conducted in four phases of theory generation, as proposed by Chinn and Kramer (2018):

Phase 1 comprised an analysis of concepts based on five research objectives that correspond with the five elements of the study population, namely, published research materials on PCa, nurses, men diagnosed with PCa, family members of men diagnosed with PCa, and oncology departments at the IHO. Qualitative data were collected by means of a scoping review and in-depth, individual, face-to-face interviews with 11 men, 7 family members and 14 nurses in order to explore and describe (1) best practices for the supportive care provided by nurses in the oncology departments for men diagnosed with PCa and their families, (2) the experiences of men diagnosed with PCa of the supportive care received from nurses in oncology departments, (3) the experiences of the families of men diagnosed with PCa of supportive care received from nurses in oncology departments, and (4) the experiences of nurses in facilitating supportive care for men diagnosed with PCa and their families in the oncology departments. A non-probability purposive sampling method was used to select information-rich participants. All responses were audiotaped and transcribed verbatim. Qualitative data were manually analysed by means of content analysis, using the Tesch's eight steps of open-coding. The following themes and sub-themes were accordingly identified: two themes and eight sub-themes for objective 1, two themes and seven sub-themes for objective 2, two themes and four sub-themes for objective 3, and three themes and six sub-themes for objective 4. Each theme was discussed, verified with direct quotations from the interviews and supported by relevant and appropriate literature. Quantitative data were collected using a five-point Likert scale questionnaire to assess the oncology departments in terms of facilitating supportive care for men diagnosed with PCa and their families. Thirty-five registered nurses answered the questionnaires. Quantitative data were analysed using the Statistical Package for the Social Sciences, version 25 (SPSS-25). The study revealed that men diagnosed with PCa are rarely offered psychological and spiritual support to enable them to cope more successfully with the hardships they face after being diagnosed with the disease. Nurses, for their part, experience various interventions regarding supportive care, as well as a shortage of resources, the lack of a conducive environment and a lack of support, as well as barriers that hinder the facilitation of supportive care for men and family. On the other hand, family members of men with PCa felt devalued in the healthcare system, as they were often excluded from decision-making regarding treatment. The findings also reveal a lack of psychological and spiritual supportive care by nurses for families.

In phase 2, a conceptual framework based on Dickoff et al.'s (1968) practice oriented theory and the four main concepts gleaned from the concept analysis (support, physical, social, psychological and spiritual support) was developed. In phase 3 of the study, the model for nurses to facilitate supportive care for men diagnosed with PCa and their families in IHO was developed. The model was developed based on four theories, namely: practice oriented theory, systems theory, holistic theory and the nursing process theory. The model was described in line with the five descriptive components, as proposed by Chinn and Kramer (2018), namely, purpose, concepts, definitions, relationships, structure and assumptions. Each component of the model was described in terms of the way it contributes to the purpose of the model. The model was evaluated in accordance with the criteria for evaluating the nursing model, as proposed by Fawcett (2005) and Parse (2005). In phase 4, guidelines for operationalising the model were developed to provide direction for nurses and members of the multidisciplinary team involved in the model facilitation process. The guidelines were developed in terms of aims and activities to address the challenges and barriers that hinder the facilitation of supportive care for men diagnosed with PCa in health facilities. Based on the study findings, recommendations are made in terms of nursing practice, nursing education, and nursing research.

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LIST OF ACRONYMS

AIDS	:	Acquired immunodeficiency syndrome
APCC	:	Australian Prostate Cancer Collaboration
BioMed	:	Biological medicine
CA	:	Cronbach alpha
CASP	:	Critical Appraisal Skills Programme
CFA	:	Confirmatory Factor Analysis
CDC	:	Communicable Disease Clinic
CGA	:	Comprehensive Geriatric Assessment
CINAHL	:	Cumulative Index of Nursing and Allied Health Literature
CMIN/DF	:	Chi-square and degrees of freedom
CPD		Continuous professional development
CSSD	:	Central Sterilization Supply Department
CUA	:	Chinese Urological Association
EAU	:	European Association of Urology
EDA	:	Exploratory Data Analysis
EFA	:	Exploratory Factor Analysis
ELCIN	:	Evangelical Lutheran Church in Namibia
EMBASE	:	Excerpta Medica Database
GFI	:	Goodness of fit index
HALE	:	Health adjusted life expectancy
HINARI	:	Health-InterNetwork Access to Research Initiative
HIV	:	Human immunodeficiency virus
HPCNA	:	Health Professions Councils of Namibia
ICU	:	Intensive care unit
IHO	:	Intermediate Hospital Oshakati
MDT	:	Multi-disciplinary team
MEDLINE	:	Medical Literature Online
MeSH	:	Medical Subject Headings
MIS	:	Management information system
MMS	:	Mean to Max Ratio Score
MoHSS	:	Ministry of Health and Social Services
NCCN	:	National Comprehensive Cancer Network

NDP5	Namibia’s 5th National Development Plan
NICE	National Institute for Health and Care Excellence
OC	Oncology clinic
OOPD	Oncology Outpatient Department
OPD	Outpatient Department
OW	Oncology ward
PCa	Prostate cancer
PCC	Population, context and concepts
PCSC	Prostate cancer supportive care
PCSGs	Prostate cancer support groups
PFA	Principal Factor Analysis
PhD	Doctor of Philosophy
PNSs	Professional cancer navigators
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analysis
PSA	Prostate-specific antigen
PubMed	Public/Publisher MEDLINE
PUHS	Public Unified Health System
SADC	Southern African Development Community
SPSS-25	Statistical Package for the Social Sciences
SRMR	Standardised Root Mean Square Residual
UK	United Kingdom
UNAM	University of Namibia
UOPD	Urology Outpatient Department
USA	United States of America
VPC	Vancouver Prostate Centre
WCH	Windhoek Central Hospital
WMA	World Medical Association

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CHAPTER 1

INTRODUCTION AND BACKGROUND OF THE STUDY

1.1 INTRODUCTION

Supportive care refers to the provision of the necessary services, as defined by those living with or affected by cancer, to meet their physical, social, emotional, informational, psychological, spiritual and practical needs during the pre-diagnostic, diagnostic, treatment and follow-up phases of cancer care, and encompassing issues of survivorship, palliation and bereavement (Carter et al., 2014; Primeau et al., 2017; Sykes, 2013). In the management of cancer, supportive care entails all the activities that assist a person with cancer and their family to cope with the cancer and its treatment, from pre-diagnosis through the process of diagnosis and treatment to cure, continuing illness or death and into bereavement. Supportive care delivery is complex and involves multiple health disciplines and people working in various agencies who are concerned with health promotion and prevention, survivorship, palliation and bereavement (Carter et al., 2014).

In this study, supportive care is based on four domains, namely, physical needs, social needs, psychological needs and spiritual needs. Supportive care needs are diverse and range from coping with the psychological effects of cancer and its treatment to psychological and psychosocial sequelae such as anxiety, depression and feelings of isolation. Access to evidence-based information throughout the cancer experience is seen as an essential aspect of supportive care. According to Primeauet al. (2017), unmet supportive care needs are prevalent in contemporary healthcare particularly for individuals affected by metastasis prostate cancer (PCa). Knowing that men diagnosed with PCa can live longer after initial treatment, the impact of supportive care on men diagnosed with PCa with regard to unmet needs upon seeking services is considerable (Allchorne & Green, 2016). Providing men and their families with supportive care and informing them of sources of support before, during and after treatment are essential to help them deal with their stress. Patients and their carers need to be clear when they are discharged what to expect and how to care for themselves (Hinkle & Cheever, 2018).

Prostate cancer (PCa) is a type of cancer that starts in the prostate, a walnut-sized gland in men found right below the bladder (Hinkle & Cheever, 2018). The majority of tumours occur in the outer aspect of the prostate gland. One in every five men will develop PCa at some point during their lives. Prostate cancer is the fourth leading cancer in incidence globally, with higher mortality reported in less developed regions than in more developed regions. It is the most common cancer among the elderly male population all over the world, with a slight preponderance in Black people. More than 75% of cases occur in men over the age of 65. The risk factors for PCa include increasing age, ethnicity, family history, endogenous hormones such as androgens and oestrogens, diets containing excessive amounts of red meat and dairy products that are high in fat (Hinkle & Cheever, 2018). Early signs of PCa include frequent urination, weak or interrupted urine flow, urge to urinate frequently at night, blood in urine or seminal fluid, erectile dysfunction and burning urination. Men diagnosed with PCa have poor quality of life, higher levels of psychological distress, increased suicide risk and more unmet supportive care needs (Chambers et al., 2018). It is therefore crucial for nurses involved with the care delivery for men diagnosed with PCa and their family to maximise their quality of life through supportive care (Paterson et al., 2016).

Currently, there is a lack of supportive care for men diagnosed with PCa (King et al., 2015). To date, the unmet supportive care needs of patients diagnosed with PCa have not been well researched, recognised or addressed in depth (Allchorne & Green, 2016). According to Oliffe et al. (2015), men diagnosed with PCa may receive supportive care from nurses, partners, families and support groups. Men diagnosed with PCa and their families often experience unmet supportive care needs (Paterson et al., 2016). Nurses involved in the care delivery for men diagnosed with PCa need to be aware of the complex physical and psychological supportive care needs, as well as the evidenced-based management care plans available, to ensure personalised and supportive care for optimise quality of life (Paterson et al., 2016).

PCa occurs twice as frequently among African American men as among white men. In addition, they are more likely to have PCa at a younger age, have more aggressive tumours at diagnosis and have higher mortality rates. Because of advances in screening and early detection, 90% of men are diagnosed at an early stage (Nelson & Kenowitz, 2015). Although Sub-Saharan Africa has low prevalence of PCa, it has one of the highest estimated incidences of the disease in the world (Kangmennaang et al., 2016). Among men diagnosed with PCa, 98% survive at least five years, 48% survive at least ten years, and 56% survive 15 years after diagnosis (Hinkle & Cheever, 2018).

Men diagnosed with PCa are likely to have a lengthy illness pathway, and the individual burden to families can be considerable. One way of managing this is to provide good supportive care for patients and their family to cope with cancer and its treatment, thereby helping patients to maximise the benefits of treatment and to live with the effects of the disease (Paterson & Nabi, 2017). Supportive care during clinical consultations with men diagnosed with PCa can prevent patient distress and improve quality of life and overall satisfaction with care, while reducing healthcare utilisation and costs. Nurses should ensure the delivery of culturally sensitive education programmes and counselling not only to men diagnosed with PCa, but also to their friends and families (Hinkle & Cheever, 2018).

1.2 BACKGROUND TO THE STUDY

PCa is a major public health problem in men worldwide and kills over 250 000 men every year (Demichelis & Stanfold, 2015). It is the second most common cancer among men worldwide, accounting for 10% of cancer-related deaths, and ranks first in Europe (Zhou et al., 2016). Currently, 250 000 men are affected by PCa in the United Kingdom (Paterson et al., 2016). In Sub-Saharan Africa, PCa is reported to be the leading cancer in men (Zhou et al., 2016). In South Africa, the rate of histological diagnosed PCa is 40.1 per 100 000 in whites and 14 per 100 000 in Black people (Mofolo et al., 2015). Many PCa cases go undiagnosed due to a lack of medical knowledge, diagnostic facilities, trained health personnel and prostate-specific antigen (PSA) testing. This has resulted in PCa being the leading cause of mortality in resource-poor settings. In Namibia, PCa is among the top five of cancers, leaving men psychologically affected (MoHSS, 2011).

Men diagnosed with PCa experience a range of unmet supportive care needs, namely, the need for psychological supportive care surrounding the management and treatment of side effects, particularly erectile dysfunction and urinary incontinence (Oba et al., 2017; Paterson & Nabi, 2017). Other supportive care needs of men diagnosed with PCa include psychological support , physical support, treatment decision support, peer support, support from partners and family, as well as individualised, tailored health information based on their needs (King et al., 2015; Paterson & Nabi, 2017). De Moraes Lopes and Higa (2014) stress the need for specialised nursing care and supportive care to be provided at the time of PCa diagnosis, as well as during the pre-treatment and post-treatment periods.

In Namibia, PCa remains a public health concern. According to MoHSS (2018) the trend of PCa in the Intermediate Hospital Oshakati (IHO) remains on the rise with 14 new cases and two deaths in 2013, 51 new cases and 13 deaths in 2014, 80 new cases and 17 deaths in 2015, 84 new cases and 19 deaths in 2016, and 95 new cases and 13 deaths in 2017. In a study conducted by Salomo, Amukugo and Pretorius (2016) on experiences of men diagnosed with PCa in the four northern regions of Namibia, men expressed that it would be tough to go through the diagnoses of PCa on their own without their family members. According to Oba et al. (2017), nurses should be readily available for men diagnosed with PCa and their families in order to provide them with supportive care during treatment decision-making. Addressing the supportive care needs of men diagnosed with PCa during clinical consultation can prevent patients' distress, improve their quality of life and the overall satisfaction with care while reducing healthcare utilisation and costs (Paterson & Nabi, 2017). Family members of men diagnosed with PCa should also receive supportive care (King et al., 2015).

The Namibian Cancer Society recommends that men in their forties should be screened annually; however, screening for PCa remains low in Namibia with only 16% of men reporting having ever been tested (Kangmennaang et al., 2016).

In Namibia, PCa accounts for 44.8 per 100 000 of all cancers among men (Kangmennaang et al., 2016). The risk factors for PCa include increasing age, a family history, changing diets, lifestyles, and socioeconomic conditions. Early diagnosis of PCa greatly increases the chances of patients' survival because treatment is more likely to be successful (Kangmennaang et al., 2016).

1.3 CONTEXT OF THE STUDY

The context of the study is the environment in which the study takes place, as well as the culture of the participants and the location (Holloway & Wheeler, 2010). In qualitative research, events and actions are studied as they occur in everyday real-life setting, therefore if a researcher understands the context, he/she is able to understand the actions and perceptions of individuals and grasp their meaning as they communicate. This study is contextual in nature because it was conducted in the oncology departments and the surgical wards of the Intermediate Hospital Oshakati (IHO) where men diagnosed with PCa are admitted and followed up. IHO is a public and referral hospital based in the Oshana region, serving the four northern regions, namely, Oshana, Omusati, Ohangwena and Oshikoto. The hospital became operational on 28 June 1966 and comprises various departments such as nuclear medicine, outpatients department (OPD), central sterilisation supply department (CSSD), casualty, laboratory services, intensive care unit (ICU), communicable disease clinic (CDC), operating theatres, dental clinic, X-ray, oncology outpatient department (OOPD), plastic surgery department, male surgical wards, male oncology wards and physiotherapy, among others. Figure 1.1 depicts the location of the IHO in which the study took place.

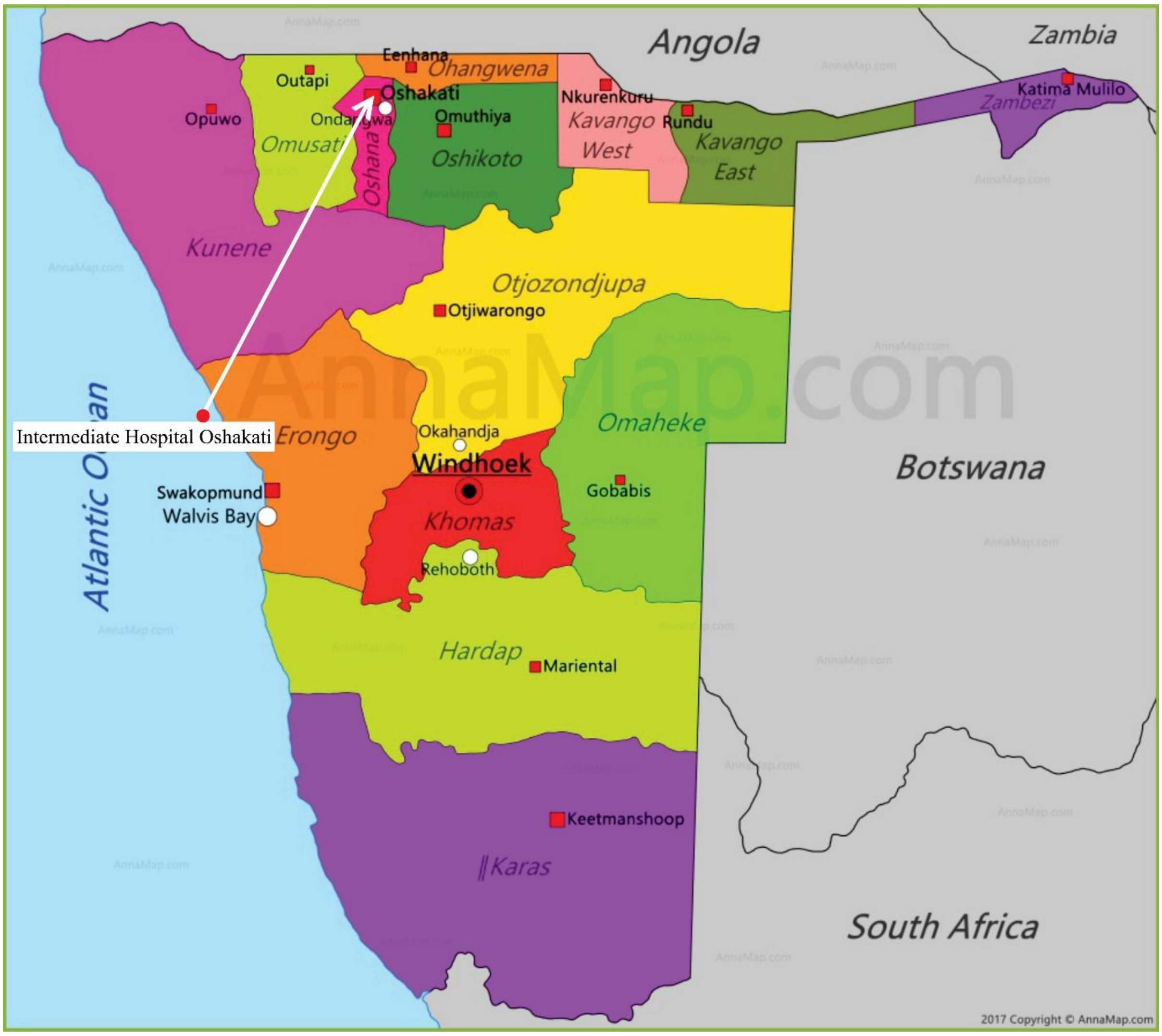


Figure 1.1: The location of the Intermediate Hospital Oshakati in Oshana Region, Namibia

1.4 STATEMENT OF THE PROBLEM

The development of the model was necessitated by the lack of a model for nurses to facilitate supportive care for men diagnosed with PCa in health facilities. Despite PCa being among the five leading male cancers in Namibia, the country does not seem to have a model, policy or guidelines to facilitate supportive care for men diagnosed with the disease. The Patient Charter of Namibia appears to be the only document published by the Ministry of Health and Social Services (MoHSS) that stresses the support of patients with chronic or long-term conditions, but it does not specify the type of supportive care to be given to men diagnosed with PCa and their families (MoHSS, 2016). During the clinical encounters with men diagnosed with PCa at the IHO, as a nurse, the researcher observed that PCa patients are rarely being given supportive care in order to cope with their diagnoses and the long-term effects of the disease. Patients with PCa frequently report that their psychological and other supportive care needs are neither identified nor addressed. This lack of supportive care for men diagnosed with PCa is contrary to Carter et al. (2014) who stress that being diagnosed with PCa poses significant quality of life concerns that require supportive care in terms of physical, social, psychological and spiritual aspects. The diagnosis of PCa and the treatment one endures in this regard calls the future into question. Accordingly, men disclose lingering thoughts about their chances of survival, which affect them both physically and psychologically, hence the need for supportive care (Hinkle & Cheever, 2018).

Globally, PCa accounts for 10% of cancer related-deaths and ranks first in Europe (Zhang et al., 2017). In Namibia, the Oshana region recorded the highest number of PCa in the country (32.2%), followed by the Khomas region (31.4%) during the 2010–2014 period (Zietsman et al., 2017). A study conducted by Cockle-Hearne et al. (2013) on the impact of supportive nursing care on the needs of men diagnosed with PCa revealed that 81% of men had unmet supportive care needs which included psychological, sexual, health system and information needs. The consequence of psychological distress that many men with PCa experience and that may require supportive care is not always assessed or managed well despite convincing evidence that being diagnosed with PCa poses significant quality-of-life concerns that require supportive care (Addie et al., 2014; Carter et al., 2014). In Namibia, a study by Salomo et al. (2016) revealed inconsistent care and a lack of physical and psychological supportive care given by nurses to men diagnosed with PCa in IHO. Chambers et al. (2018) recommend that, owing to a persisting supportive care services gap for men diagnosed with PCa, more qualitative research studies elucidating men’s experiences of supportive care are required if countries are to develop effective supportive care interventions in health facilities.

The background above has prompted the researcher to consider the following questions:

- What are the experiences of men diagnosed with PCa and their families regarding the supportive care received from nurses in oncology departments?
- What are the experiences of nurses in facilitating the supportive care of men diagnosed with PCa and their families in oncology departments?
- How prepared are oncology departments in terms of facilitating supportive care for men diagnosed with PCa and their families?

- What are the best practices for supportive care of men diagnosed with PCa and their families by nurses in oncology departments?
- What are the concepts to be identified for the development of a model for nurses to facilitate supportive care for men diagnosed with PCa and their families?

1.5 PURPOSE OF THE STUDY

The purpose statement indicates why the researcher wants to conduct the study and what he/she intends to accomplish (Creswell & Creswell, 2018). The purpose of this study is to develop a model for nurses to facilitate supportive care for men diagnosed with PCa and their families in the Intermediate Hospital Oshakati.

1.6 OBJECTIVES OF THE STUDY

Unlike the research purpose (which focuses on the study intentions), the research objectives directly specify and unpack the aim of the study, and highlight the actual measurable activities undertaken to actualise these questions (Creswell & Poth, 2018). The objectives of this study were to

1.6.1 Identify the concepts by conducting a conceptual analysis [phase 1]. Five sub-objectives were identified:

    1.6.1.1 Explore and describe the best practices for the supportive care of men diagnosed with PCa and their families exhibited by nurses in oncology departments [Phase 1]
    1.6.1.2 Explore and describe the experiences of men diagnosed with PCa of the supportive care received from nurses in oncology departments [Phase 1]
    1.6.1.3 Explore and describe the experiences of families of the supportive care received from nurses in oncology departments [Phase 1]
    1.6.1.4 Explore and describe the experiences of nurses in facilitating supportive care for men diagnosed with PCa and their families in oncology departments [Phase 1]
    1.6.1.5 Assess the oncology departments in terms of facilitating supportive care for men diagnosed with PCa and their families [Phase 1]

1.6.2 Define, classify and conceptualise the concepts as a basis for developing the model [Phase 2]

1.6.3 Develop and describe a model to facilitate supportive care for men diagnosed with PCa and their families in the Intermediate Hospital Oshakati [Phase 3]

1.6.4 Develop guidelines for operationalising the model to facilitate supportive care for men diagnosed with PCa and their families [Phase 4].

1.7 SIGNIFICANCE OF THE STUDY

On the basis of its conclusion and recommendations, this study will enable men diagnosed with PCa at the IHO to be given appropriate supportive care by nurses in oncology departments. The model developed during the study will serve as a guiding tool for the MoHSS which will ultimately lead to improved supportive care for men diagnosed with PCa and their families. Similarly, the model will serve as a tool to enable and empower nurses in oncology departments to provide more responsive, emotionally sensitive and client-centred supportive care for men diagnosed with PCa and their families based on the need. As this hospital is the biggest referral treatment centre for PCa, it is crucial that nurses acknowledge the supportive care needs in order to improve the quality of healthcare in oncology departments. The study will also be used as a source of reference by scholars intending to conduct research on supportive care for men diagnosed with PCa and their families.

1.8 DELIMITATIONS OF THE STUDY

Delimitation refers to the identified boundaries of a researcher’s study population because the researcher cannot reach the entire population. It also refers to the characteristics that restrict the population to a homogenous group of subjects (LoBiondo-Wood & Haber, 2010). This study was conducted at the IHO, focusing on the exploration and description of the experiences of men diagnosed with PCa of the supportive care received from nurses, the experiences of the men’s families of the supportive care received from nurses, the experiences of nurses in facilitating supportive care for men diagnosed with PCa and their families, and the assessment of the oncology departments in terms of facilitating supportive care for men diagnosed with PCa and their families.

1.9 PARADIGMATIC PERSPECTIVE

A paradigm is a worldview, a general perspective on the complexities of the world. A paradigm consists of a set of philosophical assumptions that guide the researcher’s approach to enquiry (Polit & Beck, 2012). De Vos et al. (2011) define a paradigm as a framework, viewpoint or worldview based on people’s philosophies and assumptions about the social world and the nature of knowledge, and how the researcher views and interprets material about reality and guides the consequent action to be taken. It is a collection of logically linked concepts and propositions that provide a theoretical perspective or orientation that tends to guide the research approach to a specific topic (Polit & Beck, 2012). According to Creswell and Poth (2018), a paradigm is a philosophical stance taken by the researcher that provides a basic set of beliefs that guides action. The paradigm serves to define what should be studied, what questions should be asked, how these questions should be asked and what rules should be followed in interpreting the answers obtained (Botma et al., 2010). Paradigms should be viewed as lenses that help to sharpen our focus on a phenomenon because they provide structures and directions that the research should take and details of how it should be performed (Polit & Beck, 2012; Scotland, 2012).

This study adopted a pragmatic worldview to achieve its objectives. Creswell (2014) recommend that a mixed method study requires a paradigmatic perspective. In this study, pragmatism opened the doors to multiple research methods, different worldviews, and different forms of data collection and analysis, which were subsequently employed by the researcher (Creswell & Creswell, 2018; Creswell & Poth, 2018). For the application of a pragmatic paradigm, the researcher adopted a mixed method by employing both qualitative and quantitative approaches to collect and analyse data rather than subscribing to only one approach (Creswell & Poth, 2018). Findings were merged to develop the central concepts as a basis for the development of a model for nurses to facilitate supportive care as recommended by for men diagnosed with PCa and their families. The significance of a paradigm in this study is that it influenced the identification of a research problem, the most appropriate methods, as well as the relevant techniques by which data were collected, analysed and interpreted. Similarly, the paradigm framed the way in which the discipline concerns were viewed as well as the direction that the research project took (De Vos et al., 2011).

In order to ensure a positivist paradigm, a questionnaire which made use of a five-point Likert scale was used to assess the oncology departments in terms of facilitating supportive care for men diagnosed with PCa and their families. Positivists value objectivity and attempt to hold personal beliefs and biases in check to avoid contaminating the phenomena under study (Polit & Beck, 2012). According to Creswell and Poth (2018), pragmatism focuses on the outcomes of the research and the actions, situations and consequences of enquiry, rather than the antecedent conditions. Instead of focusing on methods, the important aspects of research are the problem being studied and the questions asked about the problem.

The philosophical assumptions influenced the logic followed throughout this study (May & Holmes, 2012). Philosophical assumptions are the basic principles that we accept on faith, take for granted, or assume to be true without proof or verification (Creswell & Poth, 2018). Botma et al. (2010) emphasise that the quality of research findings is directly dependent on the methodological procedures followed in the study; therefore before choosing research methods, the researcher should know more about the philosophies related to the scientific nature of seeking knowledge. The following philosophical assumptions have been applied in the study, as illustrated in Tables 1.1, 1.2, 1.3, 1.4 and 1.5, namely, meta-theoretical assumptions (ontological, epistemological, and axiological), as well as methodological and rhetorical assumptions.

1.9.1 Meta-theoretical assumptions

Metatheory refers to the analysis of the theoretical underpinnings on which the studies are grounded (Polit & Beck, 2012). It is concerned with identifying and analysing the purpose of the theory needed for a particular discipline. Meta-theory allows scholars to establish criteria by which theories for that discipline are evaluated. According to Wrangler et al. (2012), metatheory is comprised of three assumptions, namely ontology (the study of being), epistemology (the nature and forms of knowledge) and axiology (the nature of values). In this study, the researcher considers the following assumptions as relevant to the study: namely ontological, epistemological, axiological, methodological and rhetorical (Creswell & Poth, 2018).

1.9.1.1 Ontological assumptions

A researcher’s ontological assumptions influence his topic selection, the formulation of the research questions and strategies for conducting research. Botma et al. (2010) state that researchers believe that people construct their own reality through their lived experiences (ontological perspective) and support the theory that knowledge is developed by interacting with people and that we construct our own interpretation and meaning of the experience (epistemology) within a phenomenological methodology by using methods such interviewing and observation. In this view, the research question is not about the reality of the world but about people’s interpretation of that reality, in this case supportive care for men diagnosed with PCa and their families. Table 1.1 depicts how ontological assumptions were applied.

Table 1.1: Ontological assumptions

Description of ontology	Application to the study
Ontological assumptions are concerned with what constitutes reality and its characteristics (Creswell & Poth, 2018; Scotland, 2012). The reality is multiple as seen by the many views obtained from participants (Creswell & Poth, 2018). It is a philosophical belief system about the nature of social reality – what can be known and how. In this study, ontology refers to the quality of supportive care for men diagnosed with PCa and their families	In this study, the reality is discovered based on worldwide best practices for supportive care for men diagnosed with prostate cancer and families by nurses in oncology departments, as well as various experiences as described by men diagnosed with PCa, their family members and registered nurses. This was achieved through observations and individual face-to-face interviews with the study participants, namely, men diagnosed with PCa, family members and registered nurses. To gain a multidimensional understanding of the phenomenon the researcher used multiple measures (triangulation) to investigate the phenomenon under study, namely, appraising research articles, conducting in-depth individual face-to-face interviews and the use of questionnaire (Botma et al., 2010). The researcher reported different perspectives as themes that were developed in the findings of the study (Creswell & Poth, 2018). The researcher used evidence of multiple realities by using direct quotations in the study, reflecting the actual words of different participants who presented different experiences of supportive care for men diagnosed with PCa and their families (Creswell & Poth, 2018).

1.9.1.2 Epistemological assumptions

Epistemology constitutes the nature of knowledge and how it may be obtained (Creswell & Poth, 2018). According to Holloway and Wheeler (2010), epistemology is concerned with how this knowledge can be created, acquired and communicated; in other words, what it means to know. It therefore attempts to answer the questions “What counts as knowledge?” and “How are knowledge claims justified?” The logical question that follows would be “What is the relationship between the researcher and that being researched (the phenomenon)”? (Creswell & Poth, 2018). The application of epistemological assumptions in this study is reflected in Table 1.2.

Table 1.2 Epistemological assumptions

Description of epistemology	Application to the study
Epistemology concerns the acquisition of knowledge and the relationship between the researcher and the researched (Wangombe, 2013). That is, it attempts to answer the question about the relationship between the researcher and what is being researched. With epistemological assumptions, researchers try to get as close as possible to the participants being studied (Creswell & Poth, 2018). Subjective evidence is obtained from participants whereby the researcher attempts to lessen the distance between him/herself and that being researched (Creswell & Poth, 2018).	Qualitative approach: Knowledge was gathered by appraising relevant research articles on best practices on the supportive care for men diagnosed with PCa and their families by nurses in oncology departments. The researcher conducted in-depth individual face-to-face interviews with men diagnosed with PCa and their family members on experiences of the supportive care received from nurses in oncology departments. The researcher conducted in-depth individual face-to-face interviews with nurses on experiences of facilitating supportive care for men diagnosed with PCa and their families. The researcher minimised the distance between him and those being researched by spending four months (December 2018–March 2019) in the field, personally interviewing men diagnosed with PCa, family members and nurses. The interviews were conducted in the field at sites where participants live and/or work in order to interact with specific participants on a specific topic and understand what the participants were saying (Creswell & Poth, 2018). The researcher gained an in-depth understanding of the phenomenon as well as specific views, perceptions, culture and experiences from different participants (Brink et al., 2013). Data were collected until saturated. The researcher relied on quotes as evidence from the different participants (Creswell & Poth, 2018). Quantitative approach: Questionnaires were used to assess the oncology departments in terms of facilitating supportive care for men diagnosed with prostate cancer and their families. It is therefore assumed that, the knowledge gained enabled the researcher to develop a model for nurses to facilitate supportive care for men diagnosed with prostate cancer and their families.

1.9.1.3 Axiological assumptions

All researchers bring values to a study, but qualitative researchers make their values known (Creswell & Poth, 2018). Axiology is concerned with values (Polit & Beck, 2012). The researcher admits the value-laden nature of the study and actively reports his values and biases as well as the value-laden nature of information gathered from the field. According to Polit and Beck (2012), axiology includes how people view themselves in relation to others, emphasising the role of values and ethics in research. Table 1.3 depicts how the axiological assumptions were applied in the study.

Table 1.3: Axiological assumptions

Description of axiological assumptions	**Application to the study**
Axiology refers to the role of values in the inquiry (Polit & Beck, 2012). It includes how people view themselves in relation to others with greater emphasis on the role of values and ethics in research. In terms of a pragmatic worldview, axiology plays a crucial role in the interpretation of results (Wagner et al., 2018). Axiological assumptions try to address what is considered ethical and moral behaviour by the researcher and how his values influence the research question and design (Hays & Sigh, 2011). Similarly, Biddle (2015) states that axiology involves ethics and identifies the roles values play the mixed methods research and the researcher's stance in relation to the subject being studied. According to Creswell and Poth (2018), the researcher acknowledges that the research is value-laden and that biases are present in relation to their role in the study context. Therefore, values and biases should be held in check, and objectivity should be sought (Polit & Beck, 2012).	In this study, the researcher employed mixed methods for data collection, analysis and interpretation of results in order to ensure both objectivity and subjectivity during the study. Ethical considerations and the rights of the research participants were upheld, protected and guaranteed prior to and during the research investigations. The researcher avoided influencing the study results by maintaining a neutral position during the entire period of the study in order to avoid being biased. However, it can nevertheless be assumed that the study participants and the researcher brought along their own values. Similarly, the researcher openly discussed values that shaped the narrative and included his or her own interpretation in conjunction with that of the participants (Creswell & Poth, 2018).

1.9.2 Methodological assumptions

Methodology is about how best evidence can be obtained, therefore the quality of the research findings is directly dependent on the methodological procedures followed in the study (Polit & Beck, 2012). Methodology focuses on gaining insight and understanding about an individual's perception of events (Nieswiadomy, 2014). In this study, the researcher served as a research instrument by utilising in-depth interviews as the primary method of collecting data, which were subsequently analysed. The methodological assumptions described in Table 1.4 were addressed as follows.

Table 1.4: Methodological assumptions

Description of methodological assumptions	Application to the study
According to Botma et al. (2010), methodological assumptions explain what the researcher believes good science practice is. It refers to the process of conducting the research by choosing the right approach, instruments, data gathering methods, and data analysis (Creswell, 2014). According to Botma et al. (2010), methodological assumptions pertain to rules and procedures that specify how the researcher must investigate what he/she believes must be known, therefore they provide the researcher with methods that he/she can follow when acquiring knowledge. This is in accordance with Polit and Beck (2012) who emphasise that the quality of research findings depends on the methodological procedures followed by the researcher.	A pragmatic approach with mixed methods was adopted in this study, in line with Creswell (2014), who emphasises that based on the methodological assumptions the researcher should choose the right approach, instruments, data collection and data analysis methods. Mixed methods research helps answer questions that cannot be answered by quantitative or qualitative research alone. A qualitative research approach was employed in order to analyse the concept of supportive care for men diagnosed with PCa, as well as their families, by exploring and describing the perceptions of men diagnosed with PCa, those of their families and those of nurses at the IHO. Similarly, a quantitative research approach was employed to assess the oncology departments in terms of facilitating supportive care for men diagnosed with PCa and their families. The researcher becomes intensively involved in the real world of the participant. The interaction between the researcher and the participants leads to an understanding of the experiences and the generation of themes (Salomo, et al., 2016).

1.9.3 Rhetorical assumptions

Rhetoric refers to the art of persuasion (Firestone, 2013). Rhetoric is normally considered something to be avoided in research because the facts are supposed to speak for themselves. The application of rhetorical assumptions in this study is reflected in Table 1.4.

Table 1.5 Rhetorical assumptions

Description of rhetorical assumption	Application to the study
Rhetoric refers to the language used throughout the research process (Firestone, 2013). It is the art of persuasion and decoration or elaboration in literature. The overall rhetorical assumption in qualitative research has to do with reporting on reality through the eyes of research participants. It involves reporting on what was seen and heard in the most objective way possible. The rhetorical structure of a research paper therefore refers to how the researcher goes about persuading the reader of the worth of what he/she is reading (Firestone, 2013).	The qualitative part of the study uses both formal and informal language. Informal, simple language was used during the interviews, verbatim transcriptions of the data, translation, and the development of themes and sub-themes. Direct quotations of the participants were used to present the qualitative results of the study. The quantitative part of the study used formal language during the design of the questionnaire, data entry, analysis, and presentation. An external research expert followed the procedures utilised by the researcher in terms of conducting a scoping review and coding to establish whether they were acceptable. The study was audited by an external auditor who scrutinised whether or not the results, interpretations, recommendations and conclusions were in line with the data. The report on this study entails rich descriptions indicating how the researcher was immersed in the setting and this gives the reader sufficient details to make sense of the situation (Polit & Beck, 2012).

1.10 THEORETICAL FOUNDATIONS OF THE STUDY

A theoretical foundation is a key component of every research study because it is used to direct the research process (Bless et al., 2013). A theoretical foundation includes theories that help to organise the study and provide the context within which the researcher examines a problem under study. Brink et al. (2018) stress that the theory used should apply to every step of the research process. In this study, the following theories were used to guide the researcher throughout the various phases of the study: Dickoff, James, and Wiedenbach's (1968) practice-oriented theory, Von Bertalanffy's (1930) systems theory, Jan Smuts' (1926) holistic theory and Ida Jean Orlando's (1961) nursing process theory. The theories are described below:

1.10.1 Practice-Oriented Theory (Dickoff et al., 1968)

This study adopted the Dickoff et al.' (1968) practice-oriented theory as a practical guideline for developing a conceptual framework as a basis for the model development. The concepts identified from the findings in phase 1 are defined and described based on the agent, recipient, context, dynamic, procedures and terminus. Dickoff et al. (1968) offered a reasoning map for describing the conceptual framework based on the answers to the following the following six questions, as illustrated in Table 1.6:

- Who or what performs the activity (agent)?
- Who or what is the recipient of the activity (recipient)?
- In what context is the activity performed (framework)?
- What is the energy source for the activity (dynamics)?
- What is the guiding procedure, technique or protocol of the activity (procedure)?
- What is the endpoint of the activity (terminus)?

The reasoning map is described below.

Table 1.6: Reasoning map

Concept	Definition of Concept in this Study
Framework	The IHO in which men are being diagnosed with PCa, treated and followed-up.
Agent	A nurse and other members of the multi-disciplinary team (MDT)
Recipient	Men diagnosed with PCa and family members
Context	Oncology departments in IHO
Dynamics	Challenges hampering the provision of supportive care for men diagnosed with PCa and their families.
Procedure	A model for nurses to facilitate supportive care for men diagnosed with PCa and their families.
Terminus	Holistic supportive care for men diagnosed with PCa and their families

Source: Adopted from Dickoff et al., 1968

The conceptual framework formed the basis of departure for the development of the model (Chapter 7) to facilitate supportive care for men diagnosed with PCa and their families.

1.10.2 Systems Theory (Von Bertalanffy, 1930)

Cornell and Jude (2015) describe systems theory as a way of assessing the relationships and reactions between individual components of a system and how that relates to the achievement of a goal. Systems theory can be used to clearly and concisely understand healthcare structures, processes and outcomes, as well as their interaction with the healthcare system. It provides a meaningful and useful means of examining challenges in healthcare organisations. The rationale for adopting systems theory was enhanced by the fact that the health system is made up of individuals within subsystems, different departments, sections and units that are interlinked and interdependent to form an integrated and holistic system.

In this study, Von Bertalanffy’s (1930) systems theory enabled the identification of the context that has an influence on the facilitation of supportive care for men diagnosed with PCa, namely, the macro (MoHSS, the Health Professions Councils of Namibia (HPCNA) and educational institutions), meso (community, support groups and NGOs) and micro contexts (health facilities, nurses and multidisciplinary teams), as illustrated in Figure 6.2 (Smith et al., 2019). The description of the three levels of context is given under the “context of the activity” in Chapter 6. The application of systems theory is illustrated in Table 1.7.

Table 1.7: Application of systems theory (Von Bertalanffy, 1930)

Main element	Application to the study
Macro context	**National and Professional Legal Frameworks** Ministry of Health and Social Services (MoHSS) Health Professions Councils of Namibia (HPCNA) Educational institutions
Meso context	**Community issues that define parameters of service delivery** Community Non-governmental Organisations (NGOs) Support groups
Micro context	**Day-to-day practice** Health facilities Nurses Multidisciplinary team (MDT)

Source: Adopted from the systems theory of Von Bertalanffy, 1930

1.10.3 Holistic Theory (Smuts, 1926)

According to Jasemi et al. (2017), the philosophy of holistic nursing theory is based on unity and a humanistic view of the patient. The theory describes approaches and interventions that are meant to satisfy a patient’s physical, social, psychological and spiritual needs. Providers of holistic care consider a patient as a whole and acknowledge the interdependence among their physical, social, psychological and spiritual aspects. In addition, holistic care emphasises the partnership between nurse and patient and the negotiation of healthcare needs that lead to recovery. According to Huljev and Pandak (2016), holistic care includes the satisfaction of patients’ physical, social, psychological and spiritual needs, rather than just the symptoms of the disease. Holistic nurses ensure that support is provided to the individual, family and community, and evaluates the patient’s complete health picture by examining how all body systems connect before determining a plan for healing. Jasemi et al. (2017) define holistic care as the provision of care for patients that is based on a mutual understanding of their physical, social, psychological and spiritual dimensions. In this study, the holistic nursing theory approach was adopted as it provides an in-depth understanding of patients’ needs and enables nurses to develop interventions that are meant to satisfy men’s physical, social, psychological and spiritual needs. Table 1.8 illustrates the application of holistic theory to the study.

Table 1.8: Application of the holistic theory (Smuts, 1926)

Main element	Application to the study
Physical	human material policies, guidelines and training materials infrastructure financial
Psychological	counselling advice and guidance encouragement problem solving coping mechanism listening effective communication relationships psychotherapy individualised information decision-making information self-esteem acceptance of the condition
Social	emotional support from family as a system friends' responses to the condition support group men's club volunteers organisation transportation for clinic visit
Spiritual	participation in religious activities peace of mind overcoming despair and guilt spiritual counselling

Source: Adopted from Holistic Theory of Jan Smuts, 1926

1.10.4 Nursing Process Theory (Orlando, 1961)

The purpose of nursing process theory is to enable the nurses to identify the patients' health needs, to establish plans to meet the identified needs, and to deliver specific nursing interventions to meet these needs through interaction with the patient, family and/or community (Berman et al., 2016). The nursing process approach requires the nurse to systematically collect data from the patient or family during the assessment phase, making a nursing diagnosis, formulating the desired plans to solve the patients' needs, and evaluating the extent to which the plan was affected in resolving the identified needs.

In this study, nursing process theory was adopted to assess and diagnose the dynamics of the recipient and the context in phase 1, identify the mechanisms (enablers) for facilitating the dynamics and barriers relating to the recipient and context in phase 2, and to evaluate and determine the effectiveness of the implementation of the supportive care interventions in phase 3. Nursing process theory consists of five elements, namely, assessment, diagnosis, planning, implementation and evaluation. Table 1.9 depicts the application of the elements of the nursing process to the three phases of the model.

Table 1.9: Application of the nursing process theory of Ida Jean Orlando (1961)

Element	Phase	Application
Assessment and diagnosis	1	Assessment of the dynamics of the recipient and the context by the agent in terms of the physical, social, psychological and spiritual needs of recipients, as well as the enablers of supportive care within the macro, meso and micro contexts, as illustrated in Chapter 6, Table 6.14. Diagnosis of the physical, social, psychological and spiritual dynamics, as well as the barriers that affect the facilitation of supportive care for men within the macro, meso and micro context.
Planning and implementation	2	Identification of the members of the multidisciplinary team and their roles and responsibilities by the agent. Identification of mechanisms (enablers) for facilitating the dynamics and barriers relating to the recipient and context (procedure).
Evaluation	3	Evaluation of the outcome (terminus) of supportive care.

Source: Adopted from the Nursing Process Theory of Ida Jean Orlando, 1961

1.10.5 Theory Generation (Chinn & Kramer, 2018)

The findings of the study formed the basis for developing a model for registered nurses to facilitate supportive care for men diagnosed with PCa and their families based on theory generation by Chinn and Kramer (2018). The developed model was also based on the conceptual framework developed in phase 2. Table 1.10 illustrates the steps used for theory generation.

Table 1.10: Steps used for theory generation during model development

Step	Application	Chapter
1	Analysis of the concepts	6
1.1	Identification of concepts	
1.2	Definition and classification of concepts	
2	Construction of the relationship statement	6
3	Description and evaluation of the model	7
4	Description of the guideline for operationalising the model	8

Source: Adopted from Theory Generation of Chinn and Kramer, 2018.

1.11 RESEARCH DESIGNS AND RESEARCH METHODS

1.11.1 Research design

A research design refers to a plan or blueprint of how the researcher intends to conduct the research (De Vos et al., 2011). According to LoBiondo-Wood and Haber (2010), the purpose of the research design is to provide the plan for answering the research questions. This study employs a mixed methods design. Mixed method entails the researcher combining qualitative and quantitative approaches with the aim to answer a research question in a satisfactory manner (Botma et al., 2010). The researcher opted for mixed methods research because it encourages the use of multiple worldviews (Creswell, 2014). It helps to answer questions that cannot be answered by quantitative or qualitative research alone. It also has certain strengths that offset the weaknesses of both qualitative and quantitative research (Creswell & Clark, 2011). Mixed research combines inductive and deductive thinking, therefore encouraging the researcher to think about a paradigm that encompasses all quantitative and qualitative research. In this study, a convergent parallel mixed methods design was used. A convergent parallel mixed methods design is a design whereby the researcher collects both quantitative and qualitative data, analyses them separately, and then compares the results to see if the findings confirm or disconfirm each other (Creswell, 2014). The intention of this design is to collect both forms of data using the same or parallel variables, constructs or concepts.

A qualitative research approach was employed in order to analyse the concept of supportive care for men diagnosed with PCa and their families by exploring and describing the perceptions of men diagnosed with PCa, those of their families as well as those of the nurses at the IHO. Similarly, a quantitative research approach was employed in order to assess the oncology departments in terms of facilitating supportive care for men diagnosed with PCa and their families. The study was contextual because it was carried out in the oncology departments at the IHO.

1.11.2 Research method

Research methodology refers to the principles and ideas on which researchers base their procedures and strategies (Holloway & Wheeler, 2010). The following four phases of theory generation by Chinn and Kramer (2018) formed the basis of this study namely; concept analysis (phase 1), construction of relationship statement (phase 2), development and description of the model (phase 3), and the development of guidelines for operationalising the model (phase 4). The phases are described below.

1.11.2.1 Phase 1: Concept analysis

The concept analysis in this study comprised of five objectives in line of the population of the study, namely: (1) published research materials on PCa, (2) men diagnosed with PCa, (3) family members of men diagnosed with PCa, (4) nurses and (5) oncology departments at the

IHO. The stages for appraising research articles, as recommended by Botma et al. (2010), were followed by the researcher in order to develop themes. Qualitative data for the first four objectives were collected by conducting a scoping review and in-depth individual face-to-face interviews with men diagnosed with PCa, family members of men diagnosed with PCa, and registered nurses working in the oncology departments at the IHO. A questionnaire with a five-point Likert scale, as illustrated by Annexure E, was used to collect quantitative data for the fifth objective.

1.11.2.2 Phase 2: Construction of relationship statement

Relationships are the linkages among and between concepts (Chinn & Kramer, 2018). As concepts are identified, ideas about relationships between and among them begin to form. The ways in which the relationship emerges provides clues regarding the theoretical purposes and the assumptions on which the theory is based. Chinn and Kramer (2018) define a relationship statement as any statement that sets out a connection or association between two or more phenomenon. In this study, Dickoff et al.'s (1968) practice theory was adopted as a practical guide for developing a conceptual framework as a basis for model development. The concepts derived from the findings in phase 1 are clearly defined and described in Chapter 6 of this study, based on the agent, recipient, context, dynamic, procedure and terminus.

1.11.2.3 Phase 3: Description and evaluation of model

The theory generation by Chin and Kramer (2018) and the conceptual framework developed in phase 2 were used to develop the model of the study as illustrated in Figure 7.1. The model is described in Chapter 7, based on the context in which the facilitation of supportive care for men diagnosed with PCa takes place, as well as the agent, recipient, dynamics, procedure and terminus. The model was evaluated using the criteria for evaluating the nursing model proposed by Fawcett (2005) and Parse (2005). These criteria address questions regarding the historical evolution of the model, as well as its significance, internal consistency, parsimony, testability, empirical adequacy and pragmatic adequacy. The evaluation of the model enables the researcher to authenticate whether the model has brought about the desired outcome necessary to meet the study objectives. The evaluation of the model is described in Chapter 7.

1.11.2.4 Phase 4: Development of the guidelines for operationalising the model

Clinical practice guidelines are systematically developed best-practice statements or a combination of concerns regarding screening, diagnosis, management or monitoring (Kredo et al., 2016). Generally, guidelines include statements of expected practice or guidance regarding the undertaking of particular tasks, therefore they are used to help assure a higher level of professional practice, reduce inconsistencies in clinical practice and promote the delivery of high quality and evidence-based healthcare.

Empirical data, conceptualisation, relationship statements, a conceptual framework and a model description formed the basis for the development and description of the guidelines for operationalising the model to facilitate supportive care for men diagnosed with PCa and their families. Reasoning strategies such as inductive and deductive reasoning, inferences, bracketing, analysis, derivation and synthesis were used during the development of the guidelines, as illustrated in Chapter 3.

1.12 ETHICAL CONSIDERATIONS

The study adopted the ethical research principles of the World Medical Association (WMA) as outlined in the Declaration of Helsinki (WMA, 2013). Approval to conduct the study was sought from the School of Postgraduate studies at the University of Namibia, the MoHSS, and the Regional Health Director of Oshana region. Three ethical fundamental principles for protecting study participants guided the study, namely, respect for persons, beneficence and justice (Brink et al., 2012; Polit & Beck, 2012).

By obtaining verbal informed consent, the researcher allocated ample time to explaining to participants individually what the study was all about and what was required from them in terms of participation (May & Holmes, 2012). Voluntary participation was ensured by explaining to participants that they were free to withdraw from the study at any time without the risk of penalty or prejudicial treatment (MacLean & Wilson, 2011). The researcher refrained from any coercion, covert data collection or deception (Leedy & Ormrod, 2010). The researcher protected the participants from harm and discomfort by ensuring that the benefits of the study outweighed the risks (Bless et al., 2013). No medical or other physical experiments were conducted on participants during the study (Matthews & Ross, 2010). As for justice, participants were selected for reasons directly related to the research, and not because they were readily available or could be easily manipulated (LoBiondo-Wood & Haber, 2010). All participants were asked similar questions. Honesty and integrity were ensured in conducting the research by strictly adhering to fundamental ethical principles as well as by reporting the results in a fair, transparent and unbiased manner (Creswell, 2014).

Other important principles the researcher observed during the study included anonymity and confidentiality (Bless et al., 2013). Participants were assured of anonymity regarding presentations, reports and publications of the study. Anonymity was preserved by coding the data in such a way that participants could not be identified in any presentation of the findings (May & Holmes, 2012). With regards to confidentiality, information collected from the research was not shared with unauthorised individuals, only the study supervisors (Guraya et al., 2014). The researcher also ensured that participant's names and that of their oncology departments were not mentioned when audiotaping and reporting the findings.

With regards to confidentiality, information collected from the research was not shared with unauthorised individuals, except the study supervisors (Guraya et al., 2014). The questionnaires and the transcribed individual interviews were filed and safeguarded in a lockable cupboard only accessible by the researcher. The researcher also created an electronic file in a password-protected computer on which the electronic data (audiotaped recordings) were stored. The questionnaires, informed consent forms and transcribed interviews will be shredded after five years after the completion of the study.

The researcher demonstrated respect for the scientific community by protecting the integrity of scientific knowledge by ensuring accuracy and honesty during the study (Botma et al., 2010). The following activities were avoided throughout the study, namely:

- *Fabrication, falsification or forgery*: The researcher did not invent the data, nor compiled the report that does not reflect what he actually did during the research process.
- *Manipulation of design and methods*: The researcher avoided manipulating designs or data collection methods of the study for the findings to support his own viewpoints.
- *Selective retainment and/or manipulation of data*: The researcher avoided choosing or using only the data which supports his viewpoints and discards the rest. No data were manipulated to reflect the researcher's perspective.
- *Plagiarism:* All sources used were acknowledged both in-text and list of references. Direct quotation marks were used when participants' exact words were used (Polit & Beck, 2012; Botma et al., 2010).

1.13 DEFINITIONS OF CONCEPTS

Creswell and Creswell (2018) emphasise that researchers should define terms that individuals outside the field of study may not understand and that go beyond the common language. A theoretical definition spells out what is meant or intended by a certain concept, whereas operational definitions link a concept with certain clearly identifiable objects in the social world (De Vos et al., 2011). In this study the concepts to be defined are derived from the title of the study namely; *"A model for nurses to facilitate supportive care for men diagnosed with PCa and their families in the Intermediate Hospital Oshakati: A hospital based approach"*. The concepts are defined as follows:

1.13.1 Model

Chinn and Kramer (2018) define a model as a symbolic representation of an empiric experience in the form of words, a picture or a graphic diagram which is set before one for guidance. In this study, a model is described according to Chinn and Kramer (2018). Guidelines for operationalising the model to facilitate supportive care for men diagnosed with PCa and their families were developed.

1.13.2 Nurse

The Namibia Nursing Act No. 8 of 2004 defines a nurse as a person registered or enrolled as such in terms of section 20, or who is regarded to be registered or enrolled in terms of section 64, in order to practise nursing and midwifery. It refers to a person who is formally educated and trained in the care of the sick and who is registered or enrolled as a nurse under section 20 and 64 of the Namibia Nursing Act No. 8 of 2004 to practise as a registered or enrolled nurse. In this study, the term *nurse* refers to all categories of nurses responsible for the nursing care of patients in oncology wards and departments of IHO. In this study, a model for nurses to facilitate supportive care for men diagnosed with PCa and their families in the IHO was developed.

1.13.3 Facilitate

To facilitate refers to making something possible or making it happen more easily (Sykes, 2013). Facilitation is about increasing the likelihood of a plan being executed. In this study, guidelines for operationalising a model to facilitate supportive care for men diagnosed with PCa and their families were developed. The facilitation of supportive care activities will be conducted in three phases, as illustrated in Figure 7.1, namely: initiation (phase 1), working (phase 2), and terminus (phase 3).

1.13.4 Supportive care

Supportive care refers to the care that helps a person with cancer and their families to cope with the cancer and its treatment, from pre-diagnosis through the process of diagnosis and treatment to cure, continuing illness or death and into bereavement (Sykes, 2013). In this study, supportive care refers to helping men diagnosed with PCa and their families to cope with the diagnosis by providing physical, social, psychological and spiritual support, as illustrated in Figure 7.1.

1.13.5 Men

The word *men* refers to an adult male human (Hornby, 2015). In this study, *men* refers to adult male persons diagnosed and living with PCa in the IHO.

1.13.6 Diagnosis

Diagnosis is the identification of a disease or condition by a scientific evaluation of physical signs, symptoms, history, laboratory tests results and procedures (O’Toole, 2013). On the other hand, to diagnose is to determine the type and cause of a health condition on the basis of signs and symptoms in the patient, as well as data obtained from laboratory analysis of fluid, tissue specimens, and other tests (O’Toole, 2013). For the purpose of this study, the diagnosis of PCa has been confirmed by the medical officer through laboratory analysis of fluid or tissue specimens and other tests.

1.13.7 Prostate cancer (PCa)

Prostate cancer (PCa) is a malignant tumour (carcinoma) of the prostate gland, a common form of cancer in men commonly detected by prostate-antigen testing and digital rectal examination, with confirmation by needle biopsy (Hinkle & Cheever, 2018). The cause of PCa is unknown, but it is believed to be hormone-related. Prostate cancer in its early stages rarely produces symptoms (Hinkle & Cheever, 2018). Symptoms of PCa in the advanced stages include difficulty and frequency of urination, urinary retention, and the decreased size and force of the urinary stream. The treatment of PCa depends on the clinical stage and ranges from surgery and radiation to hormone therapy, depending on the age of the patient, the extent of the disease and other individual factors (O’Toole, 2013).

1.13.8 Family

Family refers to a group of people related by heredity such as parents, children and siblings (O'Toole, 2013). It is a group of individuals related to one another by blood ties, marriage or adoption that forms a unit (Giddens & Sutton, 2017). The term *family* is sometimes broadened to include persons related by marriage or those living in the same household, who are emotionally attached, interact regularly, and share concerns for the growth and development of the group and its individual members. In this study, *family members* refers to a group of individuals related to men diagnosed with PCa.

1.13.9 Intermediate hospital

O'Toole (2013) defines an intermediate hospital as a health facility that provides medically related services to persons with a variety of physical and emotional conditions requiring institutional facilities. This study was conducted at the Intermediate Hospital Oshakati (IHO).

1.14 OUTLINE OF CHAPTERS

This dissertation is presented in the following chapters.

Chapter 1: This chapter serves to set the scene of the study. It introduces the study and discusses the study background, the problem statement that prompted the researcher to conduct the study, as well as the objectives of the study. The brief introduction to the pragmatic perspective of the study and the theoretical basis that guided the study are presented in this chapter. In addition, the chapter highlights the research designs and methods used in the study and the ethical issues considered, and concludes with definitions of the concepts used in the study.

Chapter 2: This chapter presents the literature review relevant to the research problem, including the results of the scoping review conducted using the Arksey and O'Malley's (2005) scoping review methodology framework which provided evidence for best practices for the supportive care of men diagnosed with PCa and their families. Themes on best practices that emerged from the scoping review are described in this chapter.

Chapter 3: The research design and methods that the researcher adopted for the study are outlined in this chapter. The chapter describes the four phases of theory generation by Chinn and Kramer (2018), namely, concept analysis (phase 1), construction of a relationship statement (phase 2), description and evaluation of the model (phase 3), and development of the guidelines to operationalise the model (phase 4). The chapter also outlines the reasoning strategies used by the researcher to think logically and come to conclusions. Further, the chapter also gives a brief description and evaluation of the model, as well as measures to ensure the validity, reliability and trustworthiness of the study. A discussion of the ethical considerations that were applied during the study process concludes the chapter.

Chapter 4: This chapter entails the presentation of qualitative results. Themes and sub-themes that emerged from the in-depth individual face-to-face interviews with men diagnosed with PCa, family members and nurses about the experiences of the supportive care received from nurses in oncology departments are outlined in this chapter and discussed against a literature control.

Chapter 5: The quantitative results are presented and discussed. These results emanate from an analysis of the quantitative data and are presented by means of descriptive statistics and correlation analysis in the form of tables and models. The chapter concludes by merging and interpreting the qualitative findings and quantitative results that enabled the identification of the central concepts.

Chapter 6: This chapter covers the definition, classification and construction of relationship statements, as well as the proposed structure. In the chapter, the main concepts of the central statement are conceptualised in order to give the conceptual definitions of the concepts. The application of the adopted theories, namely practice oriented theory (Dickoff et al., 1968), systems theory, holistic nursing theory, and nursing process theory, to the proposed structure of the model is presented. The chapter concludes with the identification of the related and essential attributes that served as a guide for model development.

Chapter 7: This chapter describes and evaluates the model for nurses to facilitate supportive care for men diagnosed with PCa and their families. The description of the model is done in line with six descriptive components as proposed by Chinn and Kramer (2018), namely: purpose, concepts, definitions, relationship, structure and assumptions. The chapter concludes with the evaluation of the model using the criteria for evaluating the nursing model as proposed by Fawcett (2005) and Parse (2005), namely, the historical evolution of the model, and its significance, internal consistency, parsimony, testability, empirical adequacy and pragmatic adequacy.

Chapter 8: This chapter presents a description of the guidelines for operationalising the model for nurses to facilitate supportive care for men diagnosed with PCa and their families. Guidelines are developed as activities to address the challenges or barriers that hinder the facilitation of supportive care for men diagnosed with PCa and their families. The guidelines are based on the sequence of the three phases of the model; namely, phase 1 (initiation), phase 2 (working), and phase 3 (evaluation).

Chapter 9: Being the last chapter of the study, this chapter concludes the research report with a summary of the main findings, the contribution that the study makes to the body of knowledge, as well as its limitations. Recommendations based on the findings are also made. A discussion of the way forward upon completion of the study concludes the chapter.

1.15 SUMMARY

This chapter covered the introduction and background to the study, as well as the problem statement that prompted the researcher to conduct the study. The purpose, objectives, paradigmatic perspectives and the theoretical foundations of the study are also outlined in the chapter. The research design and methods that the researcher adopted during the study, as well as the ethical considerations were briefly described in this chapter. In conclusion, an outline of chapters was presented. The next chapter focuses on the literature review and the presentation of the scoping review results.

CHAPTER 2

LITERATURE REVIEW AND PRESENTATION OF SCOPING REVIEW RESULTS

2.1 INTRODUCTION

The previous chapter discussed the problem statement, purpose, objectives of the study and the paradigmatic perspectives on which the study is based. This chapter focuses on a literature review which was done by means of a scoping review of various literature and published studies on the best practices for the supportive care of men diagnosed with prostate cancer (PCa) and their families, in order to fulfil sub-objective 1 of the study. A research literature review refers to a systematic, explicit and reproducible method for identifying, evaluating and synthesising the existing body of completed and recorded work produced by researchers, scholars and practitioners (Fink, 2014). It is an organised critique of the important scholarly literature that supports a study, and a key step in the research process (LoBiondo-Wood & Haber, 2010). Bless et al. (2013) describe a literature review as a search and study of current writings on the problem under investigation. The overall purpose of a literature review in a research study is to present a strong knowledge base for conducting the research project in order to develop the foundation of a sound study. According to De Vos et al. (2011), a good literature review increases the reader’s confidence in the researcher’s professional competence, ability and background.

A scoping review entails rapidly mapping the key concepts underpinning a research area; that is, the main sources and type of evidence available (Levac et al., 2010). The value of scoping reviews for evidence practice is the examination of a broader area to identify gaps in the research knowledge base, clarify key concepts, and report on the types of evidence that address and inform practice in the field (Peters et al., 2015). In this study, the scoping review enabled the researcher to explore and describe the best practices for the supportive care of men diagnosed with PCa and their families in health facilities. This chapter describes a scoping review that was conducted by using a five-stage methodological framework, as recommended by Arksey and O’Malley (2005) and updated by Levac et al., 2010, as well as the stages for critically appraising research articles as recommended by Botma et al. (2010).

2.2 SCOPE OF THE LITERATURE REVIEW

Sub-objective 1 of this study was to explore and describe best practices for the supportive care of men diagnosed with PCa and their families by nurses in oncology departments. Best practices refers to techniques or methodologies that, through experience and research, have proven to reliably lead to desired results and that are established or proposed as a standard suitable for widespread adoption (Carter et al., 2014). Best practices are nursing practices that are based on the best evidence available from nursing research. The goal of best practices is to apply the most recent, relevant and helpful nursing interventions, based on research, in real-life nursing practice. On the other hand, Carter et al. (2014) define supportive care as the provision of the necessary services, as defined by those living with or affected by cancer, to meet their physical, social, emotional, informational, psychological, spiritual and practical needs during the pre-diagnostic, diagnostic, treatment and follow-up phases of cancer care, encompassing issues of survivorship, palliation and bereavement. Supportive care is complex and involves multiple health disciplines and people working in various agencies. Primeau et al. (2017) define supportive care as a person-centred approach to meeting the informational, spiritual, emotional, social or physical needs of people with cancer during diagnosis, treatment or follow-up phases.

In this study, a literature review was conducted using Arksey and O'Malley's (2005) scoping review methodology framework and was reported using the Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA-ScR) guidelines. The scoping review method is defined as a form of knowledge synthesis that addresses an exploratory research question (Schalkwyk et al., 2020). It is aimed at mapping key concepts, types of evidence and gaps in research related to a defined area or field by systematically searching, selecting and synthesising existing knowledge (Dijkers, 2015). Key concepts, types of evidence and gaps in a defined research field are mapped by systematically searching, selecting and synthesising existing knowledge.

2.3 STAGES OF A SCOPING REVIEW

Based on the understanding of Arksey and O'Malley's (2005) scoping review methodology framework, as updated by Levac et al. (2010), the researcher believes that a scoping review is a method that would work well to answer the following research question: *"To what extent can published literature provide evidence on the best practices for the supportive care of men diagnosed with prostate cancer?"* According to this framework, the following six stages should be followed in undertaking a scoping review, namely: (1) articulating the research question, (2) identifying relevant studies, (3) selecting the study, (4) charting the data, (5) collating, summarising and reporting results, and (6) consultation (Arksey & O'Malley, 2005). During this study, the following five stages guided the scoping review. Stage 6 (consultation) could not be used as it is optional in a scoping review.

2.3.1 Stage 1: Articulating the research question

In order to direct the search strategy, an interactive process of discussion with other researchers occurred and the following research question was developed and refined namely: *"To what extent can published literature provide evidence on the best practices for the supportive care of men diagnosed with prostate cancer?"* In addition, how can best practices empower nurses to facilitate supportive care for men diagnosed with PCa in Namibia?

The objectives of this study were

- to explore and describe best practices for the supportive care of men diagnosed with PCa and their families in oncology departments
- to make recommendations to empower nurses who facilitate supportive care for men diagnosed with PCa and their families in Namibia.

The question was made clear in order to inform the subsequent stages while still reflecting the scope of enquiry. For the purpose of this review, *best practices* refers to techniques or methodologies that, through experience and research, have proven to reliably lead to desired results and that are established or proposed as a standard suitable for widespread adoption (Carter et al., 2014). The goal of best practices is to apply the most recent, relevant and helpful nursing interventions, based on research, in real-life nursing practice. Levac et al. (2010) propose that researchers define the concepts in their research question to clarify the scope of the study.

2.3.2 Stage 2: Identifying relevant studies

Given the aim of the study, which was to identify primary published and unpublished studies which answered the research question, a comprehensive search strategy was developed. An expert librarian assisted with the design and execution of search strategies, including inclusion and exclusion criteria (Daudt et al., 2013). Trial searches were run to assess whether relevant literature could be identified using the proposed strategy. The identification of databases, search strategy and selection criteria were done as follows:

2.3.2.1 Databases

With assistance of an expert librarian from the University of Namibia, studies relevant to this review were identified by searching the following electronic databases: Google Scholar, HINARI, BioMed Central, PMC, SCOPUS (through Elsevier), as illustrated in Figure 1.2 According to Jasemi et al. (2017) these databases are sufficiently large and are considered the most reliable databases for searching in the field of nursing. In addition, the reviewers also searched for relevant grey literature databases such as Grey Literature Reports, OpenGrey, and Web of Science Conference proceedings in order to identify studies, reports and conference abstracts of relevance to this review (Jolley et al., 2016). These enabled the expansion of the search and enhanced the data sources (Gamieldien et al., 2020). To ensure that all relevant information was captured, additional sources were located by means of manually searching the reference lists of relevant papers to identify other papers that may not have been found in the initial search.

2.3.2.2 Search strategy

An expert librarian and the first reviewer developed the eligibility criteria for the scoping review. A list of preliminary search terms and filtering methods were developed. The search strategy was refined to include Medical Subject Headings (MeSH terms), filters and Boolean operations, as well as through free-text terms in order to comply with searches across different databases. In the search strategy, the concept of supportive care was explored through the MeSH terms: supportive AND care; “diagnosis” OR diagnosed; “prostatic neoplasms” OR prostate cancer, as illustrated in Figure 1.2. Online citation management software was used in order to organise and cross-check the data and remove duplicates (Daudt et al., 2013).

2.3.2.3 Selection criteria

Articles were included in the review if they met the inclusion and exclusion criteria as shown in Table 2.1. All articles which met these criteria were retrieved in full-text as illustrated by Figure 2.1.

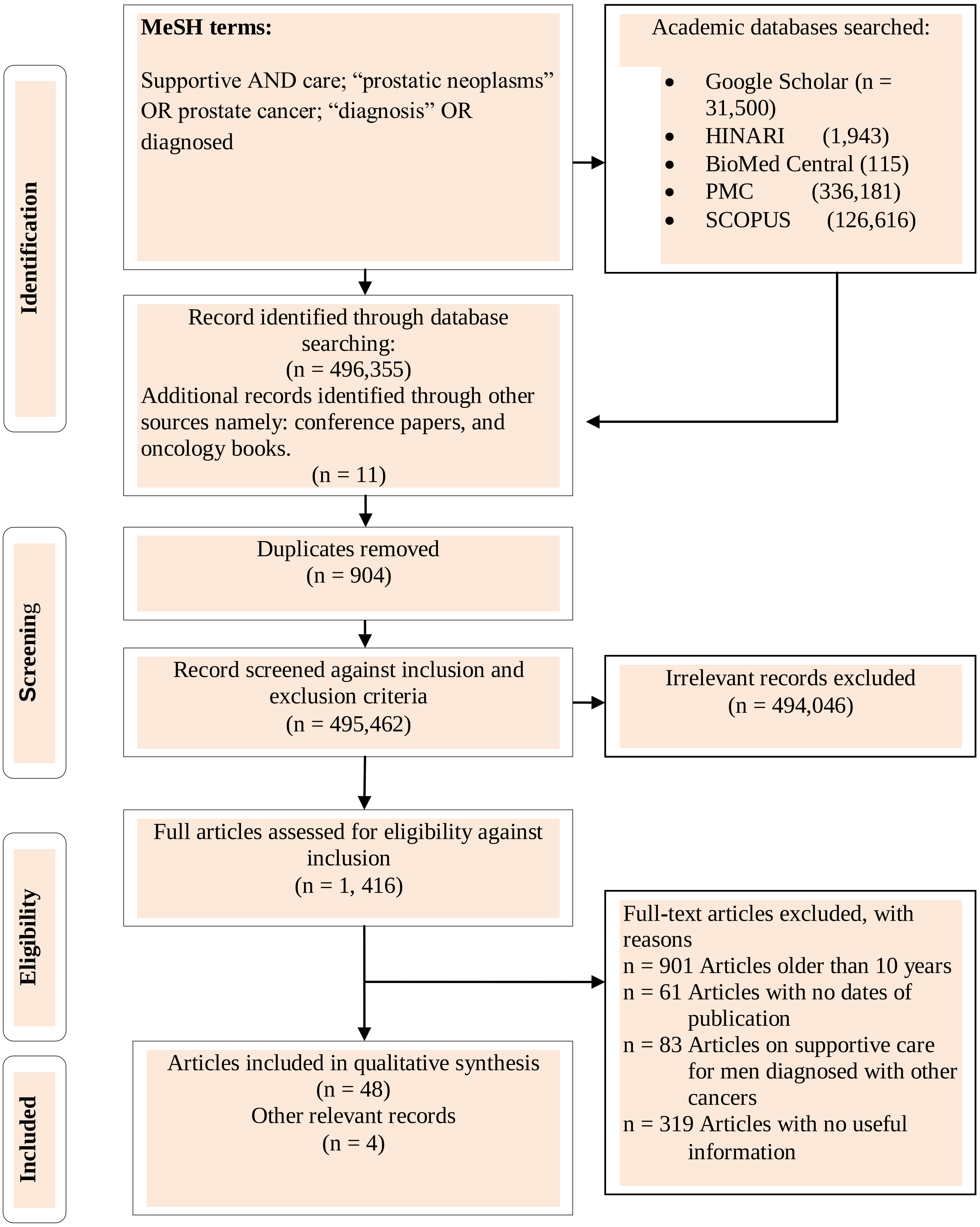


Figure 2.1: PRISMA flowchart of information through different phases of review

A total of 496,366 publications were reviewed in full, while 494,046 articles were excluded based on information in the title and abstract that did not meet the inclusion criteria. According to Botma et al. (2010), inclusion criteria may include the population, year of publication, language as well as interventions and outcome measures stipulated in the protocol, among other things. Fifty-two (52) papers met the inclusion criteria, as illustrated in Figure 2.1. This is in line with Moher et al. (2010), who emphasised that once the records have been screened and eligibility criteria applied, only a smaller number of articles will remain. A thematic synthesis was conducted in which descriptive themes were drawn from the data as recommended by Kandasamy et al. (2017). The identification of themes was partly driven by the research question (King et al., 2015).

In order to screen out studies that did not focus on the research questions, the review and selection process of articles was guided by population, context and concepts (PCC), as recommended by Peters et al., (2015). The PCC elements are illustrated in Table 2.1.

Table 2.1: PCC elements that guided the process of selecting articles

PCC Elements	Description of PCC concept
Population (s) – types/characteristics of the patient; ages of participants; health condition or disease of interest etc.	The review included: Original peer-reviewed full-text scientific research articles on supportive care for men diagnosed with PCa. Systematic and scoping reviews All study designs quantitative and qualitative studies.
Concept	Description of practices on the supportive care for men diagnosed with PCa Description of supportive care for men diagnosed with PCa
Context	Geographical – global Only research articles less than 10 years old, with titles and abstracts written in English

Adopted from Peters et al., (2015).

Exclusion criteria included non-peer-reviewed full-text research articles on supportive care for men diagnosed with PCa, articles older than ten years, and articles not written in English. Any study with a title and abstract that did not meet the inclusion criteria as described above was not considered further (Cooke et al., 2012). Duplicate articles from the same study were also excluded. Article eligibility was confirmed by an expert librarian and the second reviewer from the University of Namibia.

2.3.3 Stage 3: Study selection

The scoping review guideline for identifying and selecting studies informed the article selection and data extraction (Gamieldien et al., 2020). The scoping review was conducted in two waves of screening, namely, a title and abstract review and a full-text review. In the first wave of screening, the first reviewer conducted the screening of the title and the abstract and then passed on the results to the second reviewer for validation. Disagreements were resolved through discussion. Any article that was deemed relevant by both of the reviewers was included in the full-text review.

In the second wave of screening, the two reviewers assessed the full-text articles considered to be relevant or possibly relevant from the first wave to determine if they met the inclusion criteria. Relevant studies were included if they described the best practices on supportive care for men diagnosed with PCa. Discordant full-text articles were reviewed for a second time and further disagreements about study eligibility at the full-text review stage were resolved through discussion with a third reviewer until full consensus was obtained. Studies were excluded if they described the best practices on supportive care for men diagnosed with conditions other than PCa.

2.3.4 Stage 4: Charting the data

To organise the data, Arksey and O'Malley (2005) recommend charting and sorting data according to key themes and issues. This process provides the reader with a logical and descriptive summary of the results that aligns with the objectives and the questions of the scoping review (Peters et al., 2015). In this review, the first reviewer extracted data from the identified articles; these were subsequently validated by the second reviewer for charting. A data charting form using an MS Excel spreadsheet was utilised to review the final original research article (Gamieldien et al., 2020). The data charting form was pre-tested and an interactive process for refining the form was undertaken as the review commenced to ensure that all relevant information was extracted. This enabled the reviewers to authenticate study relevance, record study characteristics and extract information relevant to the review question.

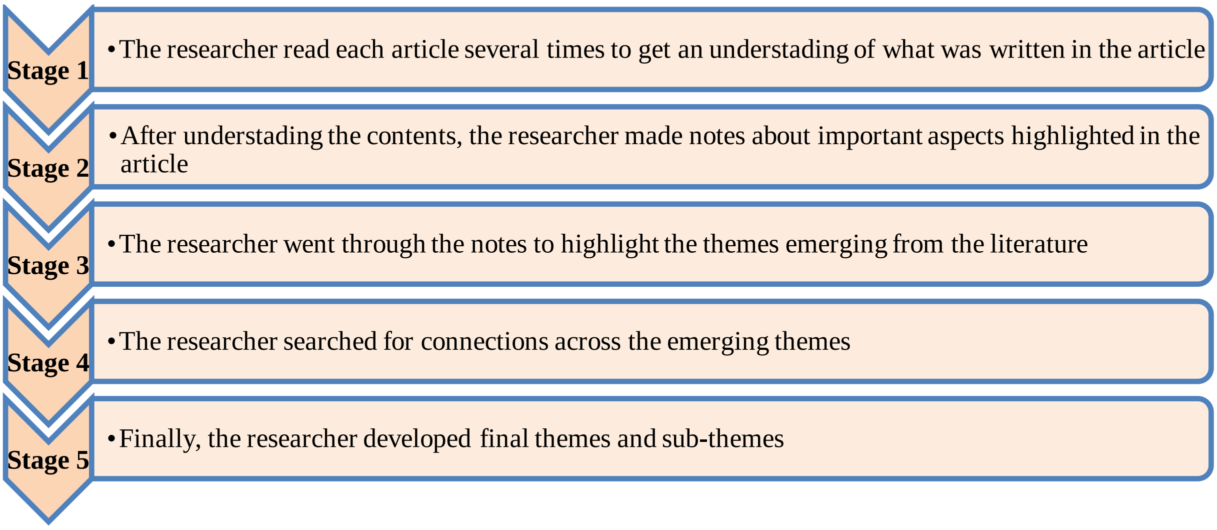
The categories of information for each study were extracted from the articles, namely, study title, descriptive status of the authors, location, study designs, duration, sample and sampling methods, research question, intervention, outcome measures, summary of findings, definition of key concepts (supportive care and prostate cancer), best practice implications and recommendations for further development. The second reviewer conducted a blind verification of a random sample of 20% of the articles in order to verify the quality of the categorisation charting process (Shumba & Iipinge, 2019). Discrepancies in the charting process were resolved through discussions by the reviewers. These data were extracted verbatim for coding and the final themes were examined, followed by a tabulation of the frequencies of each theme.

2.3.5 Stage 5: Collating, summarising, and reporting results

In this scoping review, all results were collated, summarised and reported on in order to provide a comprehensive and thorough overview of all the reviewed literature (Gamieldien et al., 2020). The best practices for supportive care identified and extracted were coded in order to categorise them according to relevant thematic domains (Jolley et al., 2016). Findings were published using tables with descriptions according to the themes. Descriptive statistics were utilised to indicate the results pertaining to best practices on supportive care, study designs, duration and sample size. Further, study purposes, methodology used, outcomes and recommendations of the studies were reflected.

2.4 APPRAISAL AND SYNTHESIS OF LITERATURE

According to Porrit et al. (2014), the importance of literature appraisal is to exclude studies of low quality and those whose results compromise rigour. After an initial reading of the literature and the exclusion of the irrelevant items, a process that thoroughly reviewed the relevant literature was undertaken, guided by the following stages during which the research articles were critically appraised (illustrated in Figure 2.2), as recommended by Botma et al. (2015):



Stage 1
- The researcher read each article several times to get an understading of what was written in the article

Stage 2
- After understading the contents, the researcher made notes about important aspects highlighted in the article

Stage 3
- The researcher went through the notes to highlight the themes emerging from the literature

Stage 4
- The researcher searched for connections across the emerging themes

Stage 5
- Finally, the researcher developed final themes and sub-themes

Figure 2.2: Stages for appraising the research articles
Source: Adopted from Botma et al., 2015

2.5 THEMES THAT EMERGED FROM AN APPRAISAL OF THE LITERATURE

Two themes and eight sub-themes emerged from the critical appraisal of the research articles. Table 2.2 gives a summary of identified themes and sub-themes.

Table 2.2: Summary of the themes and sub-themes that emerged from the critical appraisal of the research articles

Themes	Sub-themes
2.5.1 Theme 1: Aspects related to the management of PCa	2.5.1.1 A national policy on supportive care for men diagnosed with PCa and their families 2.5.1.2 Inclusion of family members in the supportive care of men diagnosed with PCa 2.5.1.3 Establishment of certified cancer units at district hospitals
2.5.2 Theme 2: Aspects related to practising oncology-related matters	2.5.2.1 Introduction of specialised oncology nursing course at higher institutions of learning 2.5.2.2 Availability of registered nurses specialising in cancer in oncology departments 2.5.2.3 Presence of registered nurse specialising in cancer when doctor breaks the bad news to men 2.5.2.4 Establishment of advocacy stakeholder meetings for PCa 2.5.2.5 Establishment of community-based face-to-face PCa support groups (PCSGs)

2.5.1 Aspects related to the management of prostate cancer

This theme covers aspects related to the management of PCa, such as the national policies on supportive care for men diagnosed with PCa, the inclusion of family members in supportive care and the establishment of certified cancer units at district hospitals.

2.5.1.1 A national policy on supportive care for men diagnosed with prostate cancer and their families

The WHO reported that as of 2010, 107 countries had national operational policies or action plans for cancer (Schear et al., 2015). In America, the National Comprehensive Cancer Network (NCCN) has guidelines that address prostate cancer treatment and surveillance for recurrent disease as well as general survivorship guidelines for managing certain side effects such as anxiety and fatigue that affect some PCa survivors (Skolarus & Wolf, 2014). Work is also underway on developing follow-up care guidelines for survivors of head, neck and prostate cancer (Cowens-Alvarado et al., 2013).

In China, guidelines for the management of PCa were first published in 2007 and are renewed every two years by the Chinese Urological Association (CUA) (Pang et al., 2016). The latest is the 2014 version, which is in line with international guidelines such as those of the European Association of Urology (EAU). These guidelines cover content such as epidemiology, diagnosis, treatment and follow-up. Clinical guidelines are intended to address these issues and offer guidance on best practices.

In Brazil, the National Cancer Institute was founded with the clear role of setting up policies on the management of cancer (Da Silva et al., 2019). Similarly, the cancer care network in Brazil, both in the public and private sectors, from prevention to palliative care, includes primary care, home care, and specialised outpatient and hospital care, in addition to support systems, regulations, logistics and governance. In South Africa, the South African Cancer Forum, consisting of civil society and healthcare providers, has advocated for the consideration of patients' views in the policymaking process.

2.5.1.2 Inclusion of family members in the supportive care of men diagnosed with prostate cancer

According to Crompton (2016), it is a principle that no surgeon, radiation oncologist or other professional should treat PCa unless they specialise in it, and no single professional should be directing treatment on their own. Patients and their family members should be informed, involved and supported. Hinkle and Cheever (2018) emphasise that it is the responsibility of all nurses working in cancer care to involve the patient and their families as fully as possible in the process of clinical decision-making. Care needs to be taken to ensure that patients and their families do not feel that decisions are being pushed onto them, creating an additional burden on the family. The interaction between patients and partners may impact the patients' treatment choices, perceptions of outcomes following treatment, and their relationship with each other long after cancer treatments have been completed. This is consistent with the findings of a study conducted by Ramsey et al., (2013), which indicates that greater involvement in treatment decision-making leads to improved partner satisfaction with treatment outcomes. Kirkman et al. (2017) stress that men with PCa and their families need information throughout the care pathway to enable them to understand the diagnosis, treatment options, self-care and support available.

In England, a national policy to improve the care of people with cancer has been introduced, influenced by concern outcomes for prostate cancer (Sinfield et al., 2010). According to De Moraes-Lopes and Higa (2014), the inclusion of family members in nursing care for PCa survivors is recommended because many family members become physically and emotionally ill in the process of caring for patients after PCa treatment. This is in agreement with Hinkle and Cheever (2018), who state that family members need emotional support to help them cope with their own fear, uncertainty and feelings associated with the illness of their partners. Similarly, engaging family during significant transitions such as the biochemical recurrence of PCa will provide maximum support and facilitate mutually acceptable decisions.

2.5.1.3 Establishment of certified cancer units at district hospitals

A cancer unit is a health facility that is capable of managing patients within a defined range of cancer, according to contemporary standards of good practice (Miguel et al., 2014). The establishing of cancer units lies at the heart of the successful application of supportive care for patients diagnosed with cancer. Services offered by these units should reach identified standards such as conforming to established guidelines and participating in externally run audit programmes. Crompton (2016) stresses that PCa units should provide interdisciplinary and multi-professional continuous education on all aspects of PCa care, including research.

According to Miguel et al. (2014), several African countries have developed serious approaches to creating resources to treat cancer patients. Angola is one of these countries. It has the National Oncology Centre in Luanda as the main centre for the treatment of cancer patients. Angola, Mozambique and Cape Verde have issued guidelines, legislation and decisions in order to build their cancer control programmes. Oncologists from these countries have decided to meet every two years to evaluate the work done in terms of supportive care for patients diagnosed with cancer. In their first and second meetings held in 2014 and 2016 respectively, it was concluded that cancer control activities should be implemented as an integral part of the health delivery system. These should be implemented through a decentralised system in which all levels of care will be involved in cancer control. The meetings also resolved to urgently establish well-resourced oncology centres where specialised clinicians, surgeons, pathologists, radiotherapists, nurses, radiologists, pharmacists and laboratory personnel are given the right conditions to comfortably deliver high-quality care for patients with cancer, at an affordable price. Currently, oncology units dedicated to cancer treatment are being developed in large hospitals in Luanda. In addition, the Angolan government has recently announced the introduction of a programme to construct public oncology units in other hospitals situated in other provinces of the country.

In Rwanda, the government has inaugurated the nation’s first cancer centre, the Butaro Cancer Center of Excellence, located in a rural area at the Butaro district hospital. The decision to open the Butaro Cancer Center of Excellence in a rural area was rooted in an existing, strong academic and clinical partnership. The Ministry of Health of Rwanda is still planning to launch four additional cancer treatment units in district hospitals nationwide. Currently, three major hospitals in Rwanda have cancer pathology, imaging, surgical oncology and palliative care programmes. In Vietnam, there are 63 provincial hospitals in the country, 43 of which have oncology departments and trained oncologists to provide supportive care. Recently, the ministry of health in that country launched a National Cancer Control Network Development Initiative as a new measure which aims to establish new cancer centres and broaden services within existing health facilities (Wagner et al., 2018). Similarly, a palliative care initiative was launched at the National Cancer Hospital and has grown to include two central hospitals as well several provincial hospitals. Local non-governmental organisations provide certain social supportive care services to patients at larger facilities.

In Mozambique, dedicated units for the treatment of cancers have been formed at the Maputo and Nampula Central Hospitals, with the radiotherapy unit starting its operations in 2019. In Brazil, cancer treatment is performed in accredited specialised care units including high-complexity oncology centres which treat all cancers (Da Silva et al., 2019). The type of accreditation by the ministry of health is exclusively based on facility structure, types of service offered by the health facility, and human resources capacity. In this regard, the National Cancer Institute was founded with a clear role of setting policies and criteria. While establishing a set of criteria that qualify services may be restrictive by accrediting only establishments that already have the infrastructure and human resources necessary to meet the established requirements, the Public Unified Health System (PUHS) of Brazil subsidises most cancer treatments because of their high cost.

In Canada, the Vancouver Prostate Center (VPC) Program and the Department of Urologic Sciences at the University of British Columbia have developed a multidisciplinary Prostate Center Supportive Care (PCSC) program to address the complex supportive care needs of men with prostate cancer (Hedden, 2018). Services are provided at no cost to participants. The programme serves patients, partners and families along the entire disease trajectory, recognising that cancer is a family disease, affecting both the individual and their social network, and that the psychological stress associated with a diagnosis of PCa is borne heavily by partners. This programme was also designed to provide opportunities for targeted research efforts, supporting the growth of the evidence base in this area.

In Germany, around a quarter of the total number of hospitals treating PCa are now certified (Crompton, 2016). These are structures with on-site interdisciplinary and multi-professional teams and infrastructure that are able to provide interdisciplinary and multi-professional curative and supportive care for newly diagnosed patients through to the follow-up, rehabilitation and care of patients with advanced disease. Interestingly, the Martini Clinic is among the certified PCa unit centres, characterised by specialisation, multidisciplinary collaboration and independent audit. Three years after their initial certification, centres are visited by an independent team of experts, including a patient representative to see on site whether what they are doing still fulfils the initial requirement. Each centre is required to be in cooperation with a PCa patient support group. The German Cancer Society certifies PCa units on the basis of performance on a wide range of indicators, including measures of interdisciplinary collaboration. According to Crompton (2016), research on breast and other cancers shows that such specialist multidisciplinary centres produce the highest treatment success rates and best patient experience.

In Europe, different national and European certification programmes for breast and PCa care have been launched, representing a promising step towards continuous quality improvement and the standardisation of cancer care (Voigt et al., 2014). To complement the existing certification programmes, an Act on Oncology approach was developed for the structured assessment of PCa centres. Act on Oncology also aims to generate a holistic view on the operational processes in each unit of a cancer centre, their interfaces with each other, and the level of integrations.

2.5.2 Aspects related to practising oncology-related matters

This theme is about aspects related to practising oncology-related matters. It includes the introduction of a specialised oncology nursing course at higher institutions of learning, the availability of registered nurses specialising in cancer in oncology departments, the presence of registered nurses specialising in cancer when doctors break the bad news to men, the establishment of advocacy stakeholder meetings for PCa, and the establishment of community-based face-to-face PCa support groups (PCSGs).

2.5.2.1 Introduction of specialised oncology nursing course at higher institutions of learning

In America, nursing of people with cancer began to change with the introduction of oncology nursing as a specialty in the United States and the creation of specialised education and training for oncology nurses (Cummings et al., 2018). This led to the recognition that nurses required additional preparation to provide comprehensive care for those who had cancer. The first university course in cancer nursing was offered at Columbia University and represented the beginning of a shift in oncology nursing education. In addition, the American Society of Clinical Oncology addresses the need for more intensive training for nurse practitioners in oncology for additional education specific to oncology as a unique role necessary for the provision of safe and appropriate supportive care for patients with cancer and their families across the cancer trajectory. Recognising the need for more oncology training, the country have developed a 12-month postgraduate fellowship programme that aims to address gaps in nurse practitioners' training related to the field of oncology. Each year, about 150 nurse practitioners become certified in oncology. Nurse practitioners completing the course will be eligible for the Oncology Nursing Society's Advanced Oncology Nurse Practitioner Certification Examination, with the aim to increase the number of oncology certified nurse practitioners in America (Begue, 2013). Passing examinations in oncology is a requirement in the American oncology workplace (Nevidjon et al., 2016). For nurses who do not attain the oncology competencies in the graduate programme, alternative educational strategies are being arranged for them to attain the knowledge, skills and abilities to competently practise in oncology.

According to Grimes et al. (2014) some specific training in oncology nursing is now included in Western European basic nurse training programmes. Postgraduate specialised training programmes have also been introduced in most Western European countries under their national cancer programmes. More recently, this training has also been introduced in some Eastern European countries such as Poland and Hungary. Specialised trainings in oncology has increased nurses' knowledge and skills, as demonstrated by examinations, testing and evaluations for nurses in the workplace. Several oncology projects in some Eastern European countries have also established different curricula for different cadres of nurses. In some cases, training curricula developed by the projects have gained recognition by educational institutions. Appropriate oncology training and education promotes nurses' confidence in educating patients and delivering quality care services in all settings and along the cancer care continuum. This is agreement with Nevidjon et al. (2016), who underline that improving and standardising cancer care education is essential to providing optimal and safer cancer care.

In Canada, there is increased specialisation and advancement of nurse training, including an increase in specialised oncology nurses and Professional Cancer Navigators (PCNs) (Cummings et al., 2018). PCNs are nurses who provide continuity for patients and their families throughout the entire cancer treatment process by helping them navigate the system and liaising with other healthcare professionals and community agencies on the patients' behalf. This is in line with Nevidjon et al. (2016), who emphasise that assisting nurse practitioners in gaining the knowledge and skills needed to competently practise in an oncology setting can only be accomplished by extending current graduate education programmes and continuing education programmes and workshops.

According to Griffin (2019), the Netherlands is also leading the way with a one-year cancer nursing programme based on a national curriculum. The country is also offering an MSc degree in Advanced Nursing Practice, different from the one-year cancer nursing programme which qualifies one as a nurse specialist. In some countries, in the absence of any leadership from government, educational bodies and cancer nursing societies are independently implementing specialist oncology training schemes. This is what happened in Australia, where universities and colleges took the initiative to organise a nationwide cancer nursing education programme without any input from the government. The better the nurses are qualified, the better they can accompany a patient along the journey through cancer. According to Griffin (2019), the Netherlands is also offering specialist training in cancer care.

Gutierrez et al. (2014) stress that providing healthcare for individuals with a suitable structure and best treatment standards, and assuring the best chances of cure, can only be achieved with qualified and specialised professionals. In Brazil, the increased demand for oncology services has resulted in the development of a specialty in that area. Higher institutions of learning in Brazil have incorporated oncology in the undergraduate curricula and started offering specialisation courses in oncology. To become a nurse oncology specialist in Brazil, at least 360 hours of training are required, which include theoretical and practical knowledge of the specialty. Currently, Brazil does have isolated centres of excellence that value oncology specialist nurse training when hiring their professionals, and which maintain continuing education programmes to enable high-quality oncology nursing services. Over the four years of their existence, the country has witnessed the undeniable positive influence on the oncology clinical nursing specialist's actions in the patient and family responses dedicated to these clients. According to Gutierrez et al. (2014), it is essential that higher education institutions rethink their strategies and priorities in order to facilitate the introduction of changes in health work practices, joining forces to create academic and continuing-education processes to meet the reality of the services and the healthcare demands of cancer patients.

At Balakovo Secondary Medical School in Russia, a comprehensive specialised cancer training programme was designed for nurses, with a specifically designed curriculum (Grimes et al., 2014). Nurses working in community polyclinics and in-patient settings, as well as those providing palliative care and community education, were all targeted for training. African countries such as South Africa and Kenya have introduced oncology nursing programmes at diploma and master's level (Mitema et al., 2019). Tanzania, Zambia and Egypt have also made significant progress in developing cancer nursing education.

2.5.2.2 Availability of registered nurses specialising in cancer in oncology departments

In order to be an effective resource for the patient, the nurse should demonstrate advanced knowledge of PCa disease and all treatment modalities, side effects and survivorship issues to be able to effectively manage patient care. This is in agreement with Crompton (2016) who strongly emphasises that people with cancer need their care managed by specialists who work as a team, using their range of experience and specialisations in an organised process. One such specialist is a cancer specialist nurse. A cancer specialist nurse refers to a registered nurse who has acquired the expert knowledge base on cancer, complex decision-making skills and clinical competencies for expanded practice, the characteristics of which are shaped by the context and/or country in which he/she is registered to practice (Peterson & Ghulam, 2017). The PCa specialist nurse role is defined as an expert point of contact for the patient and his/her family, providing both psychological and clinical support for men with PCa using a structured approach. Sykes (2013) defines an essential role of the PCa specialist nurse as to provide an initial assessment of the patient's psychological needs and provide ongoing support throughout the cancer trajectory based on further assessment. Following assessment, the nurse can then offer and organise the necessary supportive care interventions and agree a point for re-evaluation with the patient. In America, PCa specialist nurses function as a clinical expert, consultant, educator, mentor, researcher and institutional change agent

(Nevidjon et al., 2016). They are licensed independent practitioners who have been educated at the graduate level with a minimum of a master's degree.

According to Sykes (2013), the PCa specialist nurse works alongside existing healthcare providers to contribute to the delivery of effective care for men with PCa. Appropriate, timely referral to specialist treatment centres, social workers and allied health is a key element of the PCa specialist nurse's work. As such, the PCa specialist nurse should possess, and be able to demonstrate, advanced communication skills in both the patient and the multidisciplinary health contexts. It is recommended that the specialist PCa nurse assess the needs of patients using only agreed validated tools to ensure consistent, evidence-based service provision to all patients accessing the service (Sykes, 2013).

According to the study conducted by Crompton (2016) about PCa units, Europe has recognised the need to invest in specialist urology nurses who should not just be part of a support team, but also actively and clinically involved in patient care. Similarly, in the United Kingdom (UK), specially trained urology nurse specialists form part of a multidisciplinary urology cancer team, and see all newly diagnosed patients. This is a mandatory requirement laid down by the standard-setting National Institute for Health and Care Excellence (NICE). Urology nurse specialists have more contact with the patient than any other individual in the team, and have the skills to tackle many aspects of patient care, patient questions and follow-up, also provoking key clinical input (Crompton, 2016). In other words, they are required to be available at clinics for people who are newly diagnosed in order to provide additional information and support as required. This is supported by Chambers et al. (2013), who emphasise that specialised trained nursing staff should always be available to answer questions about cancer and to provide support.

According to Putt and Jones (2014), specialist acute oncology nurses are appearing all over the United Kingdom (England, Scotland, Wales and Northern Ireland). The nurses show many skills including leadership, innovation, negotiation, teaching, and importantly, expert clinical skills. In the Netherlands, advanced nursing roles are well established and regulated (Griffin, 2019). The national standards require that 50% of nurses in cancer care should be qualified by 2022. Similarly, all cancer drugs should be administered by qualified oncology nurses. The country has subsequently introduced a two-year nursing cancer programme based on a national curriculum.

According to Carter et al. (2014), the Canadian healthcare system expects to see an increase in the number of people living with cancer, therefore, it has identified the opportunity to develop nursing roles focused on supportive care for men diagnosed with PCa at various stages of the cancer care continuum. In Australia, the role of a cancer specialist nurse in the care of patients with many chronic illnesses, including PCa, is well recognised and integrated into clinical practice at both the national and international level (Sykes, 2013). The PCa specialist nurse is involved in the care of men in all treatment streams and is an integral part of the multidisciplinary team. Similarly, he/she should be available to provide advice and professional support to nursing colleagues and take an active role in disseminating information about research and other developments in PCa to nursing colleagues and others involved in cancer care.

Most often, cancer specialist nurses take the lead in triggering referrals to members of the wider multidisciplinary team such as physiotherapists and sexual counsellors, or referrals back to the overall responsible clinician. The supportive care that recognises challenges to the mental health of men diagnosed with PCa and contributes to wellbeing may best come from a team with skills in both mental and physical health (Kirkman et al., 2017). The inclusion of cancer specialist nurses in the team, care tailored to individual needs and psychosexual support is likely to promote the wellbeing of men diagnosed with PCa and their families. In a study conducted by King et al. (2015) about PCa and supportive care, men who received care from a cancer specialist nurse reported a positive experience that enabled them to discuss non-medical aspects of their illness. This was exemplified by the way nurses communicated the diagnosis and could act as patient advocates by accessing appropriate care and support. Another key element of the specialist nurse role was in terms of long-term and ongoing care and the fact that contact could be initiated by the patient.

According to Chambers et al. (2013), specialised nursing care for PCa provides a further and more in-depth level of supportive care for men and their families who are experiencing moderate to high levels of distress and/or who express the need for additional supportive care beyond that already provided. This is in agreement with a study conducted by King et al. (2015) on prostate cancer and supportive care in which men diagnosed with PCa indicated a need for more health information and more time with specialist cancer nurses to be provided with practical, emotional and psychological support, particularly after diagnosis and after active treatment. Similarly, family members indicated the need for sufficient time with knowledgeable nurses who understood their husbands' condition. The study recommended the need for improved access to cancer specialist nurses throughout the care pathway, individually tailored supportive care and psychosexual support for treatment side effects.

In Britain, oncology clinical nurse specialists play a crucial role in fulfilling key responsibilities, including providing holistic and supportive care for patients diagnosed with PCa and their families, educating and communicating with them in a timely and effective manner, and liaising with other healthcare professionals to coordinate the patient's treatment (Basketter et al., 2018). A study by Sinfield et al. (2010) on men's and carers' experiences of care for PCa revealed that information and support needs for men and their families are more likely to be met in hospitals where specialist nurses have been introduced. This is in agreement with De Moraes-Lopes and Higa (2014), who state that clinical nurse specialists are the ideal health professionals to help men and their families through education, support, encouragement and active listening.

According to De Moraes-Lopes and Higa (2014), the four important aspects of specialised nursing care include care provided at the time of PCa diagnosis, care during the pre-treatment period, care provided post-operatively, and the provision of assistance to partners and family members of men diagnosed with PCa. Clinical nurse specialists are very important in providing this kind of assistance because they help patients understand and come to terms with their diagnosis and treatment by presenting medical information in an understandable manner. This process involves patient-centred communication and the use of non-medical language. This is evidenced by the study conducted by Sinfield et al. (2010) on men and carers' experiences of care for PCa in which men and their carers reported that health information and support needs were more likely to be met in hospitals where specialist PCa nurses have been introduced. This is in line with Sykes (2013) who stresses that PCa specialist nurses should provide comprehensive, coordinated, specialised and individualised information and education to the person affected by cancer about the pathophysiology of cancer and its physical and psychological effects, treatment approaches and self-management strategies.

According to Sykes (2013), the PCa specialist nurse serves as the point of contact and assists patients to navigate the healthcare system, ensuring the timely delivery of information and access to diagnostics and treatments. Given that men with PCa often see a range of healthcare providers throughout the cancer journey, including urologists, oncologists, general practitioners, radiologists and allied health workers, there is a chance that the patient may become lost in the system and suffer avoidable psychological distress whilst accessing healthcare. In this case, the PCa specialist nurse is ideally placed to assist in the coordination of care in a complementary manner to existing service providers. Part of this coordination function includes ensuring patients have access to the full range of supportive care resources open to them in their geographical area.

In England, 34 Cancer Networks have been set up with specific quality standards of care outlined in the Manual of Cancer Services that are assessed through a peer review process. This policy initiative has resulted in an increased number of site-specific clinical nurse specialists and nurse practitioners, as well as an increasing emphasis on the role of palliative care at all stages of the care pathway (Resnick, 2015). According to Sykes (2013), meeting the patient’s supportive care needs requires the nurse to undertake assessment for psychosocial risk factors and distress, both at the time of diagnosis and on a regular basis, using a systematic, evidence-based approach. This is followed by effective communication with other members of the team and appropriate onward referral. The findings of a study conducted by King et al. (2015) revealed similar sentiments, as they indicated that the key stages when specialist nurse input was valued concerned treatment decision-making and treatment choice after initial hormone therapy has failed. Specialist nurses sometimes arranged and referred patients to support groups and played a role in helping men reframe their illness experiences in an a positive way, enabling better adaptation and coping skills. In agreement, Griffin (2019) states that the better the nurses are qualified, the better they can accompany a patient along the journey through cancer.

According to Paterson and Ghulam (2017), modern healthcare in the UK is currently undergoing a profound change in the way it delivers supportive care for men diagnosed with PCa. There has been increasing research evidence suggesting that nurses use subtle and complex skills, both verbal and non-verbal, in their interactions with patients diagnosed with PCa. A number of government strategies are now in place to provide supportive care services through the expansion of traditional nursing roles, such as cancer specialist nurses. This is in accordance with De Moraes-Lopes and Higa (2014), who point out that in the UK the roles and responsibilities of nurses have recently been extended and nurse-led services have been created with a new model of care whereby nurses are given significant responsibilities for the care of patients that is usually the responsibility of doctors in a particular setting. These responsibilities include fine-needle aspiration of breast lesions. This is in agreement with the recommendation of a study conducted by Resnick (2015) about the supportive care needs of men living with PCa in England that state that healthcare resources need to be devoted to ensuring that all men have access to the relevant specialist services, some of which could be provided by specialist nurses with the requisite training.

2.5.2.3 Presence of registered nurses specialising in cancer when doctors break bad news to men

A diagnosis of PCa can be experienced as a series of confusing events, with new information at unpredictable intervals, in an unfamiliar hospital environment, and in unfamiliar medical language (Hinkle & Cheever, 2018). In this case, the patient may be unprepared for the possibility of cancer which may result in an initial reaction of shock, numbness and disbelief. Breaking bad news about a PCa diagnosis can be a problematic issue in cancer care among healthcare professionals for a number of reasons; namely, a lack of confidence and discomfort dealing with sensitive issues, as well as lack of experience and/or training in communication skills (Hinkle & Cheever, 2018). The experience of the diagnosis and treatment of PCa is for most men a major life stress.

A study conducted by Sykes (2013) reveals that men with advanced PCa disease report high levels of psychological distress and are at an increased risk of suicide. Sykes’s study recommends that, where possible, the PCa specialist nurse should be present at the time the patient is given a PCa diagnosis in order to ensure timely continuation of the dialogue following the patient’s consultation with their urologist. In this case, the specialist nurse will play a vital role in helping men with the decision-making process following a diagnosis, and remain a key contact person for the patient throughout the care continuum. According to Sykes (2013), a significant proportion of duties of the PCa specialist nurse is to provide information and support for men newly diagnosed with PCa. In addition, the nurse has an important role in ensuring continuity of care between departments or services, and may need to clarify health information in response to the expressed patient and family health needs.

In the UK, the cancer specialist nurse is always present when the physician breaks bad news and discusses various treatment options with men diagnosed with PCa (Allchorne & Green, 2016). This is because cancer specialist nurses possess an in-depth knowledge of the physical, psychological and social effects of PCa and play a key role in patient care. According to De Moraes-Lopes and Higa (2014), specialised cancer nursing care is comprised of four important aspects; namely, care provided at the time of PCa diagnosis, during the pre-treatment period and during the post-treatment period as well as the provision of assistance to partners and family members of men diagnosed with PCa.

A study conducted by King et al. (2015) on PCa and supportive care reveals that men who had received supportive care from cancer specialist nurses reported positive experiences, enabling them to discuss non-medical aspects of their illness. This was exemplified by the way nurses communicated the diagnosis. Specialist nurses played a crucial role in helping men reframe their illness experiences in a positive way, enabling better adaptation and coping skills. According to Allchorne and Green (2016), cancer specialist nurses usually take patient and family into a consulting room and provide them with support and information leaflets on the different treatment options. Patients return in a couple of weeks to be reviewed by the oncologist and urologist who will decide on the best treatment option for them. Here, patients are provided with more information about their treatment choice and a more in-depth consultation on side effects and treatment expectations. A nurse specialist also sees patients post-operatively and gives them a recovery pack which includes leaflets on diet and exercise. Patients who saw a specialist nurse are more likely to receive written information and clear explanations about their tests, treatment options and sources of supportive care (King, Evans & Moore, 2015).

In the UK, one of the most significant developments in cancer nursing has been the recent development of a number of specialist nurse posts (Resnick et al., 2015). The clinical nurse specialist roles allow patients and their families to receive a comprehensive and holistic approach to care from a single professional who will often remain their key worker throughout their cancer journey. With their in-depth knowledge of individual patients, clinical nurse specialists are well placed to facilitate continuity of care within multidisciplinary teams, and across the boundaries of primary, secondary and tertiary care. They play a key role in developing and improving patient services such as reducing delays in diagnostic clinics and providing patient and family-centred follow-up. According to Krumwiede and Krumwiede (2012), the diagnostic confirmation of PCa may take time, resulting in men becoming anxious. Similarly, the potential for death may cause additional emotional distress among men.

2.5.2.4 Establishment of advocacy stakeholder meetings for prostate cancer

Schear et al. (2015) stress that patient advocacy is a critical strategy in improving cancer control and supportive care delivery nationally and internationally. Patient advocacy refers to a systematic approach to promote cancer-related issues and motivating others to take action. It is recognised that cancer patient advocacy provides a voice for patients and raises awareness of needs. Patients with cancer, and survivors and caregivers are all in an ideal position to provide insight into gaps within systems of supportive care. Through capacity building, their voices are a powerful tool in advocating for improvements in knowledge, practice, policy and services and in empowering others to share their stories. Patient advocacy can improve access to treatment, raise awareness of the value of prevention, and ensure that patient views are integrated into planning and policy.

In Australia, a number of PCa survivors took on activist roles, working both outside and within traditional health services to provide much needed support for men and their families, and to challenge the health system to hear their collective voice towards lobbying support to improve PCa supportive care services (Dunn et al., 2018). The activist role taken was not only for local action in providing supportive care for men, but also to gather their national collective voice in order to influence healthcare services and research.

The American Cancer Society, a pioneering organisation, started implementing patient engagement activities as early as the 1950s (Schear et al., 2015). Similarly, the National Coalition for Cancer Survivorship launched its major activities in the 1980s. The rapid growth of such activities has successfully led to advocate groups gaining sufficient influence over policymakers, researchers and healthcare providers, and has become a critical part of the shift in the healthcare paradigm from illness-centred to patient-centred care, where patients and their families are more actively participating in their care and in the creation of services and policies. Countries such as Indonesia, Canada, Chile and the UK have been engaged in cancer patient advocacy for more than 15 years.

In South Africa, the cancer patient advocacy forum is comprised of patients, civil society, policymakers and healthcare providers gathered to engage in dialogue about cancer supportive care and control (Schear, 2015). The establishment of the forum has resulted in policymakers considering patient views in the policymaking process. Patient advocacy plays a pivotal role in cancer control planning and is necessary in any resource setting to influence policy and improve the delivery of cancer control (Schear et al., 2015).

2.5.2.5 Establishment of community-based face-to-face prostate cancer support groups (PCSGs)

According to Nair et al. (2018), a large body of literature demonstrates that participation in PCSGs improves patients' quality of life and wellbeing. PCSGs refer to community-based organisations that offer information and psychological support for men who experience PCa and their families (Wellam et al., 2016). In Canada, approximately 100 community-based face-to-face PCa support groups (PCSGs) have been established as a major source of support for more than 20 years, attracting men and their partners to monthly meetings (Garrett et al., 2014). Research findings indicate that attending PCSGs provides reassurance, reduces anxiety, and improves positive outlook and the perception of being more involved in treatment decisions. Other reported benefits include mitigating the psychological impact of cancer by conveying information, empowering men with PCa, enhancing and facilitating psychological adjustment, and helping men and their partners to cope with PCa. Mogotlane et al. (2018) stress that families should be encouraged to attend support group meetings to help them to use appropriate psychological coping mechanisms. Support groups helps patients and families come to terms with the illness by developing coping skills.

In a study conducted by Wellam, et al. (2016) about Canadian nurses' perspectives on PCSGs, participants strongly endorsed the benefits of support groups in disseminating information and providing support to help decrease patient anxiety. The blend of PCa information shared at PCSGs has been shown to foster a sense of meaning and purpose for attendees, mitigate the psychosocial aspects of cancer by empowering men with PCa and help them and their families to cope with life after diagnosis and treatment. In the study conducted by Chambers et al. (2018) about living with PCa, peer support was indicated as having a relatively high uptake among men with PCa, with men reporting that peer discussions provides information and emotional support, and reduces feelings of social isolation. In Finland, tele-based support groups are being conducted through teleconferencing and are usually co-facilitated by a nurse counsellor and experienced trained peer. A peer refers to a man who has been previously diagnosed with PCa and who is physically and emotionally well to enough to provide support to others. Peer support is based on the sharing of personal mutual experience and has been widely developed in Europe, North America and Australia in the context of PCa. In the study conducted by Chambers et al. (2013), men with PCa reported that peer support helps by providing a source of useful information and advice about their cancer, helping them understand cancer better and to feel less alone and more in control of their life, as well as providing an opportunity to talk about their concerns and helping reduce feelings of self-blame. This is in line with the results of a study conducted by Frankland et al. (2019) about the supportive care of men diagnosed with PCa. The study revealed that peer support programmes that provide patients with the opportunity to talk to cancer survivor role models assist by normalising the cancer experience, decreasing feelings of isolation and promoting an optimistic outlook.

This is in accordance with Kirkman et al. (2017), who emphasise that the care for mental health may need to be extended to encouraging social engagement with the community, not necessarily limited to men with PCa but bringing together people with shared interests such community-based men's groups.

In America, a study conducted by Oliffe et al. (2008) on what PCa support groups do to help men to survive revealed that a number of PCSGs are formed to provide information about the disease and to give supportive care for men diagnosed with PCa and their families. Evidence confirms that PCSGs can play a crucial role in alleviating anxiety and providing reassurance throughout the PCa illness trajectory. These findings are consistent with the results of a study by King et al. (2015) about PCa and supportive care which revealed that men's experiences of PCSGs lifted them out of a sense of isolation and enabled them to talk about their illness experience, share information and exchange tips and ideas on dealing with treatment side-effects. Being in a mixed group with men at different stages of PCa helped men confront and accept the disease progression. Participants felt that the ideal support programme should be made available immediately after diagnosis so that they could literally walk out of the urologist's office and begin to discuss options. Participants were most interested in meeting with other men with the disease, not a physician or a nurse. The value of peer support was evident at all stages of prostate cancer, with diagnosis, treatment decision-making and advanced disease being three critical times (King et al., 2015). In a study conducted by Krumwiede & Krumwiede (2012) about the lived experience of men diagnosed with prostate cancer, participants talked about seeking health information from others who had gone through similar experience as being supportive, alleviating fears and having an enormous impact on the decision-making process. The information shared provided reassurance that the PCa experience contains common reactions that others have gone through and that they can too. The shared stories of men with PCa allowed the participants to determine whether they were better or worse off than other men in this situation. Despite the fact that each participant’s experience was significant, in the end many of the participants felt that their experience had not been as bad as others.

In Australia, the PCa Foundation of Australia website was developed by the education committee of the Australian Prostate Cancer Collaboration (APCC) with funding from the Lions International Clubs of Australia to assist men affected by PCa and their families (Chambers et al., 2013). It serves as a broad-based community organisation and the peak national body for PCa in Australia, dedicated to reducing the impact of PCa on Australian men, their partners, families and the wider community.

Similarly, a Life Now Exercise programme for men diagnosed with PCa has been established in Australia. It is a community-based exercise intervention designed to mitigate and rehabilitate the adverse effects of cancer and its treatment and improve physical and psychological wellbeing in people with cancer. Involvement in the programme is open to people with any diagnosis of cancer who are currently receiving treatment or within two years of completing treatment. The intervention consists of twice-weekly group-based exercise sessions administered in community exercise clinics under the supervision of an exercise physiologist trained to deliver the programme. According to Hinkle and Cheever (2014), the implementation of the group-based exercise is driven by international guidelines recommending high quality exercise for all people with cancer. Chambers et al. (2013) emphasises that stress management sessions before and after surgery have been found to improve men’s physical and psychological well-being.

2.6 METHODOLOGICAL RIGOUR

Methodological rigour refers to the quality of research in terms of its methodological procedures (Cwiklicki & Urbaniak, 2018). It is the means by which researchers demonstrate integrity and competence, a way of demonstrating the legitimacy of the research process (Tobin & Begley, 2004). In this study, the process of conducting a literature review consisted of the five different stages of a methodological framework for conducting a scoping review, as proposed by Arksey and O’Malley (2005). An expert librarian from the University of Namibia assisted the researcher with the design and execution of search strategies, including inclusion and exclusion criteria (Daudt et al., 2013). The researcher further consulted the study supervisor to further interrogate the inclusion and exclusion criteria and the quality of studies included. A list of preliminary search terms and filtering methods was developed. The search strategy was refined to include MeSH terms and Boolean operations, as illustrated in

Figure 2.1, as well as through free-text terms, in order to comply with searches across different databases. Trial searches were run to assess whether relevant literature could be identified using the proposed strategy. Studies relevant to the review were identified by searching various electronic databases, as shown in Figure 2.1.

In order to ensure methodological rigour, literature search strategies were well defined so that not only computer-based but also other recommended approaches to searching the literature, such as manually searching journals and networking with scholars in order to be guided to suitable publications, were applied. Reliable and valid coding procedures were used to ensure methodological rigour, making use of more than one reviewer for the critical review to reduce the possibility of bias.

The researcher adhered to UNAM's Policy for Copyright Infringement and Plagiarism in order to uphold the academic integrity of the study. All sources used in the scoping review were indicated in the list of references as per UNAM research guidelines.

2.7 SUMMARY

The scoping review aimed to explore and describe the best practices on the supportive care of men diagnosed with PCa and their families by nurses in oncology departments. The review was conducted using Arksey and O'Malley's (2005) scoping review methodology framework and was reported using the PRISMA-ScR guidelines. Five stages are traversed in undertaking a scoping review; namely, articulating the research question (stage 1), identifying relevant studies (stage 2), study selection (stage 3), charting the data (stage 4), and collating, summarising, and reporting results (stage 5). The results of the scoping review were presented and themes and sub-themes on best practices on supportive care for men diagnosed with PCa and their families were described. The next chapter describes the research design and the methods used in the study.

CHAPTER 3

RESEARCH DESIGN AND METHODS

3.1 INTRODUCTION

Chapter 2 dealt with the review of various literature related to supportive care for men diagnosed with prostate cancer (PCa) and their families. This chapter gives a detailed description and justification of the research design and methods used in the study. Mixed method research is a research design comprising philosophical assumptions as well as methods of enquiry (De Vos et al., 2011). It focuses on collecting, analysing, and mixing both quantitative and qualitative data in a single study. This study was carried out in four phases. Phase 1 comprised of an analysis of the concept of supportive care for men diagnosed with PCa and their families by nurses in oncology departments. Phase 2 focused on the development of the conceptual framework as a basis for the model development. Phase 3 dealt with the development and description of a model to facilitate supportive care of men diagnosed with PCa and their families at the IHO, while Phase 4 focused on the development of guidelines to operationalise the model. Reasoning strategies were used throughout the study in accordance with Polit and Beck (2012), who stress that systems of reasoning are very useful in research in order to understand and organise the phenomena under study.

3.2 RESEARCH DESIGN AND METHODS

A research design is the architectural and proverbial backbone of the study, which provides the structure for the research methods and design decisions that must be taken when planning the study (Botma et al., 2010). It is an overall plan for obtaining answers to the research questions, including specifications for enhancing the study's integrity (Polit & Beck, 2012). When designing the study, researchers select a specific design and identify strategies to minimise bias. According to Sarantakos (2005), the research design helps to introduce a systematic approach to the research operation, thereby guaranteeing that all aspects of the study will be addressed and that they will be executed in the right sequence. This implies that the researcher will go through the research steps, one by one, and describe adequately the activities to be undertaken in each step. Creswell and Creswell (2018) define research designs as types of enquiry within qualitative, quantitative and mixed methods approaches that provide specific direction for the procedures in a research study. A research design is a blueprint for conducting a study that maximises control over factors that could interfere with the validity of the findings (LoBiondo-Wood & Haber, 2010). Creswell (2014) stresses that the purpose of research design is to define the structure of the enquiry into a research problem to produce a valid and meaningful argument for the researcher’s audience within the available time and using the available resources. A research design focuses on the end product and all the steps in the process are anticipated to achieve the outcome (De Vos et al., 2011).

In this study, the researcher employed a mixed method research framework, as well as the theory generative approach developed by Chinn and Kramer (2018). Theory generation and practice oriented theory guided the development of a model for nurses to facilitate supportive care for men diagnosed with PCa and their families at the IHO.

3.2.1 Theory generative design

According to Walker and Avant (2014), theory development provides a way of identifying and expressing key ideas about the essence of practice. Developing theory is a complex process that involves the identification of concepts, statements, theories, linkages and definitions (Walker & Avant, 2014). This study entailed the development of a model for nurses to facilitate supportive care for men diagnosed with PCa and their families at the IHO.

3.2.2 Mixed method approach

Mixed methods research is an approach to inquiry that combines or integrates both qualitative and quantitative forms of research and data in a single research study (Creswell & Creswell, 2018). Mixed methods reside in the idea that all methods have bias and weaknesses, and the collection of both quantitative and qualitative data neutralises the weaknesses of each form of data. This is a research design with philosophical assumptions as well as methods of enquiry. As a methodology, mixed method involves philosophical assumptions that guide the direction of the collection and analysis of data, as well as the mixture of qualitative and quantitative approaches in many phases of the research process. As a method, mixed methods research focuses on collecting, analysing and mixing both quantitative and qualitative data in a single study or series of studies, meaning that a researcher collects both numeric and textual information (De Vos et al., 2011). When used in combination, quantitative and qualitative methods complement each other, neutralise the weaknesses of the other, and allow for a more robust data analysis (Venkatesh et al., 2016).

In this study, the researcher adopted a mixed method by employing both qualitative and quantitative research approach to collect and analyse both types of data concurrently. A mixed methods approach holds a pragmatic worldview and minimises the limitations of both qualitative and quantitative approaches (Creswell & Creswell, 2018). In this study, pragmatism opens the door to multiple methods, different worldviews and different assumptions, as well as different forms of data collection and analysis. Accordingly, this study adopted a qualitative, phenomenological, exploratory, descriptive and contextual design to gain insight into and discover meaning about supportive care for men diagnosed with PCa and their families.

The study started with literature review using Arksey and O'Malley's (2005) scoping review methodology framework, as updated by Levac et al. (2010). This was followed by the in-depth individual face-to-face interviews with men diagnosed with PCa, family members of men diagnosed with PCa and registered nurses working in oncology departments at the IHO. The researcher employed both verbal and non-verbal communication skills to encourage participants to verbalise their experiences on supportive care for men diagnosed with PCa and their families. The interviews ceased when data saturation was reached (May & Holmes, 2012). Similarly, a quantitative approach was applied to assess the oncology departments in terms of facilitating supportive care for men diagnosed with PCa and their families at the IHO. A questionnaire with a five-point Likert scale was used as the data collection instrument, as illustrated in Annexure E. The study was contextual in nature because it was conducted in oncology departments at the IHO which enabled the researcher to maintain focus on supportive care for men diagnosed with PCa and their families.

3.2.2.1 Qualitative design

Qualitative research refers to the investigation of phenomena, typically in an in-depth and holistic fashion, through the collection of rich narrative materials using a flexible research design (Polit & Beck, 2012). According to Creswell and Poth (2018), qualitative research is conducted because a problem or an issue needs to be explored in order for the researcher to get a complete detailed understanding of the issue. This detail can only be established by talking directly with people, going wherever the participants are – into their homes, schools or other places of work, communities, and sometimes in hospitals and outpatient settings – and allowing them to tell their stories unencumbered by what researchers expect to find or what they read in literature (Creswell & Poth, 2018; LoBiondo-Wood & Haber, 2010).

Conducting qualitative research, according to Creswell and Poth (2018), is done when researchers want to understand the contexts or settings in which participants in a study address a problem or issue. Creswell and Creswell (2018) stress that researchers should not always separate what people say from the place where they say it, whether the context is their home, family or work. During qualitative research the researcher commits to spending many hours in the field collecting extensive data, and labours over field issues such as trying to gain access and establish rapport (Creswell & Poth, 2018). The interaction of the participants and the researcher is by means of in-depth face-to-face interviews with participants. The researcher records information from interviews by making handwritten notes, audio taping, or videotaping Creswell & Creswell, 2018). The table below depicts the characteristics of qualitative research as recommended by Creswell and Poth (2018).

Table 3.1 Characteristics of Qualitative Research

Characteristics	Descriptions
Natural setting	Qualitative researchers often collect data in the field at the site where participants experience the issue or problem under study. The researcher gathers up-close information by talking directly to people and seeing them behave within their context. These face-to-face interactions might occur over time.
Researcher as key instrument	Qualitative researchers collect data themselves by examining documents, observing behaviour, or interviewing participants. They may use a protocol, but the researchers are the ones who actually gather the information and interpret it. They do not tend to use or rely on questionnaires or instruments developed by other researchers.
Multiple sources of data	Qualitative researchers typically gather multiple forms of data, such as interviews, observations, documents, and audiovisual information, rather than relying on a single data source. These are all open-ended forms of data in which the participants share their ideas freely, not constrained by predetermined scales or instruments. Then the researchers review all of the data, make sense of them, and organise them into codes and themes that cut across all of the data sources.
Inductive and deductive data analysis	Qualitative researchers work inductively, building patterns, categories, and themes from the bottom up by organising the data into increasingly more abstract units of information. This inductive process illustrates working back and forth between the themes and the database until researcher has established a comprehensive set of themes. Deductively, researchers look back at their data from the themes to determine if more evidence can support each theme or whether they need gather additional information.
Participants' multiple perspectives and meanings	In the entire qualitative research process, the researchers keep a focus on learning the meaning that the participants hold about the problem or issue, not the meaning that the researchers bring to the research or what writers express in the literature.
Context-dependent	The research is situated within the context or setting of participants or sites. This is essential because the particular contexts allow researchers to understand how events, actions and meaning are shaped by the unique circumstances in which these occur.
Emergent design	The research process of qualitative researchers is emergent. This means that the initial plan for research cannot be tightly prescribed and that all phases of the process may change or shift after the researchers enter the field and begin to collect data. For example questions may change, and the forms of data collection may be altered.
Reflexivity	Researchers position themselves in a qualitative research study. This means that researchers convey their background, how it informs their interpretation of the information in a study and what they have to gain from the study.

Holistic account	Qualitative researchers try to develop a complex picture of the problem or issue under study. This involves reporting multiple perspectives, identifying the many factors involved in a situation, and generally sketching the larger picture that emerges.

Source: Adopted from Creswell & Creswell, 2018; Creswell & Poth, 2018.

In this study, the researcher adopted a qualitative research design because it enabled them to explore and describe the perceptions of men diagnosed with PCa, family members of men diagnosed with PCa, as well as registered nurses in oncology departments on supportive care for men diagnosed with PCa and their families. The findings were conceptualised according to Dickoff et al.'s (1968) guidelines to guide the description of the model and to operationalise the model.

3.2.2.2 Exploratory design

Exploratory research is conducted where there is little or no prior knowledge of the phenomenon, in order to become acquainted with the situation. In this case, this refers to supportive care for men diagnosed with PCa and their families (De Vos et al., 2011). According to Polit and Beck (2012), exploratory research investigates the full nature of the phenomenon, the manner in which it is manifested, and the other factors to which it is related. Parahoo (2014) emphasises that in exploratory research, issues of concern, questions and unstructured information are investigated through people in their own environment and their actions can be assigned to the meanings they give. This study is located within a pragmatic worldview using multiple methods of data collection that best answer the research question, thus emphasising the importance of applying methods for conducting research that best address the research problem (Creswell & Poth, 2018). The study was exploratory because it provided an in-depth exploration of the experiences and perceptions of men diagnosed with PCa, their family members, as well as registered nurses, of supportive care for men diagnosed with PCa, which was the phenomenon under study.

To gain an understanding of the phenomenon, the researcher conducted individual in-depth face-to-face interviews with men diagnosed with PCa, their family members and registered nurses. Using an interview guide, field notes and audio recordings, the researcher obtained answers to the main questions regarding supportive care for men diagnosed with PCa and their families. The researcher subsequently interpreted the data to understand their meaning in depth (Creswell & Poth, 2018). The results of the findings of the exploratory research were conceptualised in order to formulate guidelines for operationalising the model.

3.2.2.3 Quantitative design

Botma et al. (2010) define quantitative research as an essential tool for generating knowledge in nursing science and for providing evidence for nursing practice, education and management. It is a mode of enquiry for testing theories and hypotheses, collecting descriptive information and examining relationships between variables (Polit and Beck (2012). In quantitative research, the researcher converts the data to a numerical form and subjects them to statistical analysis (De Vos et al., 2011). Statistical analysis is a procedure for assembling, classifying, tabulating and summarising numerical data to obtain meaning or information. On the other hand, the data are reduced to an intelligible and interpretable form so that the relations that exist between research problems can be studied and tested, and conclusions drawn. Data analysis does not in itself provide the answers to research questions; rather, answers are found by way of interpreting the data and the results. In this study, a quantitative approach was used to assess the oncology departments in terms of facilitating the supportive care of men diagnosed with PCa and their families. The findings of quantitative methods applied are usually presented in the form of graphs, tables and diagrams, which in this study can be found in Chapter 4. The characteristics of quantitative research are described in Table 3.2, below.

Table 3.2: Characteristics of a quantitative research

Characteristics	Descriptions
Theory	Quantitative research tests theory generated during qualitative research.
Number of concepts investigated	Quantitative research focuses on a small number of concepts while qualitative research attempts to understand the phenomenon in its entirely.
Researcher role	In quantitative research, the researcher does not participate in the data gathering, but is at a distance.
Control	Quantitative research strives for control during the implementation of the research.
Type of instrumentation	Quantitative research develops and implements research instruments.
Unit of analysis	In quantitative research, numbers are the basic element of analysis.
Data analysis	Quantitative research focuses on statistical analysis of the data.
Purpose of the research outcomes	Quantitative research strives to generalise research results to larger contents.

Source: Adopted from Botma et al., 2010

3.2.2.4 Descriptive design

Descriptive design refers to a more intensive examination of phenomena and their deeper meaning, thus leading to thicker descriptions (De Vos et al., 2011). According to Polit and Beck (2012), descriptive research is a philosophy that describes human experiences to gain more information. The purpose of descriptive research is to provide a picture of situations as they naturally happen (Polit & Beck, 2012). The researcher must describe the human experiences and behaviours without influencing the participants in their real-life situations. In this study, the information was gathered using the exact words of the participants, thus aiming to obtain a dense description of the phenomenon and its deeper meaning.

A descriptive design is used to develop theory, identify problems in current practice, justify current practice, make judgements, or determine what others in similar situations are doing, which in this study, entailed supportive care for men diagnosed with PCa and their families. The descriptive part of this study entailed a description of the experiences of men diagnosed with PCa, of their family members and of registered nurses with regard to the supportive care of men diagnosed with PCa and their families at the IHO. By using a descriptive design in this study, the researcher gained more information of the phenomenon under study, namely, supportive care for men diagnosed with PCa and their families at the IHO. A model and guidelines were also described.

3.2.2.5 Phenomenological design

LoBiondo-Wood and Haber (2010) define phenomenological study as a process of learning and constructing the meaning of human experience through intensive dialogue with persons who are living the experience. The importance of phenomenological study is that it describes the experience or phenomena as they are lived in phenomenological terms to capture the lived experiences of study participants (Polit & Beck, 2012). It generates a description of a phenomenon of everyday experience, allowing participants to have a direct experience with the phenomenon being studied, in this study, supportive care for men diagnosed with PCa and their families (Holloway & Wheeler, 2010). In this study, the researcher’s goal was to understand the meaning of the experience; in this case, supportive care as it was lived by men diagnosed with PCa and their families, as well as registered nurses, during daily consultations at the IHO.

3.2.2.6 Contextual design

Holloway and Wheeler (2010) define study context as the environment and the conditions in which the study takes place as well as the culture and location of the participants. It refers to a particular setting in which a study takes place, which may be the environment, the people and the like. The importance of the study context is that if the researcher understands the context, he will be able to locate the actions and perceptions of individuals and grasp the meanings that they communicate, because in qualitative research, events and actions are studied as they occur in everyday real-life settings.

This study is contextual in nature because it was carried out in oncology departments at the IHO in which men diagnosed with PCa are treated and followed up. The researcher opted for a contextual design in order to maintain focus on supportive care for men diagnosed with PCa and their families. This is because in qualitative studies, when doing contextual studies, one focuses on a specific context within its natural setting in order to maintain the trustworthiness of the results. In this study, this approach ensured true, valid and accurate information without the influence of external factors.

3.3 REASONING STRATEGIES

Reasoning refers to processing and organising of ideas in order to reach conclusions (Polit & Beck, 2012). It entails the drawing of inferences or conclusions with reasons. In relation to a pragmatic perspective, mixed-methods researchers can select both inductive and deductive logic and use them simultaneously in the course of conducting research that focuses on addressing research questions (Venkatesh et al., 2016). In this study, the reasoning strategies used were deductive and inductive reasoning, with analysis, synthesis, bracketing, inference and derivation being applied to clarify the concept of supportive care, and to analyse the data used during the conceptualisation of the findings, the description of guidelines for operationalising the model, proffering justifications and presenting the concluding statements.

3.3.1 Inductive reasoning

Inductive reasoning involves generalising a theory confirmed in one specific setting to another context as the theory evolves (Venkatesh et al., 2016). It is the process of developing generalisations from specific observations (Polit & Beck, 2012). Zhang and Wildemuth (2016) define inductive reasoning as logical reasoning which involves adding up truth, facts and phenomena to make generalisations based on what the researcher has observed. According to De Vos et al. (2011), inductive reasoning begins not with a pre-established truth or assumption, but with an observation. With inductive reasoning, researchers observe a sample and then draw conclusions about the population from which the sample comes. In other words, the researcher begins with a general topic and some vague ideas that he/she then refines and elaborates into more exact theoretical concepts.

In this study, inductive reasoning was used in Phase 1 during data collection using questionnaires, and the in-depth individual face-to-face interviews with men diagnosed with PCa, their family members and registered nurses at the IHO. During the interviews, the researcher made field notes, observations and tape recordings which were used during data analysis and interpretation. In Phase 2, the researcher used inductive reasoning to finalise the themes and sub-themes for conducting the in-depth interviews in this study. Through inductive reasoning in Phase 3, the concepts that formed the basis for the development of a model and the guidelines to operationalise it were identified.

3.3.2 Deductive reasoning

Deductive reasoning moves from the general to the specific or from a general premise to a particular situation or conclusion (De Vos et al., 2011). It is often referred to as a top-down approach, used mainly in quantitative research studies (Polit & Beck, 2012). Venkatesh et al. (2016) stress that deductive reasoning involves making generalisations from a specific sample that one then applies to the theoretical population.

In this study, deductive reasoning was adopted in Phase 1 by using the questionnaire comprising a 5-point Likert scale to assess the oncology department in terms of facilitating supportive care for men diagnosed with PCa and their families. During the development of the model and the guidelines, the findings enabled the researcher to describe, evaluate and operationalise the model based on the principles of Chinn and Kramer (2018). After an extensive exploration of the literature on supportive care for men diagnosed with PCa and their families, the researcher used deductive reasoning during concept analysis, in this case, supportive care. This was done in order to identify the defining attributes of the concept and their related connotations for the conceptualisation of the model and the description of the guidelines to operationalise the model (Zhang & Wildemuth, 2016).

3.3.3 Inferences

In research, inference refers to a conclusion drawn from evidence gleaned by the study, taking into account the methods used to generate that evidence (Polit & Beck, 2012). Botma et al. (2010) define inference as a generalisation made about a population from a sample of that population. Accordingly, one infers from a specific case to a general truth, from a part to the whole, from the concrete to the abstract, from the known to the unknown. In this study, inferences were drawn from interpreted data collected during the in-depth individual face-to-face interviews with men diagnosed with PCa, their family members and registered nurses, as well as from the assessment of the oncology department in terms of facilitating supportive care for men diagnosed with PCa and their families. Evidence obtained from the study enabled the researcher to draw conclusions and to develop a model for nurses to facilitate supportive care for men diagnosed with PCa and their families as illustrated in Figure 7.1.

3.3.4 Bracketing

In a qualitative study, bracketing refers to a process during which the researcher identifies personal biases about the phenomenon of interest to clarify how personal experience and beliefs may colour what is heard and reported (LoBiondo-Wood & Haber, 2010). Grove, Burns and Gray (2013) define bracketing as suspending or laying aside what is known about the experience being studied. Researchers therefore use bracketing to avoid misinterpreting the phenomenon as individuals experience it. In this study, bracketing was used during the individual face-to-face interviews during which the researcher bracketed (set aside) his personal views during the engagement with participants. During the interviews, central questions on supportive care for men diagnosed with PCa and their families were asked. Probing was used to deepen the response to a question, increase richness of the data being obtained, and to give cues to the participants about the level of response that is desired (De Vos et al., 2011). Both verbal and non-verbal communication skills were employed to encourage participants to verbalise their experiences on supportive care for men diagnosed with PCa and their families. During the interviews, the researcher remained neutral and did not allow his personal beliefs and ideas to influence the study. This is in line with LoBiondo-Wood and Haber (2010) who stress that when using a phenomenological method, the researcher’s perspective should be set aside.

3.3.5 Analysis

Walker and Avant (2014) define analysis as the ability to dissect a whole into its component parts. Analysis aims at clarifying and redefining concepts, statements and models. In this study, analysis was used in Phase 1 for concepts and identification, definition and classification. The researcher conducted a thorough examination and re-examination of the existing experiences on supportive care for men diagnosed with PCa and their families. Analysis was therefore useful during the conceptualisation, concluding statements, clarification of the concept, and description of the model, as well as guidelines for operationalising the model, as described in Chapters 6 and 7.

3.3.6 Derivation

According to Walker and Avant (2014), derivation refers to the process used by the researcher to rearrange and redefine a concept, statement or theory from one context to another, especially if the concept is outdated or has lost meaning, or where there is no theoretical base. In this study, the researcher adopted derivation by reviewing literature and by employing the practice oriented theory proposed by Dickoff et al. (1968), systems theory (Von Bertalanffy, 1930), nursing process theory (Orlando, 1961), and holistic theory (Smuts, 1926). This is in line with Walker and Avant (2014), who state that derivation involves adopting, adapting and borrowing related concepts from other fields or authors by adjusting them to fit the phenomenon under study, in this case supportive care for men diagnosed with PCa and their families. Derivation therefore enabled the formulation of meaningful concepts that facilitated the development of the model for nurses to facilitate supportive care for men diagnosed with PCa and their families (see Chapter 7).

3.3.7 Synthesis

Synthesis refers to clustering and interrelating ideas from several sources to form a new, complete picture of what is known and not known in an area (Grove & Gray, 2019). It is about clarifying the meaning obtained from several sources. In this study, the researcher synthesised the data collected from the individual interviews by examining it for similarities and differences (Walker & Avant, 2014). Data from the literature reviewed were also synthesised. Additionally, synthesis was used for theme identification during the data analysis.

3.4 RESEARCH METHODS

Research methods refer to the techniques researchers use to structure a study and to gather and analyse information in a systematic fashion relevant to the research question (Polit & Beck, 2012). Research methodology forms the basis of the research and guides data collection, data analysis and theory development. According to Creswell (2014), research methods involve the forms of data collection, analysis and interpretation that researchers propose for their studies in order to ensure the reliability of the data collected. It also includes the study population, sampling, data collection methods and data analysis methods. De Vos et al. (2011) stresses that it is imperative that the researcher clearly defines and outlines the type of methodology that will guide the research project.

In this study, a mixed method was adopted by employing both quantitative and qualitative approaches to collect and analyse both types of data concurrently (Creswell & Poth, 2018). Individual face-to-face interviews were conducted with key participants and self-administered questionnaires were administered in the oncology departments at the IHO. The model for nurses to facilitate supportive care for men diagnosed with PCa and their families at the IHO was developed based on the theory generation by Chinn and Kramer (2018) and the conceptual framework developed in Phase 2.

3.4.1 Phase 1: Concept analysis

In this study, concept analysis enabled the researcher to make a distinction between supportive care and other similar concepts. Walker and Avant (2014) define concept analysis as a process of examining the basic elements of a concept. According to Chin and Kramer (2018), the concept analysis process involves the identification, classification and definition of concepts. This is supported by Walker and Avant (2014) who emphasise that the basis for theory development depends on the identification and explication of the concept to ensure that it is solid and strong enough to uphold the structure of the theory. In this study, an operational definition was devised and the theoretical validity was ensured. The concept analysis and identification were based on the first four qualitative sub-objectives and a last quantitative sub-objective. The main concepts of the model were identified through deductive reasoning after data analysis, resulting in the development of a model for nurses to facilitate supportive care for men diagnosed with PCa and their families (see Figure 5.12).

3.4.1.1 Sub-objective 1: To explore and describe best practices for the supportive care of men diagnosed with PCa and their families by nurses in oncology departments

Design

Research design refers to an overall plan for addressing a research question, including specifications for enhancing the study’s integrity (Polit & Beck, 2012). For sub-objective 1, a qualitative research approach was systematically employed in order to analyse the concept of supportive care for men diagnosed with PCa and their families, by exploring and describing the perceptions of men diagnosed with PCa, those of their families as well as those of nurses at the IHO.

Population

Population refers to the entire group of persons or objects that meets the criteria which the researcher is interested in studying (Mills & Gay, 2016). The target population for this sub-objective was made up of original peer-reviewed full-text research articles on supportive care for men diagnosed with PCa and their families. Grey literature such as health reports from the Ministry of Health, theses and dissertations, and unpublished research were also considered.

Sample and sampling

A sample is a part or fraction of a whole, or a subset of a larger set, selected by the researcher to participate in a research study (Brink, 2012). Sampling is the process of selecting cases to represent an entire population so that inferences about that population can be made (Polit & Beck, 2012). The researcher employed a non-probability purposive sampling method in order to select information-rich published research materials on supportive care for men diagnosed with PCa and their families. The sample size for sub-objective 1 that focused on best practices was determined when the point of data saturation was reached.

The following inclusion criteria applied during the sampling process of published research materials on supportive care:

- Original peer-reviewed full-text research articles on supportive care for men diagnosed with PCa and their families
- Research articles published between the years 2010 and 2021
- Qualitative studies only
- Guidelines, policies and books on supportive care for men diagnosed with PCa and their families, not older than ten (10) years.

The sampling process was done in line with the seven steps for conducting a literature review as recommended by Creswell and Creswell (2018). The researcher adopted these steps as they allowed him to proceed in a systematic fashion in order to capture, evaluate and summarise the literature. The seven steps are illustrated in Table 3.3.

Table 3.3: Steps for conducting a literature review

Steps	Application to the study
Begin by identifying keywords	The researcher commenced by identifying keywords, in this case supportive care, in order to locate materials about the study title.
Use your computer to begin searching the database for headings	With the keywords in mind, the researcher began with the search by using the computerised database with more focus on health journals and books related to the topic.
Initially, try to locate about 50 reports of research in articles or books	The researcher set a priority for health journals and books because they are easy to locate and obtain. Books that could not be located in the local library were requested from other libraries via interlibrary loan, while others were purchased from bookshops.

Table 3.3: Steps for conducting a literature review (continued)

Steps	Application to the study
Skim this initial group of articles or chapters	Journals and books central to the study topic were collected and the researcher tried to obtain a sense of whether the article made a useful contribution to the study.
Begin designing a literature map	After the researcher identified useful literature, a literature map was designed.
Begin to draft summaries of the most relevant articles	As the researcher put the literature map together, he also started to draft summaries of the most relevant articles. Summaries were combined into the final literature review that researcher wrote in the study (see Chapter 2).
Assemble the literature review	After summarising the literature, the researcher assembled the literature review by structuring it thematically according to important concepts. The researcher ended the literature review with a summary of the major themes.

Source: Adopted from Creswell & Creswell, 2018

Data collection

Data collection refers to a precise, systematic gathering of information relevant to the research purpose or the specific objectives, questions, or hypothesis of a study (Grove, Gray & Burns, 2015). According to Grove et al. (2013), the actual steps for collecting data are specific to each study and depend on the research design and measurement methods. For sub-objective 1 of this study, the researcher followed the stages for appraising research articles, as recommended by Botma et al. (2010), namely, finding, reading and re-reading the articles, taking initial notes, developing emerging themes, searching for connections across the emerging themes and developing the final themes.

Data analysis

In a qualitative study, data collection and data analysis often occur simultaneously, rather than after data are collected (Polit & Beck, 2012). The search for important themes and concepts begins from the moment data collection gets underway. For sub-objective 1 of this study, the researcher employed document analysis, in this case, health journals on supportive care for men diagnosed with PCa and their families as recommended by Botma et al. (2010). According to Botma et al. (2010), document analysis enables the researcher to investigate people, events and systems in depth by analysing authentic written material as illustrated in Chapter 2.

3.4.1.2 Sub-objective 2: To explore and describe the experiences of men diagnosed with PCa on the supportive care received from nurses in oncology departments

Design

A qualitative research design was systematically employed in order to analyse the concept of supportive care for men diagnosed with PCa and their families. A phenomenological, exploratory, descriptive and contextual design was adopted in order to explore and describe the perceptions of men diagnosed with PCa and their families on supportive care at the IHO. This is in accordance with De Vos et al. (2011) who stress that a qualitative researcher is concerned with the subjective exploration of reality from the perspective of an insider using naturalistic observation; in this case the reality of men diagnosed with PCa at the IHO. In this study, phenomenological design generated a description of a phenomenon of everyday experience allowing the researcher to understand the meaning of the experiences on supportive care as it was lived by men diagnosed with PCa (Holloway & Wheeler, 2010). Through an exploratory design, the researcher gained insight into a specific situation, that is, the supportive care received from nurses in oncology departments. The descriptive part of this study entailed a thick description of men's experiences of the supportive care they received from nurses in oncology departments (De Vos et al., 2011). The study was contextual in nature as it was conducted in oncology departments at the IHO in order to maintain focus on the experiences of men diagnosed with PCa regarding the supportive care received from nurses.

Population

The population for this sub-objective comprised men diagnosed with PCa at the IHO.

Sample and Sampling

A non-probability purposive sampling method was adopted which enabled the researcher to purposively select information-rich participants, in this case men diagnosed with PCa at the IHO. The sample for sub-objective 2 comprised men diagnosed with PCa who were interviewed. The sample size was determined by data saturation.

Data collection

In-depth individual face-to-face interviews, field notes and tape recordings were used as methods of data collection for sub-objective 2.

In-depth individual face-to-face interviews: Interviews were conducted with key participants, in this study, men diagnosed with PCa, in order to obtain rich data about their experiences on the supportive care received from nurses in oncology departments. An individual interview is defined as an attempt to understand the world from the participant's point of view, to unfold the meaning of their experience, and to uncover their lived world (Creswell & Poth, 2018). It is a method of data collection where a data collector questions a participant verbally (LoBiondo-Wood & Haber, 2010). Grove, Gray and Burns (2015) define an interview as a technique that can allow the researcher to explore greater depth of meaning, therefore having the potential to generate in-depth information. Since the researcher was interested in collecting rich data by asking about the experiences of men diagnosed with PCa on the supportive care received from nurses in oncology departments, individual face-to-face interviews were considered the most appropriate data collection method to acquire these experiences under sub-objective 2.

Before conducting interviews, the researcher followed the ten steps for preparing and conducting interviews recommended by Creswell and Poth (2018). The steps are summarised in Table 3.4.

Table 3.4: Steps for preparing and conducting interviews

Steps	Application to the study
Determine the research questions that will be answered by interviews.	The interviews commenced with a single, open-ended thoroughly planned central question revised by the study supervisor prior to the interview in order to determine the applicability to the study, namely: **"Tell me your experiences of the supportive care you received from nurses in oncology departments after being diagnosed with prostate cancer."** Probing was done to stimulate participants to produce more information, to clarify and expand responses, and explicate meaning (Brink et al., 2012). Both verbal and non-verbal communication skills were employed to encourage men diagnosed with PCa to verbalise their experiences on supportive care received from nurses in oncology departments. Polkinghorne (1989, cited in Creswell & Poth, 2018) recommends that qualitative researchers interview from five to 25 individuals who have experienced the phenomenon. Eleven interviews were conducted for objective 2, seven interviews for objective 3, and 14 interviews for objective 4, before the point of data saturation was reached. Data saturation refers to the point when gathering fresh data no longer sparks new insights or reveals new properties, a situation which indicates an adequate sample (Creswell & Creswell, 2018).
Identify interviewees who can best answer the questions.	The researcher himself acted as both interviewer and observer. Men diagnosed with PCa, family members and nurses were interviewed in order to share their lived experiences on supportive care for men diagnosed with PCa in oncology departments. The interviews enabled rich descriptions.
Distinguish the type of interview to conduct.	Botma et al. (2010) stress that, if the focus is on exploring an experience of a person about a specific phenomenon, the choice should fall on an in-depth interview. Concurring with the above, the researcher opted for in-depth individual face-to-face interviews due to their ability to generate rich data about participants' experiences on supportive care received from nurses in oncology departments.

Table 3.4: Steps for preparing and conducting interviews (continued)

Steps	Application to the study
Collect data using adequate recording procedures for one-on-one interview.	A tape recorder was used to collect data after written consent was obtained from participants. Recorded interviews enable experiences described to be more substantial, authentic and real (Botma et al., 2010; Tappen, 2011). Tape recording allowed for a much fuller record than taking notes during the interviews (Botma et al., 2010).
Design and use an interview guide	An interview guide was used to focus the discussion, therefore enabling the researcher to maintain consistency with questions during the interviews and not to miss any questions that could ensure that rich data were obtained (Creswell, 2014). The guide was used flexibly with respect to the order of questions and the depth in which some issues were explored (Regan, Levesque, Lambert, & Kelly, 2015). An interview guide refers to the formal instrument that specifies the wording of all questions to be asked of participants (Polit & Beck, 2012).
Refine the interview questions and procedures through pilot testing	Instruments used for interviews were pre-tested during a pilot study in January 2018, at the IHO, in order to allow for their refinement, the identification of flaws and the assessment of the time frame (Creswell & Poth, 2018). A pilot study determines the feasibility of the proposed study, and allows the reliability and validity of the research instrument to be examined. In this study, the pilot study enabled the researcher to establish the content validity of the interview guide, and to improve the suitability of the wording of questions, the format and the instructions (Creswell & Creswell, 2018). Similarly, the pilot study enabled the researcher to determine the practicality of the data collection, as well as his own interviewing and observational skills. The five participants who took part in the pilot study were not included in the main study. The pilot interview proved that the questions were clear and well understood by participants and gave an indication of the time required for an interview.
Locate a distraction-free place for conducting the interview	With permission from the Medical Superintendent, nurse managers and oncology unit managers, the researcher was provided with a suitable room in each oncology department in which the interviews were conducted. The researcher certified that the rooms in which the interviews took place were friendly, relaxed and free from interruptions to ensure the free flow of expression during the interviews. Factors such as privacy, noise and ventilation were considered upon the identification of the rooms. Prior to each interview, rooms were cleaned and seating arrangements were made with two chairs placed in a non-confronting fashion. On each interview day, the researcher showed up at least 45 minutes before the set time in order to set up the room and the tape-recording equipment.
Obtain consent from the interviewee to participate in the study	Prior to the interviews, the researcher explained the aims and objectives of the study to the participants individually and what was required from them in terms of participation in order to obtain written informed consent. With regard to the use of the tape recorder, permission was obtained from the participants. Voluntary participation was ensured by explaining to the participants that they were free to withdraw from the study at any time without being required to offer an explanation.
Follow interview procedures	An interview guide was used during the interviews to direct the questions and to enable the researcher to maintain consistency with questions during the interview, as recommended by Creswell and Poth (2018). The researcher adhered to the principles and basic skills of conducting interviews, namely, communication skills, observations, probing, paraphrasing and analysis.
Decide transcription logistics ahead of time	Botma et al. (2010) describes tape-recorded interviews as the major data sources in qualitative studies. In this study, each interview was transcribed verbatim afterwards to maintain rich descriptions and thus uphold the credibility of the study. The recordings were also transcribed verbatim after the researcher had listened to them several times as soon as the interviews were completed. When transcribing verbatim, the researcher wrote down all the details of the interviews word for word. The tape recordings ensured the accuracy of the transcribed data (Botma et al., 2010).

Source: Adopted from Creswell & Poth, 2018

Data analysis

Sub-objective 2 was to explore and describe the experiences of men diagnosed with PCa on the supportive care received from nurses in oncology departments. For data analysis, the researcher adopted qualitative techniques which were used to analyse words, rather than numbers as recommended by Botma et al. (2010) namely, finding, reading, coding, displaying, reducing and interpreting. The researcher searched for general statements about relationships among different categories of data by using the Tesch's eight steps in the coding process, as recommended by Creswell and Creswell (2018). Coding refers to the process of organising data by bracketing chucks (text or images segments) and writing a word representing a category in the margins. It involves taking textual data or pictures gathered during data collection, segmenting sentences (or paragraphs) or images into categories, and labelling those categories with a term (Creswell & Creswell, 2018). Tesch's eight steps involve a process of breaking down, examining, comparing and categorising raw data. The researcher adopted these steps owing to their systematic approach and clear descriptions.

During the coding process, the researcher read the transcribed data and field notes before attaching the preliminary codes to the interesting data. This is in line with Creswell and Creswell (2018) who urge qualitative researchers to use the coding process in order to aggregate data into a small number of themes, that is, between five and seven themes, because the textual and image data are so dense and rich, therefore all information cannot be used in the study. In line of this, under this sub-objective, the researcher tried to "winnow" the data, by focusing on relevant and useful data and disregarding other (Creswell & Creswell, 2018).

This is supported by Botma et al. (2010) who state that the process of data analysis involves making sense of the text and images. By means of coding, the researcher attached preliminary codes to similar data or changed the codes to subsume similar data. Subsequently, final codes were attached to the data, patterns and relations were identified and themes and sub-themes were developed (Botma et al., 2010; De Vos et al., 2011). The credibility of the coding was ensured when the researcher and the study supervisor (independent coder), who is an experienced coder and a holder of PhD in Nursing, got together to analyse the data and reach consensus. By the end of the data analysis, four themes with ten sub-themes emerged, as presented in Chapter 4, Table 4.1. A theme refers to a recurring idea emerging from an extensive analysis of qualitative data (Polit & Beck, 2012). According to LoBiondo-Wood and Haber (2010), themes represent a way of describing large quantities of data in a condensed form. In this study, various quotations from participants in support of themes are reflected in Chapter 4. Tesch's eight steps which were used in the coding process are presented in Table 3.5.

Table 3.5: Tesch's steps of data analysis and their application to the study

Tesch's Steps of Data Analysis	Application to the study
Get a sense of the whole. Read all the transcriptions carefully and jot down some ideas as they come to mind. This step necessitates careful and repeated reading of the transcripts obtained to identify significant words and phrases.	The researcher read the entire transcript several times and immersed himself in the details, trying to get a sense of the interview as a whole by breaking it into parts. By looking over the field notes from interview transcriptions, the researcher disregarded predetermined answers and looked at what the respondents stated.
Pick one of the shortest and most interesting interviews, go through it and find the underlying meaning	The researcher's main activity was to search for relevant parts of the data and to analyse them by comparing them with other data and by classifying them.
Arrange those topics into columns headed major topics, unique topics and leftovers	The researcher wrote notes in the margins of transcripts in order to explore the database. This task was completed with several participants and similar topics were clustered together in a column headed themes and sub-themes
Assign a code to each topic and write the codes next to the appropriate segment of the text; see if new categories and codes emerge.	After arranging topics into columns in this study, the researcher went back to the data by abbreviating the topics as codes and wrote codes next to the appropriate segments of the text. In coding, the emphasis was on trustworthiness and credibility. Similar items were given the same code.
Find the most descriptive wording for your topics and turn them into categories. Seek for ways of reducing your total list of categories by grouping topics that relate to each other.	The researcher used the coding process to generate descriptions. All topics that were grouped together were checked for coherency. Therefore, coding generated a number of themes that appeared as major findings of this study and which were used as headings in the findings section.
Make a final decision on the abbreviation of each category and alphabetise these codes. To arrive at the final set of categories and codes, the researcher has to go through the materials many times.	A final column with themes and sub-themes was created.
Group the data material belonging to each category in one place and perform a preliminary analysis. Data reduction is a form of analysis that sharpens, sorts, focuses discards and organises data in such a way that final conclusion can be drawn and verified.	The act of giving the same codes to the descriptions was in essence a way to reduce data.
Recode your data, if necessary.	Data were re-coded after an initial coding

(Adopted from Botma et al., 2010; Creswell & Creswell, 2018; May & Holmes, 2012)

3.4.1.3 Sub-objective 3: To explore and describe the experiences of family of men diagnosed with PCa on the supportive care received from nurses in oncology departments

Design

A qualitative research design was systematically employed in order to analyse the concept of supportive care received from nurses in oncology departments by the family of men diagnosed with PCa. A phenomenological, exploratory, descriptive and contextual design was adopted in order to explore and describe the perceptions of such families of the supportive care received from nurses in IHO. In this study, the phenomenological design generated a description of a phenomenon of everyday experience, allowing the researcher to understand the meaning of the experiences on supportive care as they were lived by the families of men diagnosed with PCa (Holloway & Wheeler, 2010). Through an exploratory design, the researcher gained insight into a specific situation; in this study, supportive care received from nurses in oncology departments. The descriptive part of this study entailed a thick description of the families of men diagnosed with PCa perceptions of supportive care received from nurses in oncology departments (De Vos et al., 2011).

Population

The population for this sub-objective comprised the family members of men diagnosed with PCa in IHO.

Sample and sampling

The sample size for sub-objective 3 which focused on the experiences of family of men diagnosed with PCa on the supportive care received from nurses in oncology departments was determined by data saturation. In this regard, the family of men diagnosed with PCa at the IHO were interviewed. Data saturation refers to the point at which the enquirer no longer finds new information that adds to an understanding of the phenomenon (Creswell & Poth, 2018).

Data collection

The primary method for collecting qualitative data is by interviewing study participants (Polit & Beck, 2012). In-depth individual face-to-face interviews, an interview guide, field notes and a tape recorder were used to collect the data for sub-objective 3.

In-depth individual face-to-face interviews: Interviews were conducted with family members of men diagnosed with PCa in order to obtain rich data about their experiences regarding the supportive care received from nurses in oncology departments. The researcher opted for interviews owing to their potential to generate in-depth information about the supportive care received from nurses in oncology departments. Furthermore, interviews enabled the researcher to be actively involved in the process of collecting data in order to obtain authentic insight into the participants' experiences. This is in line with Botma et al. (2010) who state that interviews enable the researcher to understand the experiences of other people and the meaning they make out of those experiences. Family members who accompany men diagnosed with PCa to their follow-up visits were interviewed in oncology departments. Similarly, family members who came to visit men diagnosed with PCa admitted at the IHO were also interviewed in oncology wards. Grove & Gray (2019) urge qualitative researchers, when preparing for an interview, to establish an environment that encourages comfortable conversation. In this study, quiet rooms free from distractions were identified for the interviews, as recommended by Leary (2014) who states that when interviewing, the researcher must structure the interview setting in a way the promotes the respondents' comfort.

The researcher was present in the oncology wards during visiting hours where he interviewed family members of men diagnosed with PCa. Family members who accompanied men diagnosed with PCa for their follow-up visits were interviewed at the oncology departments. The process of interviewing continued until data saturation was achieved; this occurred after 20 interviews. Data saturation refers to the point in a qualitative study when the information being shared with the researcher from subjects become repetitive; in other words, the ideas shared by the participants have been shared before by other subjects and no new ideas emerge (LoBiondo-Wood & Haber, 2010). At this point the sample is considered adequate, and data are taken as rich and thick (Creswell & Creswell, 2018).

Creswell and Poth (2018) recommend that at the beginning of the interview the researcher should review the purpose of the study, the amount of time that will be needed to complete the interview, participants' right to withdraw from the study, and plans for using the results of the interview. Similarly, Polit and Beck (2012) stress that interviewers must prepare respondents for the interview by putting them at ease. In this study, participants were all provided with an explanation of the research objectives and offered an opportunity to read the consent letter. Participants were reminded of their rights to withdraw from the study at any point without being asked to offer an explanation. Before the interview, the researcher welcomed each participant to the interview room, offering them a chair and assuring them of confidentiality regarding the information they were going to share with him.

Interview guide: During the data collection process, the researcher made use of an interview guide to enable him to maintain consistency with questions during the interviews and not to omit any questions that could ensure the attainment of rich data (Creswell & Poth, 2018). An interview guide is a formal instrument that specifies the questions to be asked of respondents, and which helps the interviewer to remember the points to cover (Creswell, 2014; Polit & Beck, 2012).

The interviews commenced with one open-ended central question namely: "*Tell me about your experiences of the supportive care received from nurses in oncology departments after your family member was diagnosed with prostate cancer*." This is in line with Creswell and Poth (2018) who recommend that a qualitative researcher should reduce his/her entire study to a single, over-arching central question and several sub-questions. In qualitative research, a central question is a broad question aimed at exploring a phenomenon or concept in a study (Creswell, 2014).

During the interviews, probing was used to deepen the response to a question, to increase the richness of the data being obtained, and to give the participant a picture of the level of response that is desired. De Vos et al. (2011) define probing as a technique to persuade the participant to give more information about the issue under discussion. According to De Vos et al. (2011) an interview is not a dialogue, therefore the participant must do 90% of the talking because the whole point is for the participant to tell the whole story. This is supported by Creswell (2014) who emphasise that an interviewer should be skilful at personal interaction, question framing and gently probing for elaboration. Grove and Gray (2019) emphasise that once the interview begins, the role of the interviewer is to encourage the subject to continue talking. In this study, probing questions were asked as necessary based on the responses provided, in order to encourage family members to verbalise their experiences of the supportive care received from nurses in oncology departments for men diagnosed with PCa. The researcher used explanatory probing techniques such as; "*What do you mean by that*?", *Can you elaborate on that*?", *Can you tell me more about that*"? "*What does that mean to you*"?

Field notes: De Vos et al. (2011) state that it is vital to make full and accurate notes of what goes on during interviewing. If an interview is taped, Creswell (2014) recommends that researchers take notes in the event that recording equipment fails. Botma et al. (2010) define field notes as written accounts of the things the researcher hears, sees, feels, experiences and thinks about during the course of the interview. It is a record of observations in the field that reflect the words of participants as accurately as possible (Holloway & Wheeler, 2010). In this study, field notes were taken during and immediately after the in-depth interviews with participants while the memory was still fresh for a recall. De Vos et al. (2011) recommend that interviewers should always sit down immediately after an interview and jot down their impressions. The researcher also observed the participants' verbal and non-verbal gestures, such as their facial expressions, level of eye contact, tone of voice and body posture. This is in line with Polit and Beck (2012) who define field notes as a short summary of observations made during data collection. Field notes enable the researcher to be in possession of a comprehensive account by the participants and thereby ensure that rich data does not go unrecorded. It also enables the researcher to remember and explore the interview process (De Vos et al., 2011).

Tape recorder: To ensure that interview data are participants' actual verbatim responses, Polit and Beck (2012) strongly recommend that qualitative interviews be recorded and subsequently transcribed, rather than relying on interviewer notes. In support of this, De Vos et al. (2011) state that a tape recorder allows for a much fuller record than the notes taken during the interview. Botma et al. (2010) describe tape-recorded interviews as major data sources in qualitative studies. Tape-recording allow for a much fuller record than merely taking notes during the interview, this ensuring accuracy during the transcription of the recordings. With tape-recording, events recounted and experiences described during interviews are made more substantial and real (Botma et al., 2010).

The authenticity of the data collected under sub-objective 3 was ensured by the tape-recordings and the keeping of field notes (Tappen, 2011). After permission was obtained from participants, the researcher used the tape recorder to capture the interview proceedings. Tape recordings enable accurate and factual data to be gathered from participants (Creswell, 2014). Soon after each interview was over, the researcher listened to the tape-recorded interview to check the audibility and completeness (Botma et al., 2010). The recorded interactions were used for verbatim, word-for-word transcriptions, which promoted the credibility of the study (Creswell, 2014).

Data analysis

Sub-objective 3 was to explore and describe the experiences of family of men diagnosed with PCa on the supportive care received from nurses in oncology departments. In a qualitative study, the search for important themes and concepts begins from the moment data collection gets underway (Polit & Beck, 2012). Under this sub-objective, the researcher adopted qualitative content analysis as a data analysis method. Polit and Beck (2012) define qualitative content analysis as an analysis of the content of narrative data to identify prominent themes and patterns among the themes. During data analysis, the researcher broke down the data into small units, coded and named the units according to the content they represented, and grouped the coded materials based on shared concepts (Polit & Beck, 2012). As was done under sub-objective 2, the researcher adopted qualitative techniques which were used to analyse words rather than numbers, as recommended by Botma et al. (2010), namely, finding, reading, coding, displaying, reducing and interpreting. The researcher searched for general statements about relationships among different categories of data by using the Tesch's eight-step coding process, as recommended by Creswell and Creswell (2018). Tesch's eight-step process involves breaking down, examining, comparing and categorising raw data. The researcher adopted this process due to its systematic approach and clear descriptions (Creswell & Creswell, 2018). The steps are described under sub-objective 2, Table 3.4.

3.4.1.4 Sub-objective 4: To explore and describe the experiences of nurses in facilitating supportive care for men diagnosed with PCa and their families in oncology departments

Design

A qualitative research design was employed in order to analyse the concept of the supportive care given to men diagnosed with PCa by nurses in oncology departments at the IHO. To explore and describe the nurses' perceptions, a phenomenological, exploratory, descriptive and contextual design was adopted. The phenomenological design generated a description of a phenomenon of everyday experience, allowing the researcher to understand the meaning of the experiences in facilitating supportive care for men diagnosed with PCa as they were lived by nurses (Holloway & Wheeler, 2010). Using an exploratory design, the researcher gained insight into a specific situation, in this study, facilitating supportive care for men diagnosed with PCa and their families in oncology departments. The descriptive part of this study entailed a thicker description of nurses in this situation (De Vos et al., 2011).

Population

The population of sub-objective 4 comprised nurses working in oncology departments at the IHO to which men diagnosed with PCa are admitted or followed-up.

Sample and sampling

A non-probability purposive sampling method was used to purposefully select information-rich participants, in this case, nurses working in oncology departments at the IHO. This was done in line with Botma et al. (2010), who clarify that, with purposive sampling, a particular individual is chosen because he/she is seen as knowledgeable or as an expert on the issues under study or the lived experience. According to Botma et al. (2010), the selection of participants should be based on reasons directly related to the research and not because people are easily accessible. In this study, 20 nurses working in oncology departments were interviewed until data saturation occurred.

Data collection

In-depth individual, face-to-face interviews, an interview guide, field notes and a tape recorder were used to collect data for sub-objective 4. Grove et al. (2013) define individual interviews as an interaction between the researcher and the participant where the data collector (researcher) questions a participant verbally. The researcher opted for in-depth individual, face-to-face interviews owing to their potential to generate in-depth information regarding the facilitation of supportive care for men diagnosed with PCa. Botma et al. (2010) recommend that an interview should open with introductory pleasantries, an explanation of the purpose of the study, the role that the interview plays in the research, the approximate duration of the interview, as well as the confidentiality of the data. First, the researcher organised a meeting with registered nurses working in oncology wards and departments at the IHO a month ahead of time, in order to explain the purpose and objectives of the study. Thereafter, special arrangements were made with regard to the time and dates of the interviews.

The researcher conducted 14 in-depth, individual, face-to-face interviews with registered nurses on their experiences of facilitating supportive care for men diagnosed with PCa and their families. Each interview started with a central question from the interview guide namely: "*Tell me about your experiences in facilitating the supportive care for men diagnosed with PCa and their families in oncology departments?"* During the interview, the researcher took field notes on the experiences, feelings and thoughts of the participants. Field notes are a short summary of observations made during data collection (LoBiondo-Wood & Haber, 2010). They present a narrative set of written notes intended to paint a picture of a social situation in a more general sense. In addition, the researcher followed the principles and basic skills for conducting interviews, including communication skills, probing, paraphrasing, observations and analysis. When responses lacked sufficient detail, depth or clarity, the researcher probed to complete or clarify the answer, or to request further examples or evidence (De Vos et al., 2011). According to Botma et al. (2010), the quality of the interview depends mainly on the skills of the researcher as a communicator. During the interviews, the researcher established rapport by listening attentively, showing interest and understanding, and showing respect for what participants were saying (Botma et al., 2010).

With permission from the participants, a tape recorder was used to record the interviews between the researcher and the participants in order to ensure the authenticity of the data (Tappen, 2011). Tape recordings prevented the loss of data which could be caused by possible distractions during the interview process. Verbatim transcriptions of the taped interview were made before data analysis (Grove & Gray, 2015).

Data analysis

Sub-objective 4 was to explore and describe the experiences of nurses in facilitating supportive care for men diagnosed with PCa and their families in oncology departments. As was done under sub-objectives 2 and 3, the researcher adopted qualitative content analysis as a data analysis method. During data analysis, the researcher broke down the data into small units, coded and named the units according to the content they represented, and grouped the coded materials based on shared concepts (Polit & Beck, 2012). Qualitative techniques used to analyse words rather than numbers, as recommended by Botma et al. (2010), namely, finding, reading, coding, displaying, reducing and interpreting were followed. The researcher searched for general statements about relationships among different categories of data by using the Tesch's eight-step coding process, as recommended by Creswell and Creswell (2018). This process breaks down, examines, compares and categorises the raw data. The researcher adopted these steps owing to their systematic approach and clear descriptions (Creswell & Creswell, 2018). The steps are described under sub-objective 2, table 3.5.

3.4.1.5 Sub-objective 5: To assess the oncology departments in terms of facilitating the supportive care for men diagnosed with PCa and their families

Design

Sub-objective 5 of this study was to assess the oncology departments in terms of facilitating supportive care for men diagnosed with PCa and their families using a quantitative research approach.

Population

The population for this sub-objective comprised oncology wards and departments at the IHO to which men diagnosed with PCa were being admitted or followed-up. The staff complement at the IHO comprised 352 nurses, and four oncology departments. A total of 324 PCa cases were registered at the IHO from 2013 to 2017 (MIS, 2017).

Sample and sampling

The sample size for this sub-objective was four oncology departments at the IHO.

Data collection instrument

A questionnaire comprising a five-point Likert scale with good psychometric properties, namely, validity and reliability, that fit the sample and population for sub-objective 5 was used to assess the oncology departments (Creswell, 2014). The questionnaire comprised a covering letter which provided details of the aims and objectives of the study and instructions on how to complete the questionnaire. The Likert scale contained a number of declarative statements with a number of response categories after each statement; namely, strongly disagree, disagree, neutral, agree, and strongly agree (Botma et al., 2010).

Procedure for data collection

The researcher made appointments with unit managers and nurses in the oncology departments to hand out the questionnaires. These were completed and collected by the researcher immediately upon completion. Participants were asked to indicate the extent to which they agreed or disagreed with certain perceptions pertaining to supportive care in each statement. This is in line with Gliem and Gliem’s (2013) recommendation that information gathered in the medical field, opinions and descriptions of people’s environments should involve the use of Likert scales in order to allow participants to indicate which of several responses choices best reflects their response to the item. The questionnaires contained six sections, each with declarative statements related to demographic characteristics of the respondents (Section A), oncology departments (Section B), training of nurses (Section C), health policies and guidelines on supportive care (Section D), information, education and communication materials (Section E), and monitoring and evaluation (Section F), as illustrated in Annexure E. The data collection process took place over a period of four months, December 2018 to March 2019. Measures to ensure the validity and reliability of the study are illustrated in Table 3.11.

Data analysis

De Vos et al. (2011) define quantitative data analysis as a technique by which researchers convert data to a numerical form and subject it to statistical analysis. In this study, statistical analysis was done to analyse the collected quantitative data from sub-objective 5. Data from questionnaires were entered into an electronic database and analysed using the Statistical Package for the Social Sciences (SPSS-26) software (De Vos et al., 2011). All data in the questionnaire were coded by giving each an alphabetical value before being entered into the database. All records were checked against the original data after data entry and data that were wrongly entered were corrected. Descriptive statistics were used to measure the means, medians and standard deviations. The findings of this objective are presented in tables and charts in Chapter 5.

3.4.1.6 Merging of the findings for the central concepts

Merging the data involves combining the quantitative and qualitative data by means of procedures such as a side-by-side comparison, data transformation, or a joint display (Creswell, 2014). In a convergent design, the two databases are considered to be independent and the data collection and analysis proceeds for each database separately. In this study, the researcher analysed the two databases separately and used the findings from the initial exploratory data to build quantitative measures (Creswell, 2014). As stated by Creswell and Creswell (2018), data analysis in a converged parallel mixed method design consists of the following three phases:

- *Phase 1*: analyse the qualitative database by coding the data and collapsing the codes into broad themes.
- *Phase 2*: analyse the quantitative database in terms of statistical results.
- *Phase 3*: integrate the two databases, by merging the results from both the qualitative and quantitative findings.

In this study, the researcher used a side-by-side approach to merge the two mixed methods databases (Creswell & Creswell, 2018). The merged data represent the best practices from sub-objective 1, which focuses on best practices pertaining to the supportive care of men diagnosed with PCa and their families by nurses in oncology departments, sub-objective 2 which focuses on the experiences of men diagnosed with PCa, sub-objective 3 which focuses on the experiences of families regarding the supportive care received from nurses and sub-objective 4 which focuses on the experiences of nurses in facilitating the supportive care of men, and sub-objective 5 which focuses on the assessment of oncology departments. The researcher first reported the qualitative findings and then compared them to the quantitative results to see the extent to which they did or did not agree with each other. The use of a side-by-side approach enabled the researcher to produce more complete and well-validated conclusions, as presented in Chapter 5 (De Vos et al., 2011). A side-by-side approach is referred to as such because the researcher makes comparisons within a discussion, presenting first one set of findings and then the other (Creswell & Creswell, 2018). The discussion of the findings led to the identification of the central concepts and the interpretation of the central statement that guided the development of the model for nurses to facilitate supportive care for men diagnosed with PCa and their families.

3.4.1.7 Pilot study

No matter how carefully a data-collection instrument is designed, there is always a possibility of error, and the surest protection against such error is pre-testing the instrument (De Vos et al., 2011). Bless et al. (2013) define pilot study as a small study conducted prior to a large piece of research to determine whether the methodology, sampling, instruments and analysis are adequate and appropriate. Pilot study is developed much like the proposed study, using similar subjects, same setting, same treatment, and same data collection and analysis techniques (Grove, Gray & Burns, 2015). In this study, the researcher piloted the self-administered questionnaire in three oncology departments of Windhoek Central Hospital (WCH). Five in-depth individual face-to-face interviews were also conducted with registered nurses in oncology departments at the WCH. The pilot study enabled the researcher to test whether the research instrument effectively measured what it ought to measure, and to eliminate bias in the study. It also enabled the researcher to determine the feasibility of the study (Polit & Beck, 2012). De Vos et al. (2011) caution that a pilot study can alert a prospective researcher to possible unforeseen problems which may emerge during the main study. The following challenges emerge during the pilot study.

- Some questions in the questionnaire were misinterpreted by the participants.

- Some participants' voices were not sufficiently audible in the tape-recording.

The pilot study enabled the researcher to refine the wording and layout of the data collection instruments and to prune the questionnaire to a manageable length. Similarly, information that emerged from the pilot study enabled the researcher to make a tentative estimate of the length and cost of the main study (De Vos et al., 2011). It also served as the basis on which the main study was built.

3.4.1.8 Communication techniques used during data collection

De Vos et al. (2011) caution that the quantity and quality of information exchanged during the interviews depends mainly on the skills of the researcher as interviewer. Poor interviewing skills, poor phrasing of questions, or inadequate knowledge of the participants' culture or frame may result in data collection that obtains few useful data. In this study, the researcher was confined to asking questions and recording answers during the interaction with participants, but also used the following key communication techniques in order to achieve a holistic understanding of the participants' experiences, namely:

Bracketing: Bracketing has to do with suspending or laying aside what is known about the experience being studied in order for the researcher to avoid misinterpreting the phenomenon as the participant experiences it (Grove, Gray & Burns, 2015). When bracketing, the researcher identifies his/her own personal biases and beliefs about the phenomenon and sets them aside in order to fully understand the participants' experiences. It is an exclusion of the researcher's prior assumptions gained through experience so that he/she may see and hear the topic under discussion with an open mind (Holloway & Wheeler, 2010). In this study, the researcher remained neutral with regard to conviction or doubt in the existence of the phenomenon under study, in this case, supportive care for men diagnosed with PCa and their families. Therefore, the focus was on participants' perspectives by authentically recording and transcribing the participants' lived experiences (Prinsloo, 2018). Bracketing commenced during data collection and continued through the data analysis process.

Active listening: De Vos et al. (2011) stress that interviewers should have superb listening skills. Active listening refers to a skill that enables the researcher to attentively listen to the participants in order to get them to elaborate on or clarify particular issues (Townsend, 2013). It is the key to a productive and effective interaction because it enables the interviewer to understand and clarify what is being said and to provide appropriate feedback. In this study, the researcher listened actively to both verbal and non-verbal messages throughout the interviews while participants were making their contributions, maintaining eye contact, and at times nodding his head, and keeping an open disposition throughout the discussion. Field notes were used to capture non-verbal messages from participants such as deep breathing, yawning, adjustment position on a chair, nodding the head in concurring with a point or shaking the head in disagreement.

Probing: Probing is meant to deepen the response to a question, to increase the richness of the data being obtained, and to give cues to the participants about the level of response that is desired (De Vos et al., 2011). It is a technique used to persuade participants to give more information about the issue under discussion. The methods of probing employed by the researcher to encourage participants to elaborate on their answers during the interviews are listed below:

Clarifying: Clarifying responses refers to asking a participant to clarify what he/she said (De Vos et al., 2011). In this study, the researcher endeavoured to obtain clarity on unclear or vague statements from participants by saying for example: "Could you tell me more about …" You seem to be saying". Clarification enabled the researcher to establish whether what had been heard was correct.

Encouraging: To encourage means to inspire the participant to pursue a line of thought (De Vos et al., 2011). During the interviews, the researcher encouraged participants to provide rich data by sharing their experiences, saying for example; "I find that fascinating. Tell me more …".

Patience/Allowing time for elaboration: It is important for interviewers to let the participant know that his/her comments are understood and valued (De Vos et al., 2011). In this study, the researcher gave participants sufficient to think about what they wanted to add before moving on to the next question. No participant was rushed during the interview.

Acknowledging: Acknowledging refers to repeating participants' answers to show attention (De Vos et al., 2011). The researcher acknowledged the participants' answers, by saying, for example: "Did you say …".

Procuring details: In case of a lack of details in participants' answers, the researcher asked further related questions in order to solicit rich information. This is called procuring details (De Vos et al., 2011).

Paraphrasing: Paraphrasing is a verbal response where the interviewer restates what the participant has said using different words but without compromising what was said (De Vos et al., 2011). In this study, the researcher used paraphrasing during the interviews when it was needed, restating what the participants had said without adding new ideas. Paraphrasing increased understanding and clarity to the researcher (Prinsloo, 2018).

Minimal verbal response: Minimal verbal response refers to one that correlates to occasional nodding. De Vos et al. (2011) stress that a participant must do 90% of the talking because an interview is not a dialogue, but an opportunity for the participant to tell the story. In this study, the researcher used minimal verbal response such as; “mmh …, yes…, I see” in order to indicate to the participants that he was listening (Townsend, 2013).

Focusing: If the participant strays into subjects that are not pertinent, the researcher should pull him/her back as quickly as possible (De Vos et al., 2011). During the data collection process, the researcher focused only on the questions related to the study topic, in this case, supportive care for men diagnosed with PCa and their families.

Observational skills: The condition of oncology departments in terms of facilitating the supportive care of men diagnosed with PCa and their families was assessed using observational skills. The researcher also used these skills to observe the expressions of participants during the interview process.

Summarising: Summarising was carried out after participants had described their experiences of supportive care for men diagnosed with PCa (Brink et al., 2012). The researcher summarised the discussions by emphasising only on the key concepts or main points while leaving out the less important points. Summarising allowed the participants to authenticate that the researcher had accurately understood the information provided during the interviews.

3.4.1.9 Definition of concepts

Related concepts were identified following the analysis of the two databases. The concepts identified were defined based on the five rules of definition as recommended by Copi and Cohen (2014). The five rules were applied as follows:

> *Rule 1:* A definition must indicate the core characteristics of the concept. To define a term using, as its specific difference, some attributes that are not normally recognised as its attribute, even though it may be a part of that term's objective intention, would be a violation of the spirit of this rule. The rule itself might best be expressed by saying that a definition should state the conventional intention of the term being defined.
>
> *Rule 2:* A definition must not be circular. If the definiendum itself appears in the definiens, the definition can explain the meaning of the term being defined only to those who already understand it.
>
> *Rule 3:* A definition must be neither too broad nor too narrow and it must not denote either more or fewer things than are denoted by the definiendum.
>
> *Rule 4:* Ambiguous, obscure, or figurative language must not be used in a definition. Ambiguous terms in a definition prevent it from performing its function of explaining the definiendum, and they do not provide an indication of what characteristics the concept needs to have.
>
> *Rule 5:* A definition should not be negative when it comes to affirmative. What a term does mean is what the definition seeks to provide.

3.4.2 Phase 2: Construction of relationship statements

3.4.2.1 Development of the conceptual framework of the study

Careful concept development is the basis of any attempt to describe or explain phenomena (Walker & Avant, 2014). In this study, the researcher adopted Dickoff et al.'s (1968) practice-oriented theory to guide the development of the conceptual framework. Concepts are clearly defined and described in terms of agent, recipient, context, dynamic, procedure and terminus. The conceptual framework formed the point of departure for the development of the model to facilitate supportive care for men diagnosed with PCa and their families at the IHO.

3.4.3 Phase 3: Description and evaluation of the model

3.4.3.1 Description of the model

The researcher developed the model based on the theory generation proposed by Chin and Kramer (2018). The five descriptive components, also proposed by Chinn and Kramer (2018), namely purpose, concepts, definitions, relationship, structure and assumptions, were used to describe the model. Each component of the model structure is described in terms of the way in which it contributes to the purpose of the model. The model is described in Chapter 7.

3.4.3.2 Evaluation of the model

The model was evaluated in accordance with the evaluation criteria proposed by Fawcett (2005) and Parse (2005), namely, historical evolution, significance, internal consistency, parsimony, testability, empirical adequacy, and pragmatic adequacy of the model. The researcher opted for Fawcett's evaluation criteria because they offer detailed mechanisms for analysing and evaluating the model. The application of the nursing model criteria is outlined in Chapter 7. The evaluation criteria are described as follows:

Criterion of historical evolution

According to Parse (2005), the historical evolution of the model refers to the details of the model development, including the philosophical and theoretical antecedents as well as the changes in the model over time. The criterion of the historical evolution of the model requires the researcher to give an account of how the model was developed, and state the philosophical and theoretical antecedents of the model. The application of the criterion of historical evolution of the model is illustrated in Chapter 7, Table 7.1.

Criterion of significance

The criterion of significance focuses on the context of the theory when justifying its importance for the discipline of nursing (Fawcett, 2005). The theoretical context refers to both the metaparadigm concepts of nursing and the philosophical assumptions of the theory. According to Fawcett (2005), the significance criterion is met when the meta-paradigmatic, philosophical and conceptual origins of the model are explicit, when the antecedent nursing and adjunctive knowledge is cited, and when the special contributions made by the model are identified. The application of the criterion of significance of the model in this study is reflected in Chapter 7, Table 7.2.

Criterion of internal consistency

The criterion of internal consistency focuses on both the context and the content of the model (Fawcett, 2005). This criterion requires all elements of the model's work, including the philosophical claims, conceptual model and theoretical concepts and propositions to be congruent. The internal consistency criterion also requires the concepts of the model to reflect semantic clarity and semantic consistency. According to Fawcett (2005), the semantic clarity requirement is more likely to be met when a theoretical definition is given for each concept. Similarly, the semantic consistency requirement is met when the same term and the same definition are used for each concept in all of the author's discussions about the theory. In addition, the internal consistency criterion requires that propositions reflect structural consistency, which means that the linkages between concepts are specified and that no contradictions in relational propositions are evident. The application of the criterion of internal consistency is reflected in Chapter 7, Table 7.3.

Criterion of parsimony

According to Chinn and Kramer (2018), a parsimonious model is conceptually simple, which means it contains few structural elements but accounts for a broad range of empiric experiences. The criterion of parsimony focuses on the content of the model (Fawcett, 2005). This criterion requires a theory to be stated in the most economical way possible without oversimplifying the phenomenon of interest. This means that the fewer the concepts and propositions needed to fully explicate the phenomenon of interest the better. The parsimony criterion is met when the most parsimonious statements clarify rather than obscure the phenomena of interest. The application of the criterion of parsimony is illustrated in Chapter 7, Table 7.4.

Criterion of testability

Testability refers to the extent to which the theory can be tested empirically (Fawcett, 2005). The criterion of testability requires that the study must have the ability to generate empirical evidence that can be confirmed or refuted. Descriptions of personal experiences may be used to evaluate the testability of the model. The testability criterion is regarded as the major characteristic of a scientifically useful model. According to Fawcett (2005), the criterion of testability also focuses on the content of the model. The approach requires the specification of an inductive, qualitative research methodology that is in keeping with the philosophical claims and content of the theory. The criterion of testability is met when specific instruments or experimental protocols have been developed to observe the model concepts and statistical techniques are available to measure the assertions made by the propositions. The application of the criterion of testability is illustrated in Chapter 7, Table 7.5.

Criterion of empirical adequacy

The aim of evaluating the empirical adequacy of the model is to determine the degree of confidence warranted by the best empirical evidence, rather than to determine the absolute truth of the model (Fawcett, 2005). The outcome of the evaluation of empirical adequacy is a judgement regarding the need to modify, refine or discard one or more concepts or propositions of the model. The data used to determine the empirical adequacy of a model may come from multiple individuals' personal experiences or similar experiences of several individuals. The criterion of empirical adequacy requires the assertions made by the theory to be congruent with empirical evidence. Similarly, the extent to which a theory meets that criterion is determined by means of a systematic review of the findings of all studies that have been guided by the theory. The application of the criterion of empirical adequacy is illustrated in Chapter 7, Table 7.6.

Criterion of pragmatic adequacy

Pragmatic refers to the way the theory is used in nursing practice (Parse, 2005). The criterion of pragmatic adequacy evaluates the theory's application in daily nursing practice (Fawcett, 2005). This criterion requires that nurses have a full understanding of the content of the model, as well as the interpersonal and intellectual skills necessary to apply it. It is therefore important to acknowledge the need for education and special training for nurses before the application of the model. The pragmatic criterion also requires that the model is used in the real world of nursing practice. The nurse must be in a setting that is conducive to the application of the model and have the time and training necessary to apply it. The cooperation and collaboration of nurses with other members of the healthcare team have to be secured (Fawcett, 2005). The pragmatic criterion also requires the theory-based nursing actions to be socially meaningful by leading to favourable outcomes for those who participate in the actions. The application of the criterion of pragmatic adequacy is illustrated in Chapter 7, Table 7.7.

3.4.4 Phase 4: Development of the guidelines to operationalise the model

The implementation of the model in the practical setting, in this case oncology departments, was made possible by the developed guidelines to operationalise the model to facilitate supportive care for men diagnosed with PCa and their families, based on the findings for sub-objectives 1, 2, 3, 4 and 5. Guidelines for operationalising the model are described in Chapter 8.

3.5 MEASURES TO ENSURE TRUSTWORTHINESS OF THE DATA

Trustworthiness in qualitative research refers to methodological soundness and adequacy (Holloway & Wheeler, 2010). It is the degree of confidence qualitative researchers have in their data (Polit & Beck, 2012). As sub-objectives 1, 2, 3 and 4 focus on the qualitative study, the four criteria for establishing the trustworthiness of qualitative data were adopted, namely, credibility, dependability, confirmability, transferability and authenticity (Polit & Beck, 2012). Other methods used by the researcher to demonstrate to the readers that the research is trustworthy include member checking, peer debriefing, triangulation, an audit trail, thick description and reflexivity (Brink et al., 2012). This is in line with Holloway and Wheeler (2010) who recommend that qualitative research should be evaluated by criteria that have been specifically developed for it. The application of different criteria is tabulated after the discussion that follows.

3.5.1 Credibility

Credibility corresponds to the concept of internal validity, since it seeks to convince that the findings depict the truth of the reality under study, or, in other words, that they make sense (Bless et al., 2013). It refers to confidence in the truth of the data and their interpretations (Polit & Beck, 2012). LoBiondo-Wood and Haber (2010) define credibility as the steps in qualitative research used to ensure the accuracy, validity, or soundness of the data. According to Du Plooy-Cilliers et al. (2014), credibility is enhanced when the researcher spends prolonged periods of time in the field with the participants in order to understand them better and gain insights into their lives. The more experience that a researcher has with participants in their settings, the more accurate or valid will be the findings (Creswell, 2014).

To establish the credibility of the study, the following strategies were employed: prolonged engagement, triangulation, member checking, peer review, an audit trail and thick description. Table 3.6 gives a summary of how the criteria for credibility were applied in the study.

Table 3.6: Application of the credibility criterion

Criterion	**Application to the study**
Prolonged engagement	As a lecturer who follows students during clinical allocation at IHO, the researcher often engages directly with men diagnosed with PCa. Good rapport and trust established with these men enabled access to thick descriptions. The researcher spent four months (December 2018 - March 2019) in the field interviewing men diagnosed with PCa, family members of men diagnosed with PCa, and nurses. Each interview took approximately 45 minutes to 1 hour. Data were collected until the point of saturation was reached.
Member checking	The researcher validated the credibility of the data through debriefing, discussions and replaying the tape with participants in order for them to confirm the accuracy of the themes and sub-themes (Polit & Beck, 2012).
Peer review/debriefing	Ongoing consultation with a colleague who is a qualitative research expert and a PhD graduate was done to review and explore various aspects of the inquiry.
External audits	The research findings were audited by an external auditor in South Africa who examined whether or not the findings, interpretations and conclusions were supported by the data.
Triangulation	Qualitative, explorative, descriptive, phenomenological and contextual designs were used. Individual interviews, field notes, observations and tape-recordings were used as methods of data collection to enrich the data. Various relevant literature sources were reviewed to ensure credibility. Mixed-methods research was used to seek convergence and corroboration of results from different methods and designs studying the same phenomenon (Venkatesh et al., 2016).
Audit trail	A systematic collection of records and documentation that allowed an independent auditor to come to conclusions about the data was done. Records collected include raw data, interview transcripts, data reduction and analysis materials, as well as drafts of the final reports.
Thick description	Complete and comprehensive transcripts of the interviews were provided. The sample and sampling procedures, data collection and analysis were described in the study.
Transcription of the interviews	The interviews were transcribed immediately after data collection took place to minimise the risk of misinterpretation.

3.5.2 Dependability

Dependability refers to the stability of the data over time and different conditions (Polit & Beck, 2012). It demands that the researcher thoroughly describe and precisely follow a clear and thoughtful research strategy. The researcher must show that each step has been completed thoroughly and carefully (Bless et al., 2013). A study is therefore dependable if the findings of the research would be similar should the study be repeated. Tappen (2016) defines audit trail as a carefully compiled record of the conduct of the research itself, the researcher’s thoughts and the decisions that were made along the way. Brink (2012) stresses that dependability requires an audit whereby the enquiry auditor follows the process and procedures used by the researcher in the study to determine whether these are acceptable.

In this study, the researcher demonstrated that the methods used are reproducible and consistent, and that the approach and procedures used were appropriate. Dependability was enhanced digitally by recording the interviews. The application of dependability in this study is reflected in Table 3.7.

Table 3.7: Application of the dependability criterion

Criterion	**Application to the study**
Dependability audit	The questions contained in the interview guide were reviewed by the study supervisor for relevancy before the actual data collection. An interview guide was first piloted to establish whether participants understood the questions and that the questions elicited appropriate discussions.
Triangulation	Qualitative, explorative, descriptive, phenomenological and contextual designs were used. Individual interviews, field notes, observations and tape-recordings were used as methods of data collection to enrich the data. Various relevant literature sources were reviewed to ensure credibility.
Peer examination	Research experts reviewed the study to establish whether the methodology used was adequate to address the research objectives, and whether the researcher discussed the implications of the findings (Polit & Beck, 2012).
Coding	The researcher analysed textual data gathered during data collection after which themes and sub-themes emerged. An external expert auditor verified the process and procedures used by the researcher to ascertain their applicability.

3.5.3 Conformability

Conformability refers to the criterion of integrity in a qualitative inquiry, referring to the objectivity or neutrality of the data and interpretations (Polit & Beck, 2012). Similar to objectivity, confirmability is the degree to which study results are derived from the characteristics of participants and the study context, not from the researcher’s bias. According to Weiten (2014), conformability guarantees that the findings, conclusions and recommendations are supported by the data and that there is internal agreement between the investigator’s interpretation and the actual evidence. According to Bless et al. (2013), conformability requires that other researchers be able to obtain similar findings by following a similar research process in a similar context. This is being supported by Du Plooy-Cilliers et al. (2014) who state that with conformability, other researchers who look at the data should derive similar conclusions as the researcher did. Table 3.8 depicts the application of conformability in this study.

Table 3.8: Application of the conformability criterion

Criterion	Application to the study
External audit	Rigorous review of interview transcripts was conducted. Codes were used to identify the themes. External auditing was carried out by an independent expert researcher in South Africa for relevance. Literature review was conducted in the study.

3.5.4 Transferability

Transferability refers to the degree to which a study's conclusions maybe applied in other settings, or to other people under similar conditions (Tappen, 2016). It is an extent to which qualitative findings can be transferred to other settings, as an aspect of a study's trustworthiness (Du Plooy-Cilliers et al., 2014; Polit & Beck, 2012). According to LoBiondo-Wood and Haber (2010), one mechanism for promoting transferability is the amount of information qualitative researchers provide about the study contexts. Therefore, the study should have enough details for one to evaluate the relevance and importance of the data. When a qualitative researcher provides detailed descriptions, the results become more realistic and richer (Creswell, 2014). In this study, transferability was ensured through a thick description of the methodology and the use of a purposive sampling (Creswell, 2014). Transferability was also addressed by relating the study findings to similar findings in the literature (Regan et al., 2015). Table 3.9 illustrates the application of the transferability criterion.

Table 3.9: Application of the transferability criterion

Criterion	Application to the study
Dense description	Thick descriptive data were provided in the research report for readers to evaluate the applicability of the data to other contexts.
Purposive sampling	The researcher employed purposive sampling in order to purposely select the participants who gave rich information about their experiences of the supportive care received from nurses.
Triangulation	Individual interviews, field notes, observation and tape-recordings were used as methods of data collection to enrich the data collection process.

3.5.5 Authenticity

Authenticity refers to whether participants' perspectives have been genuinely represented in the research (Tylor, 2017). It refers to the extent to which the researcher fairly and faithfully shows a range of different realities (Botma et al., 2010). Polit and Beck (2012) state that when a text achieves authenticity, readers are better able to understand the lives being portrayed in the round, with some sense of the mood, feelings, experience, language and context of those lives. A text is regarded as authentic if it invites readers into a vicarious experience of the lives being described, and enables readers to develop a heightened sensitivity to the issues being depicted. In this study, authenticity was applied as illustrated in Table 3.10.

Table 3.10: Application of the authenticity criterion

Criterion	Application to the study
Authenticity	Interviews were tape-recorded in order to capture participants' experiences on supportive care received from nurses in oncology departments. Field notes used were verified with transcripts. All transcripts were checked to make sure that they did not contain obvious mistakes made during transcription (Creswell, 2014). The report of the study contains the direct quotes from the participants depicting the lived experiences of supportive care received from nurses as described by participants in Chapter 4.

3.6 MEASURES TO ENSURE VALIDITY AND RELIABILITY

Validity in quantitative research refers to establishing how well measuring instruments measure what they purport to measure (Msweli, 2011). It is the extent to which the research is plausible, credible and trustworthy. Tappen (2011) defines validity as the property of a research instrument that measures its relevance, precision and accuracy. It tells the researcher whether an instrument measures what it is supposed to measure, and whether this measurement is accurate and precise. Content validity is an assessment of how well an instrument represents all components of the variable to be measured, and always precedes data collection (LoBiondo-Wood & Haber, 2010). This type of validity is usually used when developing questionnaires, interview schedules or interview guides. Internal validity checks ensure that the findings of the research have not been affected by instruments or procedures, and that they are results of the independent variable. Similarly, external validity refers to the extent to which research findings can be generalised to settings or samples other than the one studied. In qualitative research, external validity is often referred to as transferability (Bless et al., 2013). It examines the extent to which the results of the study can be generalised.

Face validity refers to when the instrument appears to measure what it is intended to, and is essentially based on an intuitive judgement made by experts (Bless et al., 2013). Construct validity measures the relationship between the instrument and the related theory, usually established over a period of time by several people instead of by the instrument's originator alone (Bless et al., 2013). Reliability is a measure of research quality, meaning that other researchers would expect to get similar results if they were to carry out the research in a similar manner (Matthews & Ross, 2010). It is the ability of the instrument to measure the attributes of a concept or construct consistently (LoBiondo-Wood & Haber, 2010). The application of the measures used to ensure the validity and reliability of the study is illustrated in Table 3.11.

Table 3.11 Summaries of measures used to ensure validity and reliability

Phase	Method and objective	Aspects of quality control	Means of quality control
1	Quantitative [Objective 5]	Content validity	The researcher conducted literature review, discussions and consultations with the study supervisor to evaluate the relevance of the questions to the subject. Checking of the questionnaire by the study supervisor, pre-testing, and coding of the question items by the statistician improved the content validity of the instrument. Items on which there was not 100% agreement were deleted, and wording was changed. All questionnaires were completed in the presence of the researcher who assisted with clarifying the questions to the participants.
		Face validity	Two university statisticians, who were not part of the study, reviewed the questionnaire and identified questions that were hard to interpret and answer. The questionnaire was also reviewed and evaluated by experts in the field of oncology. Statistical software was used for data analysis. Multiple logistic regression analysis was done to control for confounders.
		External validity	As all the participants and respondents in this study were taken from a single intermediate hospital, the findings of the study may not be generalisable to areas outside the study boundaries.
		Construct validity	Construct validity was established by incorporating the theoretical framework and scoping review on best practices for the supportive care of men diagnosed with PCa and their families. The questionnaire was reviewed by an expert senior researcher and the study supervisor to establish the relationship between the instrument and the related theories.

Table 3.11: Summaries of measures used to ensure validity and reliability (continued)

Phase	Method and objective	Aspects of quality control	Means of quality control
1	Quantitative [Objective 5]	Reliability	The questionnaire was checked by an expert senior researcher and a statistician for completeness, consistency and accuracy to ensure reliability before it was piloted. The questionnaire was refined repeatedly to establish reliability. The questionnaire consisted of simple instructions, organised and well-arranged logical questions, clear words that were easily understandable and free from jargon, and questions that led to misinterpretation were avoided. Cronbach's alphas (a correlation coefficient) are calculated to measure how closely related the set of questions (internal consistency of the research instrument) in a questionnaire are as a group (Chetty & Datt, 2015). The reliability coefficient of the study was 0.87, which was deemed acceptable (Field, 2013). This helped to determine the reliability of the data collection tool (questionnaire). The researcher self-administered the questionnaires in order to minimise the data collector bias. Display of personal attributes such as friendliness and support to all participants was ensured.

3.7 ETHICAL CONSIDERATIONS

Ethics is the branch of philosophy that deals with morality (Grove, Gray & Burns, 2015). A moral issue is concerned with whether behaviour is right or wrong, whereas an ethical issue is concerned with whether the behaviour conforms to a code or a set of principles (Bless et al., 2013). Research ethics are central to all research involving human participants, because there are some risks involved in every study especially where human subjects are involved (May & Holmes, 2012; Polit & Beck, 2012). According to Bless et al. (2013), the goal of research ethics is to minimise the risk to participants, therefore the researcher must ensure that the research plan can pass an ethical evaluation before a single participant is contacted. This study adopted the research ethical principles of the World Medical Association (WMA) as outlined in the Declaration of Helsinki (WMA, 2013). Table 3.12 depicts the application of the three ethical fundamental principles identified as relevant to guide the research involving human subjects, as recommended by LoBiondo-Wood and Haber (2010), namely, respect for persons, beneficence and justice.

3.7.1 Application of ethical principles to the study

3.7.1.1 Principle of respect for participants' rights and dignity

As human beings, all participants have legal and human rights. Respect for persons emphasises voluntariness (Jacobsen, 2017). It implies that no research project should in any way violate participants' legal and human rights during recruitment (Bless et al., 2013).

Participants must make an autonomous choice to participate or not to participate in the study (De Vos et al., 2011). Voluntary participation in a research project implies that participants have a full understanding of the possible risks involved. Similarly, participants reserve the choice to pose questions, as well as the privilege to request for clarification, to decline to give information, and to terminate participation (Nengash, 2020).

The principle of respect for persons is upheld in this study as follows:

The right to full disclosure

- Firstly, approval to conduct the study was sought from the School of Postgraduate Studies at the University of Namibia, the MoHSS, and the Regional Health Director of Oshana region.
- The researcher allocated ample time to explain to participants individually what the study and its objectives entailed and what was required of them in terms of participation, in order to obtain verbal informed consent prior to conducting the study (Bless et al., 2013; May & Holmes, 2012).
- Anonymity of participants and confidentiality of the data obtained were ensured.

The right to self-determination/autonomy

- Voluntary participation was ensured by explaining to the participants that they were free to withdraw from the study without the risk of penalty or prejudicial treatment (MacLean & Wilson, 2011).
- The researcher refrained from any coercion, deception or covert data collection (Leedy & Ormrod, 2010).
- Each participant was asked to sign an informed consent form, as an indication that they indeed grasped the processes of the study after these had been explained to them (Bless et al., 2013).
- All participants were treated in ways that respected their individual human dignity.

- No participant was forced, either overtly or covertly, to participate in the study (Bless et al., 2013).

3.7.1.2 Principle of beneficence

The fundamental ethical rule of social research is that it must bring no harm to participants (De Vos et al., 2011).

The principle of beneficence requires researchers to conduct research that is effective and significant in promoting people's welfare (Bless et al., 2013).

Beneficence imposes a duty on a researcher to minimise harm and maximise benefits by securing the well-being of the participants (Brink et al., 2012; Polit & Beck, 2012). It is therefore important for researchers to take an active role in promoting good and preventing harm in research studies (LoBiondo-Wood & Haber, 2010).

Jacobsen (2017) emphasises that researchers should make research procedures as minimally invasive as possible.

The principle of beneficence is upheld in this study as follows:

Freedom from harm

- The researcher protected the participants from harm and discomfort by ensuring that the benefits of the study outweighed the risks (Brink, 2010).
- The researcher did not conduct any medical or other physical experiments on participants (Matthews & Ross, 2010).
- No private or sensitive information that could harm participants emotionally was obtained other than that contained in responses to the research questions.

Competence of the researcher

- According to Bless et al. (2013) part of the principle of beneficence is the question of competence, thus the qualifications of the researcher are of considerable importance. In this study, the researcher holds a Master's Degree in Nursing Science.

3.7.1.3 Principle of justice

The principle of justice is based on the belief that all people should be treated equally (Bless et al., 2013). Justice implies being fair and impartial. Investigators have ethical commitment to maintain equity by applying reasonable criteria to choose people who ought to be incorporated or rejected from the research (Grove, Gray & Burns, 2015).

The principle of justice is upheld in this study as follows:
The right to fair treatment

- Participants were fairly selected based on the inclusion and exclusion criteria for the study and not because they were readily available or could be easily manipulated (LoBiondo-Wood & Haber, 2010).
- All participants were asked similar questions. Honesty and integrity were ensured in conducting the research (De Vos et al., 2011).
- No participant was discriminated against in this study on the basis of race, gender, disability, income level or any other characteristic (Bless et al., 2013).

3.7.1.4 Anonymity and confidentiality

Other important principles the researcher observed during the study included anonymity and confidentiality by not allowing any form of identification of the instruments or research reports that make it possible to link them to a specific person or institution (Bless et al., 2013; Jooste, 2010). Bless et al. (2013) emphasise that a participant's data must never be associated immediately and obviously with his/her name or any other identifier.

The principle anonymity and confidentiality were upheld in this study as follows:

Anonymity

- Anonymity was preserved by coding the data in a way that participants could not be identified in any presentations of the findings (May & Holmes, 2012).
- Information collected from the research was not shared with unauthorised individuals except the study supervisors (Guraya et al., 2014).
- The researcher ensured that participants' names and that of their oncology departments were not mentioned when audiotaping and reporting the results.
- The questionnaires collected from respondents were numbered so as not to include respondents' names.

- The researcher assured to all aspects of the research process, from the time that the researcher made contacts with potential research participants to the publications reports and findings (Bless et al., 2013).

Confidentiality

- The questionnaires and the transcribed individual interviews were filed and safeguarded in a lockable cupboard only accessible to the researcher.
- The researcher created an electronic file in a password-protected computer on which the electronic data (audiotaped recordings) were stored.
- The questionnaires, informed consent forms and transcribed individual interviews will be shredded after five years after the completion of the study.

3.7.1.5 Obligation to adhere to practices of scientific values

In addition to respecting the rights of the participants, the researcher must demonstrate respect for the scientific community by protecting the integrity of scientific knowledge (Polit & Beck, 2012).

Obligation to adhere to practices of scientific values was upheld as follows:

The researcher tried to be accurate and, above all, honest in everything he did throughout the study by avoiding the following activities:

- Fabrication, falsification or forgery
- Manipulation of design and methods
- Selective retention and/or manipulation of data
- Plagiarism
- Irresponsible collaboration

3.8 SUMMARY

This chapter presented a review of the research methodology and design adopted for the study. The study applied a qualitative, exploratory, descriptive, phenomenological and contextual design. The researcher followed a mixed method approach and its phases were clearly outlined in this chapter. Both phases were logically discussed with reference to the design, method, population, data collection and analysis. The researcher used reasoning strategies in processing and organising the ideas and in drawing conclusions in the research.

The measures used to ensure validity and reliability in quantitative research, as well as the measures used to ensure trustworthiness in qualitative research, were outlined. The next chapter presents the qualitative results of the study.

CHAPTER 4

PRESENTATION OF QUALITATIVE FINDINGS

4.1 INTRODUCTION

The previous chapter addressed the results obtained from the scoping review. This chapter describes the qualitative findings elicited from the narrative responses obtained through in-depth individual face-to-face interviews with 11 men diagnosed with PCa, seven family members of men diagnosed with PCa, and 14 registered nurses working in oncology departments at the IHO. Participants were selected by means of purposive sampling, based on inclusion criteria and informed consent was obtained prior to data collection. The in-depth individual face-to-face interviews were conducted in a private room and lasted for about 30 to 45 minutes each. An interview guide was used to guide the researcher during the interview in terms of probing questions. With the consent of the participants, a voice recorder was also used to capture data during the interviews. All the recorded data for each interview were transcribed verbatim. Data collection ceased when the researcher reached data saturation.

The interviews aimed to answer the three sub-objectives of the study, namely: (1) explore and describe the experiences of men diagnosed with PCa of the supportive care received from nurses in oncology departments, (2) explore and describe the experiences of the families of men diagnosed with PCa of the supportive care received from nurses in oncology departments, and (3) explore and describe the experiences of nurses in facilitating supportive care for men diagnosed with PCa and their families in oncology departments. The following themes and sub-themes were identified: two main themes and seven sub-themes for sub-objective 2, two main themes and four sub-themes for sub-objective 3, and four main themes and 12 sub-themes for sub-objective 4, as illustrated in Tables 4.1, 4.2, and 4.3 respectively. The description of qualitative results is presented in the form of verbatim quotes from the participants.

4.2 EXPLORING AND DESCRIBING THE EXPERIENCES OF MEN DIAGNOSED WITH PROSTATE CANCER OF THE SUPPORTIVE CARE RECEIVED FROM NURSES IN ONCOLOGY DEPARTMENTS [PHASE 1]

This sub-objective sought to explore the experiences of men diagnosed with PCa of the supportive care received from nurses in oncology departments. This part of the study comprised of 11 male participants within the age range of 69 to 83 years. Eight (8) men have been living with PCa at least for a period of 3 to 6 years, while 3 men endured PCa diagnosis for the period of 7 to 10 years. Only 4 men out of 11 were found to be literate. The following question gave direction to the collection of data in the individual in-depth face-to-face interviews: *"Tell me your experiences of the supportive care received from nurses after being diagnosed with PCa."* Through a synthesis, two themes and seven final sub-themes were arrived at from the results of both participants (men). Excerpts from the individual interviews were used to confirm the experiences of men as expressed during the interviews. Table 4.1 depicts the themes and sub-themes that emanated from the interviews.

Table 4.1 Themes and sub-themes on the experiences of men diagnosed with PCa on supportive care received from nurses

Themes	**Sub-themes**
Theme1: Participants expressed different experiences of the supportive care received from nurses	Therapeutic nurse–patient relationship during supportive care Unwavering supportive care from nurses Family involvement in treatment and decision-making
Theme 2: Different experiences of inconsistent supportive care from nurses	Lack of psychological supportive care from nurses Some feelings of lack of health information on PCa from nurses Discussions on sexuality rarely occur Lack of spiritual support

4.2.1 Theme 1: Participants expressed different experiences on supportive care from nurses

The essence of how men viewed their experiences of supportive care from the nurses in oncology departments is described under this theme. Most men expressed immense communication and unwavering supportive care from nurses. This is reflected in the following sub-themes:

4.2.1.1 Sub-theme 1: Therapeutic nurse–patient relationship during supportive care

Literature states that it is important for nurses to empower patients, yet work closely with them by continuously assessing and monitoring changes in their condition; only then will patients have the on-going ability to act as partners with nurses in managing their own care (Chan et al., 2018). Nurses should convey a sense of caring and reassurance in their physical support for patients with PCa. Nettina (2014) states that the responsibility for informing cancer patients about the care required after the diagnosis are made lies with nurses. In this study, men diagnosed with PCa expressed good nurse–patient relationships after being diagnosed with the disease.

The above experiences are supported by the findings of a study conducted by Kirknam et al. (2017) on men's perceptions of PCa diagnosis and care in Australia. This study revealed that sensitivity, consideration, and professional warmth on the part of nurses made a valuable contribution to patients' health and wellbeing. In support of the above findings, this is what some men participants had to say:

> *"Nurses informed me that prostate cancer can be treated and I shall be going to Windhoek for it to be burned. They explained it well and asked me whether I understand and I said I understand. God should just help us to work together with our nurses and doctors so that disease can get medicines that can cure it"* [P2].
>
> *"They informed me about the blood results for example at Engela they told me that the ranges were very high. Later, they further informed me that if I see my ranges around 8, 9, or 10 that means the infection is subsiding. It gave me courage because previously I was at 100, but now I am around 5"* [P9].

Literature has it that patients valued being given medical information about their diagnosis and the current state of their disease. Prognostic information about disease severity and progression is the key point of discussion during patient–physician interaction. This is in accordance with a study by Kandasamy et al. (2017) in which most PCa patients stated that information about survival rates specific to the severity of their PCa was important for their treatment decision-making. The study concluded that most patients were generally satisfied with the information they received from doctors and nurses.

Men diagnosed with PCa in this study supported the above stated studies by stating the following:

> *"I think the information that I was given in room 5 is fine and I also concur with it. They gave me good health information"* [P3].
>
> *"I am very thankful to one nurse who encouraged me and explained to me issues regarding the operation; that the operation is not that complicated therefore may not really take too much time. That is what encouraged me to make a decision of accepting the operation"* [P9].
>
> *"This is a good thing because when I initially came here nurses gave me a health information book, red in colour, and they asked me whether I know how to read then I say yes I know how to read. It was written in many languages including*

> *Oshiwambo therefore I read it in the language that I understand. I read it and the process made my treatment to be very interesting"* [P10].

In a study conducted by Krumwiede and Krumwiede (2012) about the lived experience of men diagnosed with PCa, men found comfort with consistent nursing care, communication, caring nursing attitudes, and the use of humour by nurses.

When asked what health information they remembered being told by nurses after being diagnosed with PCa, this is what some men had to say:

> *"Nurses informed me that I was diagnosed with prostate cancer and they also asked me whether I used to hear about prostate cancer then I said yes. They told me that prostate cancer is the disease which cannot be cured but it can be treated. They also informed me that I might need to be operated so that it cannot spread throughout the whole body, therefore I need to decide whether I agree to go for an operation or not"* [P9].
>
> *"Nurses said I shall be operated on my reproductive organ and remove my testicles. They asked me whether I agree and I said yes because I am sick. They also told me that if the testicles are removed I will just be fine and get treatment from their clinic here"* [P11].

The supportive care from nurses expressed by men in this study is supported by the findings of a recent study conducted by Chambers et al. (2018) about the experiences of Australian men diagnosed with advanced PCa in which men expressed that the best time to be connected with PCa nurses was at diagnosis, with continued access throughout treatment. Men regarded PCa nurses as being central to their care.

Men diagnosed with PCa supported the above findings by stating the following:

> *"I did not notice any problem so far. Both nurses and doctors are helping us well and I did not experience any problem until now as I am sitting here"* [P2].
>
> *"If feel good about nurses' support. I usually agree with what they are telling me such as not eating too much meat, they said I should just eat less because this condition does not like much meat, food with too much protein and that is what I do"* [P11].

In a study by Albaugh et al. (2017) about life after PCa treatment, most men diagnosed with PCa expressed deep gratitude towards their doctors and nurses for meeting with them for extended periods of time and answering all their questions and concerns patiently and in detail. Patients felt well-informed about all side effects, including the sexual side effects. This is in support of Kassianos et al. (2016), who stress that health information provision is an important component of interventions, aiming to support patients with a serious health condition after diagnosis.

4.2.1.2 Sub-theme 2: Unwavering supportive care from nurses

Carter (2014) defines unwavering supportive care as strong and steady support despite opposition or other problems. According to Nettina (2014), the supportive care that nurses should provide for men diagnosed with PCa includes supporting patients to gain some feeling of control over the disease and decisions, conveying a sense of caring during physical care, comforting patients when in pain, and helping patients and their families to set achievable goals. In this study, most participants expressed unwavering support from nurses after being diagnosed with PCa. The following quotations were evident to this:

> *"One day we arrived here from Windhoek very, very late and I met one nurse who works at the prostate cancer department whom upon seeing me took me and my young boy who was also not familiar with this hospital. That nurse brought us here, in 3B. When we arrived in this ward the nurses welcomed us and told us that we arrived at the time where patients have eaten already but in that same night they gave food and we eat. The next day the nurses took us to the consulting room where they also helped us well before we left to collect our medicines at the pharmacy. They informed us to go home and come back for our follow up. So, they really support us very well and I am very thankful to them"* [P10].
>
> *"When nurses do their work they do them kindly without mistreating patients. I have spent a night here for a day but I never see any nurse mistreating patients"* [P8].

The above expressions from participants are in agreement with Krumwiede and Krumwiede (2012) who state that having a trusted relationship with one's health provider has a significant impact on the men's comfort levels during their experience. In support of this, the following participant expressed the following:

> *"I even wanted to shake hands with nurses and I think next time I will give them hands. They really gave me very strong medicine for the cough as I was asking myself what type of cough it was without even producing sputum. I shall really have to go back to them to say thank you to them because the medicines that I usually use to buy have never did anything to my cough"* [P7].

Several participants expressed gratitude for the support they received from young nurses in the oncology departments. The support provided a sense of comfort and reassurance in their time of uncertainty. The following expressions are evidenced to this:

> *"I am lucky because I used to be attended to by young nurses and they used to ask me as you are just asking me now. Previously, I was not able to walk but now at least I can walk. I think they are trying their level best to prolong my life. They support me well"* [P5].
>
> *"Here I only come across with young nurses. I even told one of the young nurses that may God bless you. Our young nurses are having good manners"* [P4].

Similar comments were also made by the following participants:

> *"The supportive care I received while admitted were very good because most of the nurses that use to attend to me are the young ones. They talk to patients very well by asking how we slept in the night, and when the doctor comes they use translate to the doctors because we patients hardly understand some languages. So, I did not really had bad experiences with young nurses"* [P4].
>
> *"When I initially came here they gave me a health information book, red in colour, and they asked me whether I know how to read then I say yes I know how to read. It was written in many languages including Oshiwambo therefore I read it in the language that I understand. I read it and the process made my treatment to be very interesting"* [P10].

One of the participants had this to say:

> *"The supportive care that I got here at Oshakati and Windhoek was just in a good order and do not have any complaint being on hunger, thirst, or about how I was sleeping, no… [shaking his head] I did not meet any problem so far at all. Both my journey to and from Windhoek I did not discover any problem because I was*

> *handled like a newborn baby. I would like really like to thank them and I wish them to continue working in the same manner that they working now"* [P10].

The findings of this study reflect similarities with those of a research study conducted by Albaugh et al. (2017) about life after PCa treatment in which most men expressed deep gratitude towards their doctors and nurses for meeting with them for extended periods and answering all their questions and concerns patiently and in detail. Over 80% had received advice and support for screening, diagnosis, side effects and treatment after care. Men cited their confidence in the healthcare team as one of their reasons for a good recovery.

4.2.1.3 Sub-theme 3: Family involvement in treatment and decision-making

In this study, family refers to the group of people related by heredity, such as parents, children and siblings (O'Toole, 2013). The term sometimes is broadened to include persons related by marriage or those living in the same household, who are emotionally attached, interact regularly and share the same concerns for the growth and development of the group and its individual members. On the other hand, family involvement refers to facilitating the participation of family members in the emotional and physical care of the patient (O'Toole, 2013). In this study, men described the involvement of family members in their treatment and decision-making as follows:

> *"I was told to go home and come back with my wife, my child and one of my family members after three weeks. I came with all of them and doctor informed them about the operation, by asking them whether they do agree with the operation"* [P4].
> *"I was told to go and get my wife, so I come with her"* [P1].
> *"After being diagnosed in 2016, the doctor informed me to go call my wife so that he can explain the decision to her"* [P6].

De Moraes-Lopes and Higa (2014) stress that nursing care actions for men with PCa should start at the time of diagnosis when the patient, family members, especially partners must participate in deciding the best course of treatment. The following verbal expressions were made in support of this:

> *"He informed me to go get my wife, children and my grandchildren and when we came the doctor asked me whether I agree to be operated. From there he operated me but I did not experience any problem with the doctor. After I was operated I started urinating well without pain. Sometimes I feel some pain in here ... [pointing*

> *on the ribs] but all my doctors as well as nurses have supported me well and nobody mistreated me"* [P8].

Another participant with similar expressions had this to say:

> *"The nurse told me to come along with my wife so that she can give consent for my operation and sign as a witness. I brought my wife and we sit with the doctor and her without nurses" [P6].*

A participant who felt that he was ignored by family members after informing them of his PCa diagnosis had this to tell:

> *"Nurses also told me that I should talk to the family but when I tried to talk to the family they only say hmm ... hmm ... [shaking his head while looking down]. From there I just said to myself that there is no use of telling them and decided to go to Oshakati hospital"* [P3].

Bowen (2019) maintains that clinical interventions should adopt a family-centred approach. Patients should be aware of the choices and treatments available for their medical care, the potential outcomes of these choices and treatments, and have their personal values and families considered in decisions about their medical care.

4.2.2 Theme 2: Different experiences of inconsistent supportive care from nurses

In this study, inconsistent means not staying the same throughout (Hinkle & Cheever, 2018). According to Primeau (2017), supportive care is of particular importance in senior adults, such as older men with PCa, who may be especially vulnerable to treatment complications or side effects, particularly when their health status is impaired. Nettina (2014) states that the supportive care that nurses should render for men diagnosed with PCa includes supporting the patients to gain some feeling of control over the disease and decisions, conveying a sense of caring during physical care, and helping the patient and family to set achievable goal. In this study, most participants revealed having experienced inconsistent supportive care from nurses after being diagnosed with PCa. This is reflected in the following sub-themes:

4.2.2.1 Sub-theme 1: Lack of psychological supportive care from nurses

Psychological support refers to any activity that improves a person's ability to function under the extraordinary level of stress observed in the context of a critical event (Nettina, 2014).

The psychological support that can be given men diagnosed with PCa in the hospital includes relieving emotional suffering and reducing the long-term negative psychological effects suffered by men diagnosed with PCa. Psychological support enables men to cope more successfully with the hardship they face after being diagnosed with PCa. Almost every man in this study expressed lack of psychological support from the nurses after being diagnosed with PCa. The following quotes from men are evident to this:

> *"Not even for a single day I receive counselling ... no! No ... [shaking his head] I was not supported psychologically. Like me, I just have a feeling that it is better for me to die because I never get any counselling from the nurses, or just by them telling me where to go for counselling no ... [pulling his shoulders up]. I was never given any counselling"* [P1].
>
> *"I was not counselled, may be others. Nurses only use to come giving us medicines, while cooks give us food but I was not counselled. What is needed here is counselling when there is an opportunity. My wife also needs to be given counselling"* [P6].
>
> *"I was not counselled. I came here for few months but I never got counselled by nurses. I was just asking myself ... [taking a deep breath] what could be this disease that I might have? I was very concerned and start thinking too much consequently developing difficulty to sleep well"* [P7].

The above sentiments from the participants are supported by the findings of a study by Chan et al. (2018) about patients' perceptions of their experiences with nurse–patient communication in oncology settings that reveal that nearly 50% of newly diagnosed cancer patients and those with recurrent cancer do not receive adequate psychological support due to the inability of the nurses to pick up cues from patients or handle patients' emotions. The study also found a widespread belief among patients that nurses have little to do with providing psychosocial care, therefore patients have been observed to prefer to seek emotional support from family members and friends rather than from healthcare professionals. In support of the participants' statements, a study by King et al. (2015) about PCa and supportive care revealed that the psychological distress that many men with PCa experience is not always assessed or managed well. Literature also has it that cancer survivors are often left with symptoms, side effects and psychological concerns as a consequence of their treatment (Frankland et al., 2019).

In this study, most participants expressed a lack of understanding of the emotional impact of PCa by people who have not experienced the disease. Participants felt that there is a lack of empathy on the part of health professionals, leaving them depersonalised. The following quotes serve as evidence:

> *"Nurses told me that if I am not operated I will just die. That is all what the nurses told me. I did not get any counselling. I am just thinking that there is no use ... no ... no ... no ... it could just be better if they killed me. That is better. I am just praying to God that I should not commit suicide because I am having a wife. No, they only give me my health passport to go collect medicines from the pharmacy"* [P1].
>
> *"Aaa ..., noo ...[shaking his head] I did not come across any nurse who says let us sit and talk about this disease. No! At least for the nurses to say tatekulu who have been diagnosed with this disease and from now you should live like this or like that… noo… [shaking his head] I did not experience it"* [P6].
>
> *"I was only counselled by my two grandchildren who informed me to accept the diagnosis. They also counselled me not to fear for the removal of the testes because I already have children therefore there is no need for me to be concerned as an old man. I have accepted it in totality. I never saw nurses who came to me for counselling. They did not say anything about counselling since the time I was diagnosed* [P8].

Two participants had the following to say:

> *"Counselling was not brought under my attention. No, they did not give me any information. The doctor only informed the nurses that we should go home and we were asking ourselves that how can we go home without being healed but they just say we will get healed at home*" [P7].
>
> *"Noo… [looking down] I was only told not to think too much. No. I never seen a nurse coming to me talking to me like the way you are doing now. I have only seen students"* [P5].

As cited above, participants' experiences reflect that the healthcare delivery systems seem not to account for patients' needs. The following participants had this to say:

> *"Nurses did not give me counselling noo… [shaking his head] No counselling, noo… [raising his index finger on air]. What I noticed especially among the senior*

> *nurses is that, they like shouting to us patients. Such shouts use to make me feel sicker. I have noticed such bad behaviour among the senior nurses but the young ones use to talk to us very politely. But the senior ones… noo… [shaking his head] they like shouting at patients really. As a patient you are already sick and there comes a person shouting at you, until your condition go worse simply because of that. Noo…!"* [P4].
>
> *"Noo… noo… [shaking his head] I was never counselled in this ward. I was only counselled at Windhoek when I went to visit one of my friends who is also a patient and found them being counselled and I could not get out of the room because that is also want I wanted. So, I sat and listened. So, I was only counselled in Windhoek and I came back very satisfied from there"* [P10].

The above sentiments from participants are in line with the findings of a study conducted by Salomo et al. (2016) about the experiences of men diagnosed with PCa which found that men are rarely engaged in counselling processes. The study recommended that nurses need to become informed about the psychological issues affecting men diagnosed with PCa in order for them to meet their mental health needs accordingly. Zelders-Steyn et al. (2012) stress that it is important to identify men's supportive care needs, to understand how current care is experienced and to learn what perceived gaps there are in the healthcare provision from the patients' point of view before developing education and other supportive care interventions.

4.2.2.2 Sub-theme 2: Some feelings of lack of health information on prostate cancer from nurses

In a study by Carter et al. (2014) on healthcare providers' perspectives of the supportive care needs of men with advanced PCa, nurses reported delivering health information for men and being open to answering questions although they thought men were unable to retain the information provided. This does not correspond with the findings of this study as most participants expressed a lack of health information on PCa from nurses.

The following quotes are clear indications of what participants experienced as far as a lack of health information on PCa from nurses is concerned:

> *"No, there they did not tell me anything about this disease. Personally as I am here I cannot tell how I have acquired that disease and even last night in this ward we have been discussing about the possible causes of this disease with one man who is also a patient with this disease"* [P10].

> *"They only informed me that I am having prostate cancer, and that I only have to sign for an operation. We did not discuss anything with them about the disease. No, I was not given any information about that"* [P7].

One participant who seemed to be very disappointed with the lack of information from nurses regarding lifestyle after the diagnosis of PCa had this to say:

> *"They did not even inform me how I should behave or what I should eat while I am having this type of disease. They never advised on how I should be especially when I go home. They also did not tell me that there is also this and that …, no"* [P9].

In agreement with the above statements from participants, a study by Salomo et al. (2016) on the experiences of men diagnosed with PCa revealed that in most cases men diagnosed with PCa have been treated without being given health information about the disease. This is contrary to King et al. (2015) who stresses that nurse practitioners should eliminate all the indirect aspects of communication that undermine patients' trust. Nurses should be able to answer questions and clarify points in words that patients can understand.

In this study, some participants had this to say:

> *"Noo… [shaking his head]. Nurses did not give health information about this disease. No, they did not give me anything. The only health information the nurses told me was to drink a lot of water so that I cannot get allergic reaction. They said I also need to eat well and then drink a lot of water in order to avoid my blood from getting thick"* [P4].
>
> *"They did not talk about that, no… [shaking his head] they did not talk about it. Even my wife was not informed until now. I shall only inform her as from now on because the testes were only removed yesterday"* [P11].

Literature has it that vague or unclear information about cancer, its treatment and its life-threatening nature is frequently highlighted in research with cancer patients (Kandasamy et al., 2017). Poor communication with patients and partners is associated with psychological distress and lower satisfaction with care (Regan et al., 2015). In this study, participants clearly depicted the lack of health information on PCa from nurses in oncology departments in IHO.

The following excerpts are evidence of this:

> *"About the health information from nurses, I did not experience anything of that sort from the nurses. Maybe because of time that is why they did not tell me anything"* [P6].
> *"I was not even given any information on how helpful are the medication they gave me, unless may be they will do that during my next follow up on the 23 August. They did not tell me the information regarding the medications but only informed me that they will refer me to Windhoek"* [P7].

The above excerpts from the participant interviews are contrary to Searle et al.'s (2010) belief that nurses should always remember that silence about the patient's condition is frequently a traumatic form of communication, therefore patients need visible evidence that the nurse is concerned for their well-being. This concurs with the findings of a study by Albaugh et al. (2017) about life after PCa treatment in which men diagnosed with PCa emphasised the importance of education and comprehensive health information before and throughout the process of PCa treatment.

4.2.2.3 Sub-theme 3: Discussions on sexuality rarely occur

Sexuality refers to the feelings and activities connected with a person's sexual desires (Hornby, 2015). Sexual health is an important part of an individual's overall physical and emotional well-being, thus it is important for oncology nurses and specialists to assess men for psychological distress resulting from sexual changes and make appropriate referrals for managing the psychosocial aspects of sexuality. A study by Allchorne and Green (2016) on identifying the unmet care needs of patients with PCa found that healthcare professionals commonly make assumptions about patients' sexuality without asking them, therefore they are more likely to address clinical concerns than those related to relationships and intimacy. A similar study by Bowen (2019) found that the primary concern encountered by men with PCa centred on quality-of-life issues specifically incontinence and sexuality. The same picture was revealed by this study. The following statements relate to this phenomenon:

> "*No… [shaking his head], even to tell me that I may not be able to do sex as usual, no… [shaking his head], they did not say anything on that. I think with regard to the sexual issues they just assumed that I will find out for myself as the time goes… [laughing]"* [P7].

> *"With regard to the floppiness of the testicles and difficulty on having sex, they did not say anything about it may be because ...[breathing deeply], what else can I ask?"* [P7].

De Moraes-Lopes and Higa (2014) stress that nurses must assess and continually monitor levels of depressive symptoms, sexual function distress, marital interaction distress and any other indication of the need for psychological interventions in men with PCa. In contrast, a study by Nair et al. (2018) about the supportive care needs of multicultural patients with cancer found that the needs related to sexuality such as receiving information about sexual relationships and changes in sexual feelings scored low, 16.7% and 9.5% respectively out of 85% of the patients population surveyed. In a similar study by Flynn et al. (2012), the majority of men diagnosed with PCa did not receive the sexuality information they need from their oncology providers. The results of this study revealed similar findings. The following quotes serve as a testimony to this:

> *"They asked me whether I am married and I said yes, and then they only said I should not indulge in sexual activities any longer. That is what they kept on telling me without explaining further"* [P11].
>
> *"I am even having a wife at least I need to be informed how to be with my wife as a man with prostate cancer. My wife also needs to be given counselling"* [P6].

The findings of a study by Flynn al. (2012) revealed a similar situation where 78% of survey participants (men with PCa) expressed that it was important to have discussions with healthcare professionals about sexual problems. A large majority of men (64%) also thought it was helpful to include partners in discussions about their sex lives. The above findings are in accordance with Primeau et al. (2017) who highlight that the consequences of metastatic PCa and treatment side effects affect not only men but also their partners. Partners may experience unmet needs related to care burden, relationships or sexuality and psychological distress. In a study by Krumwiede and Krumwiede (2012) about the lived experiences of men diagnosed with PCa, most men felt more sympathy towards their spouses as they felt their spouses were the ones greatly impacted by the sexual dysfunction.

Flynn et al. (2012) emphasised that communication about sexuality with healthcare providers is important for a number of reasons. During and after treatment, patient–provider communication is critical to the identification and treatment of sexual problems that may be distressing for patients and impair their quality of life. One participant who felt devalued due to inconsistent nursing care and lapses in communication had this to say:

> *"One nurse has talk about that but did not go into details. She only asked me the number of children that I have and told her. She informed me that they will insert me with a pipe and said she does not know how I will use it because I might want to indulge into sexual activities with my wife. I said how can I do that in this situation? She never replies back"* [P10].

The above excerpt serves as a clear indication that critical information about the side effects of cancer treatment is not well communicated, leaving men to cope with negative, unexpected side effects and potentially long-term changes in quality of life. In agreement with the above sentiments, the study conducted by King et al. (2015) about men's experiences of support when diagnosed with PCa revealed that men reported having a difficult time talking to healthcare providers about sexuality-related issues and many reported not being asked by the nurses about it. A clear picture is revealed in a study by Regan et al. (2015) in which nurses and oncologists suggested that although they are often faced with distressed couples, they did not believe that providing psychological support was part of their role and were either reluctant to engage with couples or simply did not have the ability, time or resources to explore psychological issues with them. In a study by Regan et al. (2015), the provision of information was raised by couples as an area of improvement, particularly as it pertains to the emotional consequences of the diagnosis and treatment of PCa. Most couples preferred nurses to be completely transparent in the information provided about the disease and the likely outcomes. Nelson and Kenowitz (2013) stress that issues related to sexual dysfunction and intimacy should get consideration as the vast majority of men experience a change in sexual functioning and the impact can be severe.

Bowen (2019) stresses that clinical intervention regarding PCa should adopt a family-centred approach because studies indicate that 33 to 98% of PCa survivors report poor quality of life due to sexual dysfunction after treatment. According to Paterson et al. (2016), sexuality is an essential part of one's personality and cannot be separated from it, therefore when sexual dysfunction is persistent it often causes difficulties within the person and between couples. Pretorius et al. (2010) share similar sentiments, stating that it is very important for nurses to remember that when they deal with sexuality, they do not deal with one individual but deal directly or indirectly with a couple.

4.2.2.4 Sub-theme 4: Lack of spiritual support

The literature emphasises that spiritual beliefs and practices are found to relieve one's suffering (Berman et al., 2016). Spirituality is a dimension within an individual which encompasses the need to find meaning in life and a relationship with a supreme being (Mogotlane et al., 2013). The spiritual needs of the patient include the need for meaningfulness and the need for the expression of religion. In this study, one of the experiences expressed by men diagnosed with PCa was the lack of spiritual support. This was evidenced by the following quotes:

> *Sometimes the pastor use to visit our room but only focus more on patients who are very sick. He usually come and pray for them, sometimes accompanied by either family members or by nurses. As Christians, we also want the pastor to pray for us because we also belong to certain denominations. Yes ... [while smiling] it is really needed* [P3].

Another man had this to say:

> *I heard there is an ELCIN pastor in the hospital. I only use to see him passing by going to that room ... [raising his head while pointing to the neighbouring room]. Maybe he was called by the family members of these patients in that room. But, I think it could be good if the pastor can just pray for all the patients because we are all sick. As of now, we only get prayers from our family members who come to visit us. Why are the nurses not calling the pastor on our behalf as patients?... noo… noo… [shaking his head while looking down]* [P6].

In support of the men's statements, Mogotlane et al. (2013) maintain that holistic care in nursing includes giving spiritual care. The nurse has a responsibility to ensure that clients' spiritual needs are attended to, either through direct intervention or by arranging access to individuals who can provide spiritual care. Interventions may include expressions of feeling, prayer, meditation, reading and discussion with clergy or a spiritual adviser. Berman et al. (2016) state that the nurse should be instrumental in identifying the client's desire for spiritual support and notify the appropriate person.

When asked to describe the spiritual support they receive from nurses after being diagnosed with PCa, this is what some men had to say:

> *With regard to prayers, those of us who are not members of ELCIN seem not to be catered for. The pastor who is here belongs to ELCIN church only. I think we should also be considered on spiritual issues. Who will pray for us?… [smiling while looking up]* [P2].
>
> *My pastor stays far from this place. I will only be able to see him after being discharged from the hospital. I do not know whether nurses use to pray for patients in hospitals. If I get visitors may be they can pray for me. I am just on my own now* [P1].

The above excerpts are contrary to Mogotlane et al.'s (2013) assertion that the assessment of patients on admission should include a comprehensive history-taking regarding the patient's religious beliefs with regard to health and illness, in order to ensure that these beliefs and practices are taken into consideration when planning nursing care. The patient should be asked directly about his/her spiritual needs.

4.3 EXPLORE AND DESCRIBE THE EXPERIENCES OF FAMILY ON THE SUPPORTIVE CARE RECEIVED FROM NURSES IN THE ONCOLOGY DEPARTMENTS [PHASE 1]

According to Urden et al. (2018), the term *family* means whatever the patient states is the family. Røen et al. (2019) stress that despite the known positive effects of systematic cancer support, families still do not receive sufficient supportive care. Healthcare professionals should therefore prevent and relieve suffering in families of patients with advanced cancer. In this study, seven (7) family members of men diagnosed with PCa were interviewed namely: four (4) spouses aging between 46 to 57 years old, two (2) sons of 33 and 44 years old, and a daughter of 40 years of age. The following themes were identified during data analysis: a feeling of being devalued in the healthcare system and lack of privacy, as shown in Table 4.2 below.

Table 4.2: Themes and sub-themes on the experiences of family on the supportive care received from nurses

Themes	**Sub-themes**
Theme 1: Feeling of being devalued in the healthcare system	Lack of family involvement in treatment and decision-making Lack of psychological supportive care from nurses to families Lack of spiritual support for family
Theme 2: Non-conducive environment for counselling men	Lack of privacy

4.3.1 Theme 1: Feeling of being devalued in the healthcare system

The theme of feeling of being devalued in the healthcare system emerged after most family members expressed lack of family involvement in treatment and decision-making, as well as lack of psychological supportive care from nurses. In this study, devalue refers to giving a lower value to a person by making him/her less important that he/she really is (Hornby, 2015). The following sub-themes were identified by the researcher under the theme, feeling of being devalued in the healthcare system.

4.3.1.1 Sub-theme 1: Lack of family involvement in treatment and decision-making

Bowen (2019) maintains that effective shared decision-making in PCa requires clinicians to effectively engage and inform both patients and family members about the proposed treatment options. However, the findings of this study revealed that family members of men diagnosed with PCa expressed a lack of family involvement in treatment and decision-making by nurses in oncology departments. This is what some of the participants had to say:

> *"No, they did not involve us… [shaking her head]. And one thing I give fault to the nurses is that my father came here three times from the day he was diagnosed but none of them cared to talk to us or call a family member, they only did what they did. Luckily my cousin who is a nurse here she is the one who called us and informed us. So, they were supposed to at least ask the family member to come and tell us that no we found this tissue… [raising her hand up] or any term to describe something in the hospital before they say the word cancer"* [P1].
>
> *"Things were not really explained to us as a family but we were only told that he will be going for an X-ray. Later they informed us that he was diagnosed with prostate cancer. They did not really give us clear information at the beginning. At least I expected them to add more health information in order for me to know how to take care of him very well"* [P4].

The above excerpts are a clear indication that family members in this study experienced a lack of family involvement in treatment and decision-making concerning their loved ones. Røen et al. (2019) concur with these findings because in their study on supporting family members of cancer patients, family members were reported to be less satisfied with the coordination of care and involvement of family in treatment and decision-making. The study revealed that family support was hampered by a lack of education and by healthcare systems being tailored to the patients, and not to the family. The study concluded that there is a need for feasible models of family support to be included in clinical practice.

When asked about family involvement in treatment and decision-making by nurses at the oncology department, this is what some participants had to say:

> *"No, you only go there and visit your patient and came out of the ward without being informed of anything about your patient's condition. It was only one day when we were informed that he was diagnosed with prostate cancer"* [P4].
>
> *"They did not give me any health information on how we should take care of him at home at least where we can, no… [shaking his head]"* [P5].
>
> *"Nurses need to inform us as family members of these patients on how we should take care of them"* [P4].
>
> *"I need to be informed as to the time medicines should be taken, what time he should eat and that I see to it that he eat at all times"* [P4].

Similar to the findings of this study, in a study conducted by Røen et al. (2019) carers of patients with advanced cancer reported that not receiving personal attention from healthcare professionals complicated their grief, inducing feelings of anger and of being abandoned. Hinkle and Cheever (2018) stress that it is the responsibility of all nurses working in cancer care to involve the patient and their families as fully as possible in the process of clinical care and decision-making. Most family members interviewed in this study agreed with this and recommended that:

> *"It is good for the nurses to train people on how to take care of these pipes while at home. At least they should tell us that this pipe works like this… and this… [demonstrating with his hands], yes, at least we need such health information because that will enable us to remember what they informed us at the hospital for example cleaning it and so on"* [P5].
>
> *"Family members are the people who are close to the patient and supposed to support him right from the beginning. Nurses are simply the… the… [scratching her head] people in between the treatment even if they are the ones who are doing the work. Most of the support is supposed to come from the family who stay 24 hours with the patient"* [P1].

> *My final comments are that, I am just urging our nurses to help our patients well and to give us health information especially us who usually bring our patients at the hospitals. They should at least inform that patient with prostate cancer should be handled like this and this, yes, rather than just using our common sense. That is all I can add* [P5].

The above findings are in agreement with those of Greeff and Thiel (2012), who state that the family is the source of emotional and social support and therefore provides the context of adjustment in which the patient responds to the disease. Similarly, a qualitative systematic review of men's experience of and need for supportive care by Kirkman et al. (2017) found that the most valued form of support men experienced following diagnosis was from peers one-to-one and from partners. The study by Wang et al. (2018) about unmet care needs of advanced cancer patients and their informal caregivers found that the disease-related information needs were the most commonly reported unmet needs of informal caregivers. The study concluded that the unmet needs of informal caregivers are often ignored and excluded from healthcare planning.

4.3.1.2 Sub-theme 2: Lack of psychological supportive care from nurses to family

Family members of men diagnosed with PCa expressed a lack of psychological support from nurses. The following quotes from participants are evidence of this:

> *"No, I never got counselling. I need to be given counselling for example that my husband is being diagnosed with prostate cancer. At least I should be informed of the things that I should do as well as those that I do not need to do. Things like that are needed because some of the things are new to us, so we need to be well informed about them"* [P6].
>
> *"No, they did not give me any counselling. Most of the time nurses only give health information after being asked. I think there they are failing to give health information to the people"* [P5].

Nair et al. (2018) state that negative patient and family experiences can be a reflection of healthcare delivery systems that do not take into account patient and family needs. The psychological support provided for the people surrounding men diagnosed with PCa is very important, especially at the time of receiving a cancer diagnosis and undertaking treatment.

When asked to describe the psychological support they receive from nurses in oncology departments, this is what family members had to say:

> *"No, I did not receive any counselling. I did not receive counselling regarding my father"* [P1].
>
> *"No, I was never counselled. Counselling was never given to me"* [P3].
>
> *"No, I have not yet been counselled. Maybe they are still to give me some counselling. Counselling is needed at least for me to be made to understand especially about these things that I do not have an idea about. Yes, one really needs to be counselled"* [P6].

The concerns expressed by participants in this study are supported by Cheah et al. (2016) who stress that psychological support from the relevant qualified health personnel is important as it helps patients and family to cope with psychological and emotional stress. This is in line with a review of the psychological adjustment of female partners of men with PCa by Chambers et al. (2013) which concluded that partners report more distress than do men themselves.

4.3.1.3 Sub-theme 3: Lack of spiritual support to family

Cummings et al. (2018) describe spiritual support as an essential part of cancer nursing as it enables men and families to cope more successfully with the hardships they face after the diagnosis of PCa. Hinkle and Cheever (2018) stress that enquiring about family spirituality can enable the identification of possible support systems, as well as beliefs and customs that need to be considered in planning supportive care. Another simple assessment technique during supportive care is to enquire about the patient's and family's desire for spiritual support. Family members in this study expressed a lack of spiritual support after the diagnosis of PCa in their loved ones. The following quotes from the participants are evident to this:

> *"I heard there is a pastor in the hospital for patients only. Maybe he only use to pray for patients. As a family, we were not really spiritually supported in the hospital. Nothing….[shaking her head while looking up]"* [P1].

Other family members had the following to say:

> *"Spiritual support?... [leaning forward while shaking her head] Is there a church here in the hospital? We only come to visit our patient and never come across any spiritual support. May be it used to be given to the patients only"* [P4].
>
> *"I think that question should be directed to the patients because they are the ones who are sick and the pastor used to pray for them on their hospital beds. We as a family only come to visit our loved one. Pastors only pray for the patients but not for their family members. We go and attend our church at home"* [P6].

In support of the participants' statements, literature indicates that attention to the spiritual component of the illness experienced by the patients and family is not new within the context of nursing care, yet many nurses lack the ability or skills to assess and intervene in this dimension (Hinkle & Cheever, 2018). A spiritual assessment is a key component of comprehensive nursing assessment for terminally ill patients and their families. In agreement with the above sentiments, a study conducted in the United States of America (USA) found that many cancer patients and their families, even when not religious, feel it is appropriate for physicians and other members of the health team to enquire about their spirituality (Cummings et al., 2018). The study recommended that the patient's and family's spiritual needs should be met by establishing an empathic connection with patients and their families, by engaging with them in spiritual discussions or referring and introducing them to members of a spiritual team, when available.

4.3.2 Theme 2: Non-conducive environment for counselling men

This study revealed that the oncology departments in which men diagnosed with PCa are housed were not conducive for counselling. This was a concern raised by most family member participants in which they stated that overcrowded and dilapidated buildings make it difficult for counselling to take place unhindered. Participants also indicated their shocking experiences of seeing their family members (men) being counselled in overcrowded and noisy rooms. The following sub-theme was identified during the data analysis:

4.3.2.1 Sub-theme 1: Lack of privacy

Family members of men diagnosed with PCa who participated in this study revealed numerous experiences of lack of privacy in oncology departments. This was evidenced by the following accounts:

> *"I think the consulting room is not appropriate for counselling. I do not see any other better room specifically for counselling here"* [P5].
>
> *"Counselling was just done as we are now ..., there were about two to three nurses. I thought maybe that is how it should be because it was me, my grandmother and the three nurses. Should it be done like that?... I don't think so"* [P2].
>
> *"Rooms should at least reflect the hospital setting"* [P5].

When asked to describe their experiences of oncology departments in terms counselling men diagnosed with PCa, this is what some family members had to say:

> *"Nooo… noo… noo… [shaking her head], the rooms are not conducive for counselling. Rooms need to be improved for them to be up to standard because most the windows are broken and some of them are not even closing. Even the water taps are broken, there is nothing here"* [P7].
>
> *"These rooms really need to be renovated. Look at the floor [shaking her head while pointing to the floor]"* [P5].
>
> *"I don't think so [looking up] when people are coming here they want to be private. This is a department where by anybody passes by, so, I think a cancer department in the hospital should have its own area but not a place whereby anybody passes by and… [trying to think] you know... sometimes people like their things private. Listen to these noises... [pointing to the patient's room] .just listen ...* [P1].

In support of the above excerpts, some family members had the following to say:

> *"Look [pointing to one of the patients' rooms] the room is so overcrowded with patients. How can the nurses discuss a private issue with a patient in such a situation? Is that normal?"* [P8].
>
> *"Patients' beds are too close to each other. How do you engage a patient in a private conversation, really? How can one do that? [shaking his head]"* [P1].
>
> *"You never know what that other person is going to spread after that. Keep rooms for a specific patient and relatives only, but not a lot of people walking around and all that"* [P1].

Similar findings were obtained in a study by Chan et al. (2018) that revealed a crowded ward environment and background noise. The patients' beds were so close together that their conversations with nurses were easily overhead by their neighbours. The study concluded that the lack of privacy in the ward could discourage patients from engaging in any private conversations with the nurses.

4.4 EXPLORE AND DESCRIBE THE EXPERIENCES OF NURSES IN FACILITATING THE SUPPORTIVE CARE OF MEN DIAGNOSED WITH PROSTATE CANCER AND THEIR FAMILIES IN ONCOLOGY DEPARTMENTS [PHASE 1]

The results for this sub-objective were obtained from 14 registered nurses between the ages of 30 to 60 years old working in oncology departments at the IHO, namely: the Oncology Outpatients Department (OOPD), the Nuclear Medicine Department, the Oncology Ward (W 3B) and the Oncology Clinic. Nine (9) registered nurses had working experiences of at least 3 to 10 years, while five (5) had 11 to 25 years of working experiences in oncology departments at the IHO. Nine (9) registered nurses had Bachelor Degrees in Nursing Science, while five (5) were in possession of Masters Degrees in Nursing Science as their highest academic qualifications. Out of fourteen participants, only one (1) was male.

Non-probability purposive sampling enabled the researcher to search for information-rich participants who could illuminate the phenomenon under study, and who were knowledgeable about the question at hand, which in this study refers to supportive care (Lo-Biondo-Wood & Haber, 2010). This is in line with Du Plooy-Cilliers et al. (2014) who state that purposive sampling maximises the range of specific information obtained from a particular context, in this case supportive care. The following inclusion criteria were considered during purposive sampling:

- The participant should be a registered nurse at the Intermediate Hospital Oshakati.
- Participant should have worked in the oncology department for not less than two months.

The exclusion criteria include; registered nurses who have worked in the oncology departments of the Intermediate Hospital Oshakati for less than two months, as well as those who work at other hospitals than the Intermediate Hospital Oshakati.

The data collection process followed a qualitative approach, done mainly through individual in-depth face-to-face interviews with the aim of exploring and describing the experiences of nurses in facilitating supportive care for men diagnosed with PCa and their families. The researcher was actively involved in the process of collecting data in order to obtain an authentic insight into the participants' experiences. An interview guide was used as data collection tool to enable the researcher to maintain consistency with questions during the interviews and not to miss any questions that could enable the attainment of rich data (Creswell, 2014). The interviews started with a single, broad, well-planned question reviewed beforehand with experts in the field in order to ensure its appropriateness and applicability (Botma et al., 2010). The following central question was asked:

> *"Tell me your experiences of facilitating supportive care for men diagnosed with prostate cancer and their families in the oncology department".*

Probing questions were used to elicit more useful information than the participants volunteered during their initial reply. Probing involves repeating the original question, although sometimes it can be a long pause intended to communicate to participants that they should continue (Polit & Beck, 2012). In this study, the researcher encouraged more complete responses to open-ended questions by using non-directive supplementary questions, such as "What do you mean by that?", "Could you please elaborate more?", "What else would you like to comment on regarding the supportive for men diagnosed with PCa and their families?" The researcher ensured neutral probes that did not influence the content of the response, as recommended by Polit and Beck (2012). A tape recorder and field notes were used during the interviews in order to capture all the expressions of the participants, as recommended by Creswell & Creswell (2018).

According to Burns and Grove (2011), the number of participants in a qualitative study is adequate when saturation and verification of information is achieved in a study area. In this study, a total of 14 interviews were conducted before data saturation was reached. Data saturation is said to be reached when the ideas surfacing in the dialogue are ones previously heard from other participants (LoBiondo-Wood & Haber, 2010). It is the situation of having heard the themes before.

Table 4.3: Themes and sub-themes on the experiences of nurses on facilitating supportive care for men diagnosed with PCa and their families

Themes	**Sub-themes**
Theme 1: Nurses' experiences of different interventions for supportive care	Good multidisciplinary health team for supportive care for men Patient and family involvement in supportive care for men Use of basic knowledge as well as learning from others
Theme 2: Nurses perceive a shortage of resources and the lack of a conducive environment to	Shortage of resources (human and materials) to facilitate supportive care

facilitate supportive care	Unconducive environment for counselling due to a lack of counselling rooms
Theme 3: Nurses expressed different experiences with regard to the lack of support systems for men, family and community	Lack of support for men from the family Lack of knowledge on PCa among men and the community Men bearing the diagnosis of PCa (denial) Lack of spiritual support for men
Theme 4: Nurses' experience of barriers that influence the facilitation of supportive care	Lack of clinical policies and guidelines on supportive care Lack of support from hospital management and MoHSS for oncology departments Lack of trainings for nurses on supportive care

The process of data analysis resulted in the identification of central concepts from the main themes and sub-themes. Four themes and 14 sub-themes were identified and are presented in Table 4.3. In this study, themes serve as major findings in the qualitative part and displayed multiple perspectives from individual participants, supported by diverse quotations. The following abbreviations were used to identify the direct quotations from individual participants namely: participant number one [P1], participant number two [P2], and so on.

4.4.1 Theme 1: Nurses' experiences of different interventions for supportive care

Participants were asked to describe their experiences in facilitating supportive care for men diagnosed with PCa and their families in the oncology departments. Various interventions for supportive care emerged as the main theme, with three sub-themes namely: sub-theme 1: Good networking among multidisciplinary health team that facilitates supportive care for men; 2: Family involvement in supportive care for men; 3: Use of basic knowledge as well as learning from others.

4.4.1.1 Sub-theme 1: Good multidisciplinary health team for supportive care for men

Cancer is distinguished by its inter-professional and multispecialty model (Nevidjon, 2016). A multidisciplinary team is a group of healthcare workers and social care professionals who are experts in different areas with different professional backgrounds, united as a team for the purpose of planning and implementing treatment programmes for complex medical conditions. Voigt et al. (2014) stress that multidisciplinary disease management is increasingly advocated because it is associated with improved outcomes in PCa. During the interviews, participants expressed their experiences of effective networking among the multidisciplinary health team that facilitated supportive care for men diagnosed with PCa and their families in the oncology departments. A good multidisciplinary health team improves the care for patients and families with specific health needs.

Participants expressed the following regarding networking among the multidisciplinary health team:

> *"Sometimes if you as a nurse fail, we also make use of our chaplain in the hospital just to give that moral support… spiritual support because it is not easy… [breathing deeply while adjusting herself on a chair]. We normally call the chaplain here. You also bring in the doctor to support the patient more because what we are dealing with is a sensitive area, sensitive issue, therefore the patient cannot be helped by one person alone in treatment and the way forward"* [P4].

In support of the above excerpt, another participant stated:

> *"Our pastor is always available and always interested to be called on these cases although not only cases on prostate cancer, but, jaa… [looking up], if you brief him on that case he always attend and give some spiritual… [closing her eyes]… yes"* [P10].

Another participant expressed similar sentiments:

> *"When there is a need for counselling, we talk to the doctor and we also involve the social worker, so with the patient and family we go to that room… [pointing to the patients' room]. Sometimes you also have to involve the social worker to search for the patient's family"* [P5].

The above excerpts are a clear indication of nurses' experiences of the presence of an effective multidisciplinary team in the oncology departments. This is in agreement with Voigt et al. (2014) who point out that a horizontal management approach is more appropriate for aligning and integrating the different medical, supportive and management functions to achieve high medical and operational standards of care. Carter et al. (2014) maintains that supportive care delivery is complex and involves multiple health disciplines and people working in various agencies.

A study conducted by Crompton (2016) on the case for PCa units revealed that multidisciplinary PCa units provide a structure where urologists, radiation oncologists, medical oncologists and psychologists specialising in PCa collaborate to decide the best treatment and care options. According to Chambers et al. (2011), men who receive a multimodal supportive care intervention will have fewer unmet supportive care needs, and greater improvements in the quantity and quality of physical activities.

4.4.1.2 Sub-theme 2: Patient and family involvement in supportive care for men

Hinkle and Cheever (2018) indicate that it is the responsibility of all nurses working in cancer care to involve the patients and their families as full as possible in the process of clinical decision-making. During the interview, patient and family involvement in the supportive care for men diagnosed with PCa and their families was greatly emphasised by participants.

This is what some participants had to say:

> *"As nurses, we also try to integrate the family so that they know what is on the ground"* [P2].
> *"If the man is married, the wife has to be involved. If there is nobody, the children have to be involved if they are older people, not young"* [P4].
> *"We tell patients that if you have people come with them to the hospital so that we tell them how to take care of you"* [P5].
> *"We also have to talk to the family member because in some cases you tell the patient that this is what is going on but they don't get it. But if the family member tries to explain to the patient, the patient use to understand very well"* [P14].

Another participant supported this:

> *"We always tell patients to bring someone who can assist them when coming to the hospital so that they cannot suffer. So, we inform them to come with their relatives just to make them understand what is going to happen to them"* [P6].

This is what some participants commented when asked to describe how they involve family members in the supportive care of men diagnosed with PCa:

> *"I usually tell the family go and do this… [pointing to her right side without specifying what to be done] … try to do this … pointing to her right side], let him come for follow up… [looking up]. If the patient is not doing well bring him back to the hospital we are here, we are always here to nurse"* [P4].
> *"As a nurse, you give health education to the patients together with their families and show them how to care for the urine bag, this is how you have to take of … and if the patient is bedridden for palliative care, this is how you have to care for the*

> *person, this is how you have to care for the pressure sores, yes ... [raising her hands up] like that…"* [P5].

The literature emphasises that men with PCa and their families require education about how to manage the drainage system and to be aware of the signs and symptoms that should be reported to the primary provider (Hinkle & Cheever, 2018).

When asked how often nurses involve the family during the supportive care of men diagnosed with PCa, this is what they had to say:

> *"We tell patients that during the next follow up when you are back, come with your wife and two people as your next of kin so that we can explain to them of what is going to happen"* [P6].
> *"We do counselling for those who want their family members to be involved especially their partners. Some men might not have wives or partners but they might have someone either a daughter or a family member that they respect and know that this person is able to listen to my situation and is able to take care of me, so we try to include the person that is most close to the patient"* [P7].
> *"What we usually tell patients is that they need support, because once you are diagnosed with prostate cancer that is the time you most need somebody closer to you and during this situation is where the support is more needed. The same information that we give to the patients it is also the same information that is being given to the family"* [P9].

The content of the above excerpts are in agreement with Ulla-Sisko et al. (2018) who state that partners suffer negative changes in psychological well-being and may even report more cancer-specific distress than the patients; therefore better wellbeing in the spouse is likely to enhance the well-being of the patient. In a study by Regan et al. (2015), healthcare workers identified the value of extending psychological support to include both patients and their partners as a means of improving quality of life. Communication was also identified as having reciprocal value for patients and partners, as both benefited from discussing the impact that cancer was having on them and assisted couples in maintaining a strong relationship in times of crisis. According to De Moraes-Lopes and Higa (2014), the inclusion of partners and family members in the nursing care of PCa survivors is recommended because many of these family members become physically and emotionally ill in the process of caring patients after PCa treatment.

4.4.1.3 Sub-theme 3: Use of basic knowledge as well as learning from others

This sub-theme emerged as registered nurses spoke of reliance on the use of their basic knowledge as well as learning from others when facilitating supportive care for men diagnosed with PCa. This is evidenced by the following quotes:

> *"The only knowledge that I am using is just the knowledge from school when we were taught on that topic how to give health education with that condition. I just use the knowledge from the school and from my seniors"* [P11].
>
> *"The supportive care that I am giving might not be enough to the men although I am trying best to give what I have been taught and what I have seen others doing. I give what I have learned throughout my training or throughout what I have experienced when I worked with my colleagues"* [P12].

Other registered nurses expressed their lived experiences as follows:

> *"The knowledge that we have is just something that we picked up ourselves as we are working with patients on daily basis. We really need to be trained ... and [looking up] things like that [smiling]"* [P14].
>
> *"What we are doing now is just our general knowledge trying to apply to the situation"* [P5].

In a study by Cowens-Alvarado et al. (2013), on advancing survivorship care through the national cancer survivorship resource centre, primary care providers reported that they were not being fully informed about the scope of the cancer care, resulting in lack of consensus on the role of each provider in caring for cancer survivors. Only about one-half of primary care providers reported feeling comfortable and confident in their knowledge and skills in providing follow-up care for cancer survivors. The above findings are in agreement with the participants of this study who stated the following:

> *"Sometimes you ask yourself a question, is this really how I have to do it? Especially when you do not have a senior person in your unit, it is quite hard. You will be questioning yourself until such a time you will find yourself doing it better and until everything is going well"* [P5].

> *"I just get the experience from the specific doctors who are dealing with these patients. You see, I get it from the doctors just by seeing how they are doing it"* [P10].
>
> *"Sometimes you look at what other nurses are doing then you ask them, why are you doing that? Then they will tell you that we are preventing this and that to happen. Then you say ahaaa... [smiling] jaa. That is how we are just learning on the job. It is a bad experience... [shaking her head]. I mean it makes you feel incompetent. In fact you are incompetent because you have not being trained therefore no experience, but you learn even if it is difficult"* [P5].

In agreement with the above quotes, Grimes et al. (2014) recommend that countries introduce postgraduate specialised training programmes in oncology nursing, as nurses could only play a greater role in supportive care if their capacity were enhanced appropriately. Appropriate training and education could promote nurses' confidence in delivering quality cancer care services in all settings and along the cancer continuum.

Another registered nurse who expressed lack of knowledge on supportive care had this to say:

> *"You just try your luck to help the person who is in need you do not really know whether what you are doing is right or wrong. If there was a guideline maybe it would be better. We might not give supportive care which is needed but we try what we use to do and save some life. We were suggesting that there should be a cancer nurse"* [P3].

The above excerpts from the interviews with registered nurses are contrary to Bowen's (2019) findings which indicated that nurses involved in the care of men diagnosed with PCa require a thorough knowledge and understanding of the disease and its progression in order to confidently care for and support these patients. The literature emphasises that the provision of supportive care must be carefully targeted in terms of its content and the timing of delivery (King et al., 2015).

4.4.2 Theme 2: Nurses perceive a shortage of resources and the lack of a conducive environment to facilitate supportive care

Oxford Dictionary (2015) defines resources as things that you can use to help you to achieve something, especially in your work or study. In this study, participants were asked to describe the challenges experienced during the facilitation of supportive care for men diagnosed with

PCa and their families. A shortage of resources and a non-conducive environment in oncology units emerged as the most prevalent obstacles to the facilitation of supportive care for men diagnosed with PCa and their families.

4.4.2.1 Sub-theme 1: Shortage of resources (human and materials) to facilitate supportive care

Shortage of resources to facilitate supportive care for men diagnosed with PCa and their families were highlighted by the registered nurses participants. The following quotations are evidence of this:

> *"Aah… noo… noo… [shaking her head] ... aa... medication wise yes, we are having but let's say beds or wheelchairs or walking crutches… there they are neglecting us. We are only having high beds, you can go there and check for yourself ... [pointing to the patients' rooms with a smile], no wheelchairs for patients to go around because they are having problems with their legs, no walkers at least to have them ngaa… (at least) moving in their rooms. Aah ... [breathing deeply]"* [P3].

One registered nurse participant responded:

> *"We do not always have what we want. Like the doctor want to do biopsy but there is no biopsy needle. Sometimes patients use to go and buy because doctor himself is an expert in prostate cancer, but needs to confirm. Sometimes… this equipment is not always available. Really, we become frustrated... [shaking her head unhappy] and patients are frustrated. The family did not come to hear that they must buy this specific thing ... (referring to a biopsy needle) ... [raising her right hand up]"* [P4].

A study by Carter et al. (2014) on healthcare providers' perspectives on the supportive care needs of men with advanced PCa reveals that limited resources in clinical practices significantly impede healthcare practitioners' ability to provide optimal supportive care. The study suggested that members of the healthcare team should determine areas of improvement for patient care and what resources should be reallocated to make improvements. Similarly, a study by Catherine and Ghulam (2017) identified challenges in providing optimum supportive care and the identification of unmet needs due to limited resources in the clinical setting. The following statements are accounts of this phenomenon:

> *"Like now we are facing economic crisis countrywide and sometimes here and there we end up not having all the necessary resources that are needed for patients who are diagnosed with prostate cancer. The resources at this moment are very scarce. You find that most of the time we are running out of resources and it is your responsibility to order the materials and sometimes you find that there is no stock of*

> *such materials. It is quite a bit ahh… [shaking the head] sometimes the resources are not available, sometimes they come but sometimes they don't. You just have to try"* [P6].

Another registered nurse participant stated:

> *"Even the patients' medications are in shortage. Even food I do not think they are enough because people are just talking about money… money… [shaking her head while looking down] there is no money and the medications are now not available in adequacy"* [P8].

A registered nurse who was more concerned about infections due to lack of resources on supportive care in the unit stated:

> *"During that time, we were sorted because the urinary catheters were there, urinary bags were there and even the plasters and other things were there, but nowadays people are crying of the resources. Things are no more there... [raising her hands on air]. Lack of resources may also increase infections. Due to lack of resources patients may stay with a urinary catheter for even more than two months, because one may not be able to change this catheter because there is nothing to replace the one that was in use"* [P9].

During the interviews, registered nurses expressed experiences lack of resources to facilitate supportive care for men diagnosed with PCa. These were highlighted by the following statements:

> *"Uhhh… [shaking her head] there are a lot of challenges. There are a lot of challenges, sometimes lack of enough instruments like the introducer for the catheter. There was also a time where we did not have the suprapubic catheter pack. The other challenges are that uh… [shaking her head with eyes closed] even that set for doing irrigation because there is a specific irrigation to be done on the bladder so sometimes you may not find them, so that is also a challenge. There was even a time that a doctor took money from his own pocket to go buy the suprapubic catheter... [shaking her head]"* [P10].

Another registered nurse participant narrated:

> *"Sometimes you find yourself having the patient lying in your ward and there is something that you need to help that patient with, but you do not have it in your unit. We do not have a proper bed for example when you are caring for that patient you do not struggle. Sometimes you find yourself that the bed on which the patient is lying on is not good even for you who is caring for the patient or even for the patient himself. You cannot just reach what you want to reach because of the resources which are not available"* [P12].

In support of the participants' statements, a study by Paterson and Nabi (2017) on a model of consultation in PCa care revealed that nurses are confronted with challenges in providing optimum supportive care due to limited resources in the clinical setting.

4.4.2.2 Sub-theme 2: Non-conducive environment for counselling due to lack of counselling rooms

Apart from the lack of resources, registered nurse participants in this study also expressed the non-conducive environment in the oncology units as a hindrance to supportive care for men diagnosed with PCa and their families. The following expressions are evident to this:

> *"There is no conducive environment because, you are having like one room with ten men for oncology by then it sounds difficult to talk unless you are having a group talk. I think this people need a special centre just for them. Oshakati is now becoming a bigger place, even bigger than aa… aa…, the patients are more, so at least a centre for them, so that they will get more support. Conducive environment for counselling is one of the top number one, so that this people can be open with you. Sometimes you find that patient cannot express himself with you because ... not because of... [looking up] how do you call it ... not isolation but ... jaa.., privacy"* [P2].

Another registered nurse participant mentioned the following:

> *"The environment is not conducive as sometimes you talk to the patient while on this bed [pointing on her right side] there is one patient, and still on this bed [pointing on her left side] there is another patient. So, the environment is not really conducive for counselling patients"* [P1].

One registered nurse participant stated:

> *"Ahh… [shaking her head] the environment is just somehow and really not conducive because there is no proper room for us to give counselling to the patients. You will not feel good because at least you need a conducive environment where you can give health information to the patient at least where the patient can also feel free when you are talking to him"* [P12].

The above excerpts are in line with the findings of a study conducted by Chan et al. (2018) about patients' perceptions of their experiences with nurse–patient communication in oncology settings which revealed that a lack of privacy in a ward could discourage patients from engaging in any private conversations with the nurses. Similarly, the crowded ward environment, the background noises, and the distance between the patients' rooms and the nursing station were not conducive to communication. A study by Cheah et al. (2016) about the supportive care needs for PCa patients in Sarawak identified health and information needs as common needs among PCa patients. Patients obtain information regarding their disease and treatment during their consultation time with the doctors, however, due to limited time given and the consultation rooms which are not conducive to obtaining such information, many of the patients were unable to fulfil their needs. This is in contradiction to Nettina (2014), who emphasise that it is critical for nurses to ensure privacy, time and space for consultation before imparting significant information to men diagnosed with PCa.

4.4.3 Theme 3: Nurses expressed different experiences with regard to the lack of support systems for family and community

A support system refers to a network of personal and professional contacts available to a person for practical or emotional support. According to Renzi et al. (2017), the presence of supportive partners, relatives and friends for men diagnosed with PCa is a major resource in all phases of the cancer trajectory from diagnosis to therapies. A qualitative systematic review of men's experiences of supportive care by Kirkham et al. (2017) revealed that the most valued form of support men experienced following the diagnosis was from family members. Similar results were also found in a study by Krumwiede and Krumwiede (2012) in which all men indicated that the most significant emotional and physical support they received was from their family members. The support provided a sense of comfort and reassurance in their time of uncertainty.

When asked to describe their experiences on supportive care from family members for men diagnosed with PCa, the registered nurses in this study expressed different experiences with regard to the lack of support systems in terms of family and community. The following sub-themes were identified during data analysis:

4.4.3.1 Sub-theme 1: Lack of support for men from the family

Following the confirmation of PCa diagnosis, men submit to anticancer treatments of which the majority of these are complex and time-intensive, and affect a person's quality of life (Hinkle & Cheever, 2018). Therefore, as with other major illnesses, men newly diagnosed with PCa often turn to their wives or significant others for support (Ramsey et al., 2013). Oliffe et al. (2015) define support as helping people and being kind to them when they are having a difficult time. According to Krumwiede and Krumwiede (2012), the support that men diagnosed with PCa should receive from their families includes accompanying them to the hospital for treatment follow-ups, assisting with transport money, supporting the treatment decision-making made by men, encouraging them to adhere to their treatment as prescribed and to remind them about the next treatment follow-up dates.

When the registered nurses in this study were asked to describe their experiences regarding supportive care from family members for men diagnosed with PCa, their responses were in contrast to Krumwiede and Krumwiede's (2012) finding above. Most registered nurses experienced poor supportive care from the families of men diagnosed with PCa. This is evidenced by the following:

> *"The other challenges that I see are the relatives ... [shaking her head]. Some of these relatives if you call them for you talk to them about supportive care, some refuse totally, they refuse to come"* [P13].
> *"We can also talk to his wife as nurses or as doctors, some will come but some will not come my dear... [shaking her head] Never! You find yourself with a patient depressed and there is none of the family to assist"* [P13].
> *"Uhh… [breathing deeply while adjusting herself on a chair] for now I think the doctors have even realised that they are treating patients but even if they need families, families are just not there at all"* [P3].

Other registered nurses had this to say:

> *"Family members will ask you that when you are inserting a urinary catheter in a patient to go home with, who will do A and who will do B? These are the things.*

> *Some family members even say that the patient can stay in the ward and let him be your patient"* [P9].
>
> *"Another challenge is caring for the catheter. Some patients are with someone who is not even willing to help at home. You find the patient coming to the hospital saying ...noo... I just came alone as no one is willing to bring me. So, it is a challenge because even if you want to give health education, by giving to the patient alone when that patient comes back you will just clearly see that there is no care at home"* [P12].

One registered nurse, who indicated that a research study should be done in order to determine the contributing factors to the lack of supportive care for men from the family, had this to say:

> *"There is not much care at home. These things need to be followed up, a research should be done and see what is really wrong there at the homes. Why are they not supporting their family members?... Why?"* [P2].

Registered nurses who witnessed the rejection of men diagnosed with PCa by family members had this to tell:

> *"Some of the women say, aa...... what can I do with this paralysed man who has no money to and on a wheelchair? Although we talk to them they do not accept. We talk to them every time together, the man and a wife, some accept but some do not accept, that is what I observe with my eyes"* [P13].
>
> *"Yes, they will not come, or some children for that tate [referring to men diagnosed with prostate cancer] might come but some refuses to come. They will simply say when I was in school he did not support me, so why should I support him in such a condition?* [P13].
>
> *"Some wives say that they are too young and now they have a patient who is having a urinary catheter, so they are thinking about sexual intercourse that I said before. You hear them saying that they are going to divorce and look for another somebody who can satisfy their feelings"* [9].

The above excerpts clearly depict a lack of supportive care for men from family members diagnosed with PCa. This contradicts Krumwiede and Krumwiede's (2012) findings which stress that family members have a significant responsibility for providing physical and emotional care throughout the cancer trajectory. According to Van Vuuren (2013), an experience of rejection by loved ones has the effect of compromising the quality of a person's life and results in feelings of abandonment or self-loathing. Men diagnosed with PCa regularly require physical support particularly during the advanced stage of the disease. These include support with walking, feeding and bathing, and turning the patient while in bed. Misconceptions about cancer, stereotyping, fear of the unknown and lack of knowledge on PCa are among the contributing factors to rejection.

4.4.3.2 Sub-theme 2: Lack of knowledge on prostate cancer among men and the community

Nettina (2014) defines a lack of knowledge as a state of being uninformed. The knowledge of PCa that men and the community are expected to possess includes what PCa is, causes, signs and symptoms and prevention methods. Registered nurses in this study revealed a lack of knowledge on PCa among men and the community. The following excerpts are evidence of this:

> *"I do not think men do have knowledge. May be the one who have knowledge are the one who are in town, but we have people in rural area and I do not think these people are having knowledge because at many times when they come they are at a late stage meaning that they did not come on time because they do not have knowledge on prostate cancer"* [P12].
>
> *"No… [shaking her head] they do not have knowledge on prostate cancer, they do not even know whether the prostate gland is in men or in women"* [P10].
>
> *"I do not think they have too much knowledge on that, may be they only know that there is prostate cancer but the awareness for the condition need to be taken to the community so that they will know more about it"* [P11].

In support of the above excerpts from the interviews with registered nurses, a study conducted by Salomo et al. (2016) indicated that the men in the study diagnosed with PCa had never received health information from nurses regarding PCa despite their several follow-ups. Mogotlane et al. (2018) stress that providing health information to patients is a legal, moral and professional responsibility of all nurses.

This is what some registered nurses had to say when asked about the knowledge on PCa displayed by men and the community:

> *"Most of men don't have an understanding of what is going on, they don't understand even the family do not understand of what is going on. Prostate cancer is not known in the community at all"* [P14].
>
> *"I do not think men do have that information or knowledge on prostate cancer that it can also kill"* [P12].
>
> *"The community does not know prostate cancer as well, because patients are from the community. I think we need the information too much so that we can share"* [P8].

Similar comments were also made by the following registered nurses:

> *"I have seen only some, let me say only some... [looking up], as many of them they do not know, and that is what I said at the beginning that some of them they believe that they are witched but that one is not witching as it just a disease like others"* [P13].
>
> *"You come to the patient and you ask, what did the doctor say or what do you know about this condition? The patient will simply say I do not know anything"* [P11].
>
> *"When the person is diagnosed with prostate cancer and then you explain that condition to the patients, sometimes is like for the first time that they can hear that men can also suffer from such type of cancer, meaning that they were not even aware that there is prostate cancer on men side"* [P12].

When asked about their recommendations with regard to the lack knowledge on PCa among men and the community, this is what the registered nurses had to say:

> *"I recommend that at least the information should be given including the behaviour ... [yawning] the behaviour of individuals in the community with more emphasis on the prevention of this disease and the caring on how to care and the awareness of the whole issue of prostate cancer"* [P10].
>
> *"I think they need awareness in the radio for them just to know that regular check-ups is being done once a year at least for it to be diagnosed early and intervention can be done if it is possible"* [P2].
>
> *"What I want to add is only that, family members need to be made to understand about prostate cancer so that we can fight together about this disease"* [P1].

A study conducted by Nakandi et al. (2013) about the knowledge, attitudes and practices of Ugandan men diagnosed with PCa revealed that only 10.3% had good knowledge of the presenting symptoms of PCa, while 47.9% did not know any ways of screening for PCa. Literature suggested that in order to equip men with knowledge on PCa, healthcare workers should provide educational activities concerning PCa at the places where men congregate such as barber shops, sport stadiums and the workplace, rather than waiting for men to come to the health facilities (Nettina, 2014).

4.4.3.3 Sub-theme 3: Men bearing the diagnosis of prostate cancer (denial)

Nettina (2014) define bearing as to accept a difficult or unpleasant situation. Denial refers to a refusal to accept the unpleasant truth about a situation, or that something is not true or did not happen. The sub-theme of men bearing the diagnosis of PCa in denial emerged as registered nurses spoke of varied reactions expressed by men after the diagnosis of PCa. According to the registered nurses, some men were in a denial state while others were totally shocked by their diagnosis. The following statements are accounts of this situation:

> *"Here in the ward most patients are in the denial stage, sometimes you tell a doctor that I think the social worker need to intervene here. Aah… [breathing deeply]"* [P2].
>
> *"Most of the patients are in denial and do not want to accept that it is the diagnosis the doctor has given, so we have to take it up with the social worker"* [P14].
>
> *"Uhmm… when I say they don't accept their diagnosis they really say straightforward that I don't accept this"* [P5].

Most registered nurses expressed that denial was more prevalent among young men than old men. This was evident in the following accounts:

> *"When young men are told that they are having prostate cancer they think that that is it, because nobody told them that no is not the end of the world. So, after we talk to them, most of them use to understand and accept"* [P14].
>
> *"A younger person will be in shock, not really in shock but he can't understand why. But you must just tell them. It is a challenge"* [P4].
>
> *"Most men especially older people tend to agree quickly, but the young ones… ah… [shaking her head while looking down]"* [P1].

In support of the above, Nelson and Kenowitz (2013) stress that strategies for dealing with men waiting for a possible cancer diagnosis must incorporate the need to mitigate the adverse psychological consequences for this stressful event. The literature points out that the risk factors for higher distress include younger age at diagnosis, lower education and advanced stage disease (Chambers et al., 2013). The inclusion of specialist cancer nurses in the team is therefore likely to promote wellbeing.

When asked to describe the support care registered nurses give to men diagnosed with PCa and who are in shock and/or in denial, this is what nurse participants had to say:

> *"Those who are shocked by the diagnosis, we counsel them and when they come back for follow-up we check whether there is a change"* [P8].
>
> *"If they go in denial, we still have to convince them and talk to them but if we fail, the only option that we have to take is either to call or to refer to the social worker"* [P14].
>
> *"There are times you talk to the patient, you talk..., you talk..., and the patient still does not want to accept, so, that way it is not only the nurse but we call in people to intervene like the pastor or doctor"* [P11].

Similar comments were made by the following registered nurses:

> *"I remember one man came here, he did not really think of having prostate cancer, so you have to explain. He was thinking nooo... [shaking her head] it can't be. He was thinking of being witched, so we ended up involving social workers. I don't remember if he finally agreed to go for therapy or radiation. He was really not happy"* [P3].
>
> *"We do ongoing counselling by talking to the patients and referring to those other patients who has been in the same predicament"* [P7].
>
> *"We usually try to talk to them as most of them are going through emotions"* [P14].

The above quotes from the registered nurses are contrary to the results of a study conducted by Salomo et al. (2016) about the lived experiences of men diagnosed with PCa in the four northern regions of Namibia, in which men expressed a lack of psychological support from nurses after being diagnosed with PCa. Similarly, a study conducted by Evans et al. (2013) about men in counselling revealed a lack of engaging men in the process of counselling. The study urged nurses and counsellors to become conversant with the issues affecting men so that they may better serve their mental health needs. Psychological support enables men to cope more effectively with the hardships they encounter following the diagnosis of PCa.

4.4.3.4 Sub-theme 4: Lack of spiritual support for men

Spirituality is defined as connectedness with self, others, a life force, or God that allows people to experience self-transcendence and find meaning in life (Hinkle & Cheever, 2018). Spiritual support for people with chronic illnesses includes humour, faith healing, guided imagery and positive affirmations. Cummings et al. (2018) maintain that spiritual support in oncology must be addressed with utmost respect, taking into account individual and cultural differences in patients' preferences, beliefs and rhythms. Supporting someone through this requires the nurse to be available, but not to impose any preconceptions or to impose their own. In this study, registered nurses expressed a lack of spiritual support for men diagnosed with PCa. The following two participants' statements are evident to this:

> *"The situation on spiritual support is that, you first have to talk to the patient to ascertain whether he is a Christian. You may say I am going to call a pastor and the patient refuse simply because he is not a Christian at all. In that case… [taking a deep breath while looking up] there is less one can do. So, you simply have to leave it there"* [P9].

Another two nurse participants had this to say:

> *"In most cases we always talk to them. If we did not manage to get a pastor, we simply refer them to the social worker. Here we are only having a pastor for ELCIN"* [P14].
> *"If we do not find the pastor, we just push everything to the social workers"* [P10].

The above statements from participants indicate a lack of spiritual support for men diagnosed with PCa. This is of contrary to Hinkle and Cheever (2018) who emphasise that it is important that the spiritual beliefs of patients and families be acknowledged, valued and respected because spiritual support helps people to discover a purpose in life, understand the ever-changing qualities if life, and develop their relationship with God. This is supported by Cummings et al. (2018) who points out that spiritual support serves as a component of hope, and patients and families often find comfort and emotional strength in their religious traditions or spiritual beliefs, especially during chronic or terminal illness.

When asked to describe their experiences of spiritual supportive care for men diagnosed with PCa and their families, this is what some one of the nurse participants had to say:

> *"Some men refuse to be given spiritual support because they believe that they are being witched. So, we just leave them… [laughing]"* [P13]

Another nurse participant had this to say:

> *"I do not recommend other churches here… [shaking her head while raising her right index finger up] except Catholic, Elcin and Anglican churches. These ones I think can help, but others noo… noo… noo… [shaking her head]. Some churches are just making waa… waa… waa…[referring to making noise]. No, I do not allow!"* [P8].

The above excerpts are contrary to Hinkle and Cheever (2018) who holds that access to spiritual support is an important aspect of cancer care, therefore supporting a patient through this requires the nurse to be available but not to impose any preconceptions or their own spiritual beliefs. Nurses require an understanding of their own beliefs and spirituality, a degree of self-awareness, and an ability to learn and grow in response to the experience of suffering in others. Cummings et al. (2018) stress that dedicated physical spaces where patients' spiritual concerns can be discussed and addressed separately from clinical issues should be established in hospitals.

4.4.4 Theme 4: Nurses' experiences of barriers that influence the facilitation of supportive care

A barrier refers to an obstruction, obstacle or blocking agent. It also refers to anything that prevents progress or makes it difficult for someone to achieve something (Hinkle & Cheever, 2018). A study by Carter et al. (2014) about healthcare providers' perspectives on the supportive care needs of men diagnosed with advanced PCa reveals a variety of barriers in meeting such supportive care needs, including a lack of management strategies, poor knowledge among healthcare workers and the "old school" nature of men diagnosed with the disease. In this study, it was found that nurses do not provide effective supportive care for men diagnosed with PCa and their families as they are not fully knowledgeable or informed about the scope of PCa care. The study also identified a lack of comprehensive clinical guidelines to inform supportive care in oncology departments. The following sub-themes were identified under the barriers that influence the facilitation of supportive care as experienced by registered nurses participants.

4.4.4.1 Sub-theme 1: Lack of clinical policies and guidelines on supportive care

Registered nurse participants expressed how the lack of policies and guidelines hinders the facilitation of supportive care for men diagnosed with PCa and their families in the oncology department. This lack of guidelines results in inconsistencies when facilitating supportive care. The following excerpts from the interviews with the registered nurse participants are evidence to this.

> *"The lack of guidelines is impacting us in a negative way because if we have something or a guideline that is showing you that this is how you should do it… [yawning]. I mean that from this stage you do like this. As of now we are just doing things haphazardly as we do not know the order of should things be done. We are doing not so well without guidelines. We are just relying on the doctors by asking them whatever we are doing. We do not know whether it haphazard or it is correct but that is how we do it"* [P5].
>
> *"I worked here for 2 years now but I have never seen… [laughing] a policy or a guideline regarding prostate cancer. Not even a pamphlet that say men at this age should go for screening, I did not see anything. Noo… noo... [shaking her head]"* [P5].

According to Resnick et al. (2015), guidelines for PCa care are developed by an expert workgroup composed of multidisciplinary experts specialising in the care of patients with PCa and the treatment of long-term and late effects experienced by PCa survivors, thus assisting healthcare providers in clinical decision-making. In this study, this was found to be in agreement with nurses participants who expressed the following:

> *"It is not an easy situation of doing something where you are not guided. Even the SOP, Standard Operating Procedures, is not there for that specific case even if the doctor is not there, so… [taking a deep breath], it is just like that … [shaking her head]"* [P9].
>
> *"It is very challenging as sometimes you find yourself stuck. No guidelines... [shaking her head]. As I speak now, we are just being told that if cancer is at a*

> *certain stage the next thing is what… but we do not know whether we are following the guideline”* [P5].
> *“To tell you the truth, I cannot really describe any guidelines that I have seen. I really do not ... aa… aa… I have not tried to do any research or any study of finding out but I have just experience handling people with my own experience not necessarily by finding or by following guidelines”* [P7].

Other registered nurses participants shared their concerns by expressing the following:

> *“Uh… [raising her hands on air] aaye ... to be honest, I did not see any guidelines or policies available specifically for supportive care you provide to men diagnosed with prostate cancer and their families. No, I never saw any guideline on that”* [P9].
> *“I am even surprised that you are asking about these guidelines because I never heard about them. I did not know, I just do not know whether there is a guideline for prostate cancer”* [P11].
> *“Up to now we do not have policies. Having outdated policies might be better, but not having policies at all like in our case ... aiyeee… noo… [waving her index finger in the air while shaking her head]. That is a sign that you cannot expect anything soon”* [P3].

In support of the above excerpts, this is what other registered nurses had to say:

> *“Yes, there are policies for other conditions, but specifically to prostate cancer even if there is I would not even say I have been ignorant to check on them but noo… there is nothing”* [P2].
> *“The way I see it, prostate cancer is not regarded as something to… how do I put it… it is not in the same category with other diseases but it is a bit far from others. If you just go to any certain ward and you ask for the guidelines example for malaria, everyone knows about it or you ask any guideline for TB anyone will sing that song but not for prostate cancer”* [P11].

One registered nurse had this to say:

> *“Maybe the guidelines are there on the other side where they normally spent most of their day but for us we are only dealing mostly with their treatment. Yes* [P2].

Shallwani et al. (2019) define clinical guidelines as systematically developed statements to assist practitioner and patient decisions about appropriate healthcare for specific clinical circumstances. Relevant guidelines are valuable in guiding cancer survivors, caregivers and health professionals on appropriate care after cancer diagnosis and informing the development and implementation of evidence-based interventions in clinical practice. Moreover, these knowledge tools are useful in identifying gaps in the evidence base and guiding future research. A study by Grimes et al. (2014) on new models for elevating practice and the status of community-based nursing across the spectrum of cancer care has recommended the introduction of policies which provide nurses with the resources and the necessary empowerment to educate patients and their families about PCa. Nurses could be particularly effective, given that physicians often do not have sufficient time to empower patients and their families. Community nurses were identified as instrumental in this regard. For example, the National Comprehensive Cancer Network (NCCN) in America has guidelines that address PCa treatment and surveillance for recurrent disease, as well as general survivorship guidelines for managing certain late effects that affect PCa survivors (Skolarus & Wolf, 2014).

4.4.4.2 Sub-theme 2: Lack of support from hospital management and MoHSS for oncology departments

The findings of this study revealed a lack of support from hospital management and the MoHSS for oncology departments. The following excerpts are evidence of these findings gleaned from registered nurses participants:

> *"I feel like we are not getting enough support from the hospital management. They tell us that our unit does not have a lot of work… [shaking her head]. I don't think they do care with us from the administration… [shaking her head]. We do not allow their words to discourage us. I am telling you even if we have only three nurses at this ward and you have three nurses at other wards they just come and take one nurse to go to other wards as if there is no work here. That is how they do it"* [P5].
> *"I do not think the management give us much support. If you have not worked there and you did not experience how difficult it is then you cannot act quickly, as I said I worked here but things are not changing... [shaking her head]. They are not supportive that is why they even remove the staff who are allocated here and shift them to other departments. If they were supportive enough, they could have left the staff members. You find that staff members who are having experiences for example*

> *by doing irrigation are being shifted to the medicine departments where there are no patients that requires an irrigation… [shaking her head]… no, they are not supportive. Nurses will be demoralised to stay there and they cannot even enjoy their work because they are just under pressure…., yes [nodding her head]"* [P10].
>
> *"I do not think the ministry see prostate cancer as anything that needs policies and guidelines. I mean ministers, ministry system… [shaking her head] they are not helping us that much. Even if you complain nothing is coming up so… [shaking her head]. Hospital management or Ministry should recognise that prostate cancer is just a disease like any other disease. I think it will be very helpful for us to have policies or guidelines where we can base our supportive care"* [P3].
>
> *"Our seniors should show interest in this matter. They are not showing interest in this matter [shaking her head] … aa… aa… I don't think they show interest"* [P4].

Lack of support and caring is described as ignorance evidenced in a lack of specific supportive role behaviour from hospital management (Malatji et al., 2017). Additionally, support from managers is acknowledged as contributing greatly to staff morale. Cummings et al. (2018) stress that supporting oncology nurses is vital to ensure people with cancer are appropriately cared for and guided through their individual journeys in a time of utmost need and vulnerability. According to a study Malatji et al. (2017), adequate and efficient staffing patterns are not only essential for providing quality care, but are also important for healthcare providers' job satisfaction, prevention of burnout syndrome and work-related stress. Some nurses constantly complain about staffing patterns and verbalise their dissatisfaction with the issue of staffing patterns and state that it should be addressed by management and policymakers as this is not only a problem for the nurses but also affects the quality of patient care.

Staffing patterns refers to the numbers and categories of staff assigned to the unit. A study by Miguel et al. (2014) about establishing cancer units in low or middle income African countries revealed that nearly 8 million of people die of cancer every year, but many of these deaths can be avoided with increased government support, and funding for prevention, detection and treatment. In a study by Malatji et al. (2017) on nurses' experiences regarding staffing patterns in surgical wards, nurses identified management support and caring with regard to staffing patterns as essential to a healthy environment in order to deliver quality care. Participants alleged that they experienced a lack of management support with the current staffing patterns and staff shortages. Managers were not available for staff meetings to support staff or to address the shortage of staff and staffing patterns. Participants added that managers are not readily available as they are always rushing from ward to ward without providing support. The study concluded that working with unsafe staffing patterns is the most stressful situation for nurses, as nurses believe that staff shortages diminish the quality of their work. In this study, most nurses voiced the perception of a lack of support from the hospital management as well as from the MoHSS.

The following excerpts encapsulate what most of the participants had to say:

> *"I do not want to lie [shaking her head], what I have seen here is just a doctor who come for ward rounds. But I do not see any additional person from hospital management, even the matron of the hospital just to pass by and say I am just here to see how you are doing… noo… noo… [shaking her head]"* [P2].
>
> *"The commitment is not that much, because with other diseases like HIV/AIDS sometimes the Ministry do campaigns and those disease are having support from other countries, but for prostate cancer is just within the country… [pulling her shoulders up.] I do not know. You cannot even see people visiting schools so that they can check men of prostate cancer, but in HIV they do counselling even at the cuca shops and they are getting support from the Ministry of Health and Social Services but for prostate noo… [shaking her head] it is somehow"* [P12].

Other participants had this to say:

> *"I think the Ministry did not recognise this condition as a serious one because I did not even hear the Ministry going in public and say let us stand up, noo… [shaking her head]"* [P13].
>
> *"When it is comes to the Ministry of Health and Social Services, prostate cancer is not really much considered like cervical cancer, or breast cancer, as those are the conditions which it mostly tackle. When it comes to prostate cancer I do not see effort made to reduce prostate cancer and if it is there maybe it has not yet reached me"* [P9].

The participants' experiences align with the findings of a study by Adeloye et al. (2016), which estimated the incidence of PCa in Africa and revealed huge concerns about the response to prostate cancer from the governments of many African nations. The study recommended the urgent re-prioritisation of health programmes in Africa to improve research and training, diagnosis, treatment and the overall management of PCa in the region.

4.4.4.3 Sub-theme 3: Lack of training for nurses on supportive care

The registered nurse participants strongly expressed the need for training on supportive care to enable them to acquire the knowledge and skills needed to practise competently in the oncology setting.

> *"We need to be trained enough so that we can have enough knowledge. The knowledge that we have is just something that we picked up ourselves as we are working with these patients. We really need to be trained ... and [looking up]"* [P14].
>
> *"It makes me not to give at least enough support to the patients because I did not attend any training and that is why may be some of the patients when they are leaving the hospital, the care given to them might not be regarded as helpful because you are just giving that little you have. I need at least some training so that I can give proper counselling to the patients and the family"* [P12].
>
> *"Uh… [shaking her head] I did not attend any training. The training which I have attended was just for palliative care, once. That is not enough because palliative care was too general and not specific to prostate cancer. The things that I have learned there was just about how to manage pain and prostate cancer was not included. I never heard of any training on supportive care for men diagnosed with prostate cancer"* [P10].

The above sentiments are in agreement with a study by Mitema et al. (2019) on cancer treatment in Africa which revealed a lack of specialised oncology education as the major barrier to effective patient care. The study also found inadequate treatment facilities and insufficient staff, in particular a lack of nurses trained in oncology nursing. In fact, six (6) out of twenty-two (22) African countries reported having no trained oncology nurses at all. A study conducted by Cockle-Haerne et al. (2012) on psychological issues and support for cancer patients revealed that nurses lacked knowledge and appropriate skills to offer tailored support to patients with cancer and expressed the need for additional training. This is in line with Grimes et al. (2014), who maintain that health authorities should introduce new policies that approve expert training for oncology nurses and entitling them to take independent measures to support cancer patients. It is further emphasised that particular emphasis should be put on capacity building among nurses in terms of education, training and empowerment. A study by Cowens-Alvarado et al. (2013) on advancing survivorship care found that many cancer survivors do not receive appropriate clinical care and support which may have a negative impact on their long-term health outcomes and quality of life. The study further revealed that only one-half of primary care providers reported feeling comfortable and confident in their knowledge and skills in providing follow-up care for cancer survivors. It was therefore considered important that formal training and the development of an educational programme in oncology should start at university level or at medical schools, during medical residency training and after residency training. The same should also happen with nurses and other health experts involved in cancer care. This is contrary to the results of this study where most nurses in the oncology departments revealed that they were not trained on supportive care for men diagnosed with PCa. This is what some nurses had to say:

> *"I was just trained on palliative care. This palliative care was for the patient with cancer, but not specifically for prostate cancer. That is the only workshop I can remember"* [P9].
>
> *"Noo… noo … noo… [while shaking her head] I never receive any training about that. I only do it based on my experience because it is now for a long time I have been working here and I see how is their condition aa… aa … and they even know that this is my nurse who usually give me counselling, so we share the ideas, yah… [nodding her head]"* [P8].
>
> *"No, I did not receive any training. I have just acquired some knowledge since I started working at this ward. First, we were students and we use to come here with our books,… yaah [adjusting herself well on a chair] I just picked up knowledge"* [P1].
>
> *"I did not receive any training regarding working with patients diagnosed with prostate cancer, but as a nurse you have to make some initiatives on how to work with this type of patients. We usually handle them according to diagnoses"* [P14].

In Kenya, the government advocates for career paths for cancer professionals (Kenya Ministry of Health, 2017). The support and coordination of scholarships for specialised training for specialised health professionals is therefore regarded as the whole continuum of cancer care. Carter et al. (2014) support the previous statement by emphasising that working with men with PCa requires training and resources to properly address the supportive care needs of men and their family members. In this study some nurses indicated a lack of training on supportive care, despite having worked with men diagnosed with PCa for a long time, by saying:

> *"I feel there is a need for training. There are no trainings at all, not even in-service trainings on prostate cancer unless it is ourselves just discussing especially when we got new recruits or when we get a new procedure then we call them come…come…them we discuss with them. They do not send us for trainings"* [P5].
>
> *"No I have not been trained on counselling, but this is based on health education which we were taught during our basic course. I have not gone through any training about counselling but when you look at the situation and you look at how the patient is, you put yourself into the patient's shoes and you try to at least comfort him"* [P7].
>
> *"I did not receive any training, I just got on-the-job training by the seniors that I found here who have been quite a while working with prostate cancer patients. Noo…, I did not receive any counselling training"* [P2].
>
> *"There is a very big gap as I said at the beginning that we experience a lot of challenge on these patients. The fact is that there is no specific training that we got about prostate cancer and we still working this patients"* [P14].

A study by Regan et al. (2015), encompassing a qualitative investigation of healthcare professionals', partners' and patients' views on psychological issues for couples coping with cancer, revealed a lack of appropriate training for healthcare providers on the management of psychosocial distress faced by men with PCa as a prominent organisation-level barrier. In this study, a registered nurse who doubted her own competency in facilitating supportive care for men diagnosed with PCa had this to say:

> *"The challenge is that ... aa… aa ... [while looking up] patients may ask you the question that you just do not know what to answer. So all what we use to do is to tell them that ... ok…, is fine… that question I will not be able to answer maybe I will call the doctor so that the doctor can talk to you. That makes patients to feel bad"* [P14].
>
> *"Patients will continue to ask a lot of questions that we do not even know what to answer. We are not trained specifically on prostate cancer, for example a patient*

> *may ask you 'will I be able to produce normally like previously when I did not have cancer?' It is quite challenging to give an answer without being trained"* [P14].

The above situation expressed by the registered nurses differs from that recommended by Searle (2010), who points out that the responsibility for informing cancer patients about the care required after the diagnosis is made lies with the nurses. This is supported by Mogotlane et al. (2015) who stress that patients should be provided with health information in order to be able to make informed decisions and choices about their health. Literature emphasised that lack of information about the diagnosis, available treatments and prognosis causes patients to feel anger, frustration, fear and uncertainty (De Moraes-Lopes & Higa, 2014). This is in line with a study conducted by Krumwiede and Krumwiede (2012) about the lived experiences of men diagnosed with PCa which revealed that inconsistent nursing care by not responding to the patients' needs in a timely manner and not appearing competent in the treatment process placed a strain on the nurse–patient relationship. De Moraes-Lopes and Higa (2014) recommend that clinical specialists in urology are the ideal health professionals to help patients and their families through education, support, encouragement and active listening.

4.5 SUMMARY

The findings of this chapter were obtained from the first three sub-objectives of the study, namely, to explore and describe the experiences of men diagnosed with PCa on the supportive care received from nurses in the oncology departments, to explore and describe the experiences of the families of men diagnosed with PCa on the supportive care received from nurses in oncology departments, and to explore and describe the experiences of nurses in facilitating the supportive care of men diagnosed with PCa and their families in the oncology departments. Although many men expressed gratitude for the supportive care they received from nurses, the findings gave a clear picture that men diagnosed with PCa are rarely offered psychological and spiritual support in order to enable them to cope more successfully with the difficulties they face after being diagnosed with the disease. Nurses experience different interventions for supportive care, a shortage of resources and the lack of a conducive environment, the lack of support system, as well as barriers to the facilitation of supportive care for men and their families. With regard to the families, most family members felt that their presence in the healthcare system was not being valued as they were often excluded from the treatment and from decision-making. The findings also revealed a lack of psychological and spiritual supportive care for families from nurses. The next chapter focuses on the presentation of the quantitative results of the study.

CHAPTER 5

PRESENTATION OF QUANTITATIVE RESULTS

5.1 INTRODUCTION

This chapter presents the results of the analysis of the quantitative data that were gathered. The chapter uses a positivist approach to assess the oncology departments in terms of facilitating supportive care for men diagnosed with PCa and their families. The chapter starts by discussing the background to the analysis, providing the justification and rationale for the analytical approach adopted. The descriptive presentation of data, which includes the demographic information covered in section A of the questionnaire as well as descriptive statistics of the raw, unprocessed and untransformed data from sections B to F, highlights the presence of underlying factors that can provide useful insights critical for the oncology department's assessment.

The third section discusses the data preparation and screening, exploratory factor analysis (EFA), and confirmatory factor analysis (CFA), which resulted in the identification of five important ideas or factors linked to nurses' experiences of enabling supportive care. The findings were then merged with the key findings of the qualitative phase. The chapter ends with a summary.

5.2 BACKGROUND OF DATA ANALYSIS

The study used an exploratory data analysis (EDA) method to identify systematic relations between variables without taking into account prior expectations as to the nature of those relations (Creswell, 2014). The EDA approach was meant to identify trends in the quantitative data obtained from the questionnaire survey administered to 35 registered nurses working in the oncology departments at the IHO. The questionnaire comprised a covering letter which provided details of the aims and objectives of the study and instructions on how to complete it. The Likert scale contains a few declarative statements with scaled responses to each statement, namely, strongly disagree, disagree, neutral, agree, and strongly agree (Botma et al., 2010). The study used a survey questionnaire consisting of six sections; namely, section A (demographic data pertaining to the respondents), section B (assessment of oncology departmental preparedness to facilitate supportive care), section C (level of training for registered nurses on supportive care), section D (adequacy of IEC materials on supportive care in oncology departments), section E (adequacy of the provision of health policies and guidelines on supportive care), and section F (assessment of the monitoring and evaluation of supportive care activities in the oncology departments).

The chapter begins with the presentation of the demographic data and a description of the oncology departments. Secondly, the descriptive statistics produced to acquire general knowledge on the variables investigated in the questionnaire are discussed. Descriptive statistics were also employed to assess the oncology departments in terms of their preparedness to facilitate, monitor and evaluate the level of training, adequacy of IEC materials, and the adequacy of health policy and guideline provision in the supportive care of men diagnosed with PCa and their families. The chapter then proceeds with factor analysis, which sought to reduce dimensions and extract factors from the six sections of the survey instrument.

Thirdly, a multivariate inferential analysis was done to establish the relationships and associations between preparedness, policies, monitoring and evaluation, training, and the education of registered nurses in facilitating supportive care for men diagnosed with PCa and their families. Multivariate exploratory techniques were used to discover patterns and trends in multivariate data sets. To discover the underlying relationships and answer the research questions, the study used principal factor analysis (PFA) and CFA to address the following objective:

- To assess the oncology departments and underlying factors in terms of facilitating the supportive care of men diagnosed with PCa and their families.

5.3 DESCRIPTIVE PRESENTATION OF DATA

This section covers the demographic data pertaining to the respondents. These are discussed in the following sections:

5.3.1 Demographic information (Section A)

This section describes the demographic data pertaining to the registered oncology nurses, which include gender, age, highest qualification, type of oncology department at which the respondent is currently working, and years of working experience as a registered nurse. These data were obtained from five questions that respondents had to complete in Section A of the questionnaire (Annexure E). The rationale for including the demographic data was to determine whether there would be any significant relationship between the demographic properties of the respondents and their responses to supportive care, as well as to provide any information that might be significant for the study findings. Table 5. presents the demographic information results.

Table 5.1: Demographic information of the respondents

Item	Variable	Description	N	%
SecA_1	Gender	Male	1	2.9
		Female	34	97.1
SecA_2	Age group	20–29 years	5	14.3
		30–39 years	10	28.6
		40–49 years	12	34.3
		50+ years	8	22.9
SecA_3	Highest level of education	Bachelor's degree	29	82.9
		Postgraduate degree	6	17.1
SecA_4	Years' experience as a registered nurse	Less than 5 years	6	17.1
		5–9 years	8	22.9
		10–14 years	7	20.0
		15 years +	14	40.0
SecA_5	Department	Oncology ward	33	94.3
		Oncology clinic	1	2.9
		UOPD	1	2.9

5.3.1.1 Gender of the respondents (Item 1)

Table 5.1 summarises the demographic information, including the gender distribution of the respondents. The findings indicated that most of the nurses in the oncology were female (97.1%), with only one male nurse (2.9%). These results are in line with Shallal (2011), who states that nursing is considered by some to be a predominantly female profession. The results are consistent with the gender representation of the registered nurses working in the oncology departments at the IHO where there are more females than males.

Although more men are now joining the nursing profession, caring for the sick has been done predominantly by women, especially in the healthcare sector. The findings suggest a lack of diversity in the department, which may affect its effectiveness in facilitating supportive care for men diagnosed with PCa and their families. Furthermore, the results show that the department does not have specialised oncology nurses for dealing with these men, which was confirmed by all 35 nurses interviewed (100%).

5.3.1.2 Age range of the respondents (Item 2)

The age distribution of the 35 respondents in this study is presented in Table 5.1. The results show that the largest proportion of respondents that completed the questionnaire were aged 40–49 years (34.3%; n = 12), followed by 30–39 years (28.6%; n = 10). Respondents aged 50 years and above comprised 22.9% (n = 8), leaving those aged 2029 years to comprise 14.3% (n = 5). The findings suggest that there were more respondents distributed between the ages of 40-49, and fewer respondents in the age group of 50 and above.

5.3.1.3 Highest qualifications of the respondents (Item 3)

The educational background of the registered nurses was of interest to the researcher as far as the facilitation supportive care for men diagnosed with PCa and their families is concerned, to determine whether a link exists between level of educational qualifications and the level of service delivery. As indicated in Table 5.1, the majority of the registered nurses held bachelor’s degrees in nursing (82.9%; n = 29), while 17.1% (n = 6) had postgraduate degrees in nursing, but with no specialisation in oncology nursing.

5.3.1.4 Types of oncology department respondents were working in (Item 4)

Table 5. shows that most of the registered nurses (94.3%; n = 33) were working in the oncology ward, while 2.9% (n = 1) and another 2.9% (n = 1) were working at the oncology clinic and the Urology Outpatient Department (UOPD), respectively.

5.3.1.5 Years of nursing experience in the oncology department (Item 5)

The number of years of working experience serves as an important organisational asset for healthcare workers for determining the delivery of quality healthcare to the clients (George, 2014). Table 5.1 illustrates the number of years of nursing experience of the respondents in the oncology departments. The results indicates that of the 35 respondents, 40% (n = 14) indicated working experience of 15 years or more, while 20% (n = 7) had been working for a period of between 10 and 14 years. Similarly, the results also indicated that 22.9% (n = 8) of respondents have working experience of 5–9 years. Only six (17.1%) respondents indicated having worked for less than five years. The results reveal that most respondents possess a reasonable period of nursing working experience in the oncology departments.

5.3.2 Assessment of oncology departments

The assessment of the oncology departments were done in five sections namely: sections B, C, D, E, and F. The assessments are described as follows:

5.3.2.1 Section B: Preparedness for facilitating supportive care

This section presents the descriptive statistics on statements relating to preparedness for facilitating supportive care. Table 5.2 presents the findings.

Table 5.2: Descriptive statistics for preparedness for facilitating supportive care

Code	Statement		N	%
SecB_6	The department is well equipped with adequate required resources for supportive care for men diagnosed of prostate cancer and their family	Disagree	16	45.7
		Neutral	5	14.3
		Agree	14	40.0
SecB_7	The department has the capacity to diagnose prostate cancer	Disagree	3	8.6
		Neutral	6	17.1
		Agree	26	74.3
SecB_8	The department is headed by knowledgeable supervisors who are committed to the departmental supportive activities	Disagree	6	17.1
		Neutral	10	28.6
		Agree	19	54.3
SecB_9	The department offers supportive care to men diagnosed with prostate cancer and their families	Disagree	4	11.4
		Neutral	8	22.9
		Agree	23	65.7
SecB_10	The department offers routine psychological counselling to men diagnosed with prostate cancer	Disagree	14	40.0
		Neutral	10	28.6
		Agree	11	31.4
SecB_11	The department offers routine psychological counselling to family members of men diagnosed with prostate cancer	Disagree	16	45.7
		Neutral	13	37.1
		Agree	6	17.1
SecB_12	The department is not conducive for counselling men diagnosed of prostate cancer and their families	Disagree	23	65.7
		Neutral	6	17.1
		Agree	6	17.1
SecB_13	The department collaborates well with other units in a hospital on supportive care activities	No	35	100.0
SecB_14	There are no licensed counsellors or specialised therapists (e.g., sex therapist) for supportive care in the department	Disagree	1	2.9
		Neutral	9	25.7
		Agree	25	71.4
SecB_15	The department receives support from the hospital management by making the required resources for supportive care available, e.g. skilled personnel, equipment	Disagree	12	34.3
		Neutral	10	28.6
		Agree	13	37.1
SecB_16	The department receives support from the Ministry of Health and Social Services by making the required resources for supportive care available, e.g. equipment etc.	No	35	100.0
SecB_17	The departmental services for supportive care are accessible 7 days a week e.g. Sunday – Saturday	No	35	100.0

Table 5.2 indicates that the level of agreement on the preparedness to facilitate supportive care was mixed, thus suggesting the existence of underlying factors related to availability (100%), psychological counselling (17.1 to 31.4%), and resources (40%). To better understand these factors they are explored further in section 5.3.2.

5.3.2.2 Section C: Level of training for registered nurses in supportive care

This section presents the descriptive statistics for the statements that assess the level of training for registered nurses in supportive care. The findings are presented in Table 5.3.

Table 5.3**:** Level of training for registered nurses in supportive care

Code	**Statement**		**N**	**%**
SecC_18	The department receives support from the Ministry of Health and Social Services by making training (on opportunities on supportive care) available to the nursing staff	Disagree	19	54.3
		Neutral	12	34.3
		Agree	4	11.4
SecC_19	Registered nurses are trained in the supportive care of men diagnosed of prostate cancer and their families	Disagree	25	71.4
		Neutral	8	22.9
		Agree	2	5.7
SecC_20	Registered nurses are trained in palliative care	Disagree	16	45.7
		Neutral	9	25.7
		Agree	10	28.6
SecC_21	Registered nurses are trained in counselling men diagnosed with prostate cancer and their families	Disagree	32	91.4
		Neutral	3	8.6
		Agree	0	0.0
SecC_22	The department does have registered nurses specialised in oncology	Disagree	35	100.0
SecC_23	There is an orientation programme on supportive care (for men diagnosed with prostate cancer and their families) in place for newly recruited registered nurses	Disagree	24	68.6
		Neutral	8	22.9
		Agree	3	8.6
SecC_24	The department has an in-service training programme for nurses on supportive care for men diagnosed with prostate cancer and their families.	Disagree	18	51.4
		Neutral	12	34.3
		Agree	5	14.3

Table 5.3 similarly shows that mixed results were observed in Section B. Accordingly, further transformational analysis and dimension reduction is needed to better understand the experiences of the nurses with regard to their level of training in supportive care.

5.3.2.3 Section D: Provision of health policies and guidelines on supportive care

This section presents the descriptive statistics for the statements assess the provision of health policies and guidelines on supportive care. The findings are presented in Table 5.4.

Table 5.4 shows that the majority of the nurses (51.4% to 94.3%) felt that no health policies and guidelines on supportive care was provided. The variables with responses that indicate high disagreement have a low agreement with the statements. As such, these questionnaire items were transformed to present the positive agreement score, thus reducing the scores for the positive items in Section D to a range of between 5.7% and 14.3%.

Table 5.4: Provision of health policies and guidelines on supportive care

Code	Statement		N	%
SecD_25	The polices (with mechanisms) on supportive care for men diagnosed with prostate cancer and their families are available in the department	Disagree	33	94.3
		Neutral	1	2.9
		Agree	1	2.9
SecD_26	Guidelines (with mechanisms) on supportive care for men diagnosed with prostate cancer and their families are available in the department	Disagree	31	88.6
		Neutral	2	5.7
		Agree	2	5.7
SecD_27	Registered nurses are conversant with the policies and guidelines on supportive care for men diagnosed with prostate cancer and their families	Disagree	30	85.7
		Neutral	2	5.7
		Agree	3	8.6
SecD_28	Departmental activities on supportive care are performed in line with the existing policies and guidelines (if any)	Disagree	18	51.4
		Neutral	13	37.1
		Agree	4	11.4

5.3.2.4 Section E: Information, education and communication materials (IEC)

This section presents the descriptive statistics on statements that assess the adequacy of IEC materials in the oncology departments. Table 5.5.5 presents these results.

Table 5.5: Availability and Accessibility of IEC material

Code	Statement		N	%
SecE_29	There are adequate IEC materials on supportive care for men diagnosed of prostate cancer and their families	Disagree	25	71.4
		Neutral	8	22.9
		Agree	2	5.7
SecE_30	IEC materials are written in the local language that men diagnosed with prostate cancer and their families can understand	Disagree	30	85.7
		Neutral	3	8.6
		Agree	2	5.7
SecE_31	There is an educational programme in place on supportive care for men diagnosed with prostate cancer and their families	Disagree	22	62.9
		Neutral	11	31.4
		Agree	2	5.7
SecE_32	Health education is strictly offered to men diagnosed with prostate cancer and their families at initial and follow-up visits	Disagree	13	37.1
		Neutral	12	34.3
		Agree	10	28.6
SecE_33	The department conducts community mobilisation and awareness of the supportive care for men diagnosed with prostate cancer and their families	Disagree	21	60.0
		Neutral	11	31.4
		Agree	3	8.6
SecE_34	Research articles or books on the supportive care of men diagnosed with prostate cancer and their families are available in the department	Disagree	30	85.7
		Neutral	3	8.6
		Agree	2	5.7

Table 5.5 shows that the majority of the nurses (60% to 85.7%) felt that the amount of IEC materials in the oncology departments was not adequate. Similarly, the descriptive statistics did not clearly segregate those agreeing from those disagreeing, thus justifying the need for factor analysis.

5.3.2.5 Section F: Monitoring and evaluation of supportive care activities in oncology departments

This section presents the descriptive statistics for the statements that assess the monitoring and evaluation of supportive care activities in oncology departments. Table 5.6 presents the results.

Table 5.6: Monitoring and evaluation of supportive care activities

Code	Statement		N	%
SecF_35	The nursing staff in the department conduct regular meetings on the supportive care for men diagnosed with prostate cancer and their families	Disagree	13	37.1
		Neutral	8	22.9
		Agree	14	40.0
SecF_36	The departmental activities on supportive care for men diagnosed with prostate cancer and their families are evaluated on a regular basis	Disagree	14	40.0
		Neutral	14	40.0
		Agree	7	20.0
SecF_37	A tool for monitoring and evaluating the departmental activities on supportive care for men diagnosed with prostate cancer and their families is in place	Disagree	28	80.0
		Neutral	5	14.3
		Agree	2	5.7
SecF_38	Departmental activities on supportive care for men diagnosed with prostate cancer and their families are well documented and accessible for future references	Disagree	13	37.1
		Neutral	5	14.3
		Agree	17	48.6
SecF_39	Hospital management offers annual awards to the department for exceptional performance on supportive care for men diagnosed with prostate cancer and their families	Disagree	28	80.0
		Neutral	3	8.6
		Agree	4	11.4

The results in Table 5.6 indicate moderate to low levels of agreement between the questionnaire items in section F. These findings are in tandem with findings from the other four sections. Therefore, there was a need to do data preparation and screening that would ensure that problematic variables were removed, screened and transformed in a way that allowed for easier interpretation. The following sections outline the processes and procedures followed in coming up with the underlying factors identified and the conceptualised factors derived from the questionnaire item statements.

5.4 ANALYTICAL PRESENTATION OF DATA

The analytical presentation for this section comprises of data preparation and screening. The results are presented and described as follows:

5.4.1 Data preparation and screening

Data from questionnaires were entered into an electronic database and analysed using the Statistical Package for the Social Sciences (SPSS version 26). Data preparation and screening involved an error-checking process, data cleaning and correction of any omissions, ambiguities and errors in the responses made during data entry. To increase the reliability and reduce the dimensionality of the survey questionnaire items, the researchers used a pre-estimation screening method on the data. Using the SPSS version 26 data preparation menu the variables with issues were adequately transformed and recoded and missing values were searched for. In addition, the questionnaires with substantive missing data or poor-quality responses were removed before analysis. The data preparation and screening process began with identifying and removing variables with no variability. Accordingly, four questions were removed due to a lack of variability, with 100% responses, showing that the respondents indicated consensus on the questions asked. Table 5.7 presents the screened and flagged variables.

Table 5.7: Screened variables

Item	N	Minimum	Maximum	Mean	Std. Dev	Skewness	Kurtosis
SecB_13	35	0	0	0.00	0.00		
SecB_16	35	0	0	0.00	0.00		
SecB_17	35	0	0	0.00	0.00		
SecA_1	35	0	1	0.97	0.17	-5.92	35.00
SecD_25	35	0	1	0.06	0.24	3.99	14.75
SecC_21	35	1	2	1.09	0.28	3.09	8.03

Item	Description
SecA_1	What is your gender?
SecB_13	The department collaborates well with other units in a hospital on supportive care activities
SecB_16	The department receives support from the Ministry of Health and Social Services by making the required resources for supportive care available, e.g. equipment etc.
SecB_17	The departmental services for supportive care are accessible 7 days a week e.g. Sunday – Saturday
SecD_25	The polices (with mechanisms) on supportive care for men diagnosed with prostate cancer and their families are available in the department
SecC_21	Registered nurses are trained on counselling men diagnosed with prostate cancer and their families

The screened variables in Table 5.7 show the answers to questions that were obvious and are known to all the respondents as being true. The findings indicated that the department is dominated by women and that it does not operate seven days a week. In addition, the respondents were undecided or neutral on whether the department receives support from the Ministry of Health and Social Services (MoHSS). Lastly, it was noted that the department does not collaborate well with other units in the hospital on supportive care activities. In addition, the respondents indicated that registered nurses were not trained in counselling men diagnosed with prostate cancer and their families.

The study uses kurtosis and skewness measurements to see if the data were normally distributed, since statistical tests resulting from deviations from the normal distribution are ruled invalid if the deviation is sufficiently large (Hair et al., 2013). Additionally, reliability tests were done using Cronbach's alpha statistics that helped to reduce the number of problematic variables and improved the statistical model fitness and eliminated problematic variables during the factor analysis. After the elimination of problematic variables, the Cronbach's alpha increased to 0.813, which was greater than the acceptable requirement of 0.7.

5.4.2 Presentation of the results

The purpose of the data analysis was to organise, simplify and give meaning to the phenomena that were investigated during the research investigation. Additionally, to answer the research questions and satisfy the study objectives, the research made use of factor analysis and data reduction methodologies. The factor analysis and data reduction started by examining the emerging factors and the factorability of the questionnaire item from sections B to F of the questionnaire. The questionnaire variables were then collated and thematically grouped using the emerging factors from the exploratory data analysis done using SPSS version 26 and graphically modelled with SPSS AMOS version 23.

The quantitative data analysis of the emerging factors was conducted in two phases. The first phase involved descriptive statistical analysis, while the second phase involved inferential statistics. The analysis also involved the transformation of raw data into a type to explain a variety of factors for a situation that promotes understanding and interpretation. The descriptive statistical tools such as the mean, percentage, and frequency were used to describe and summarise the variables. The second phase included inferential statistical analysis, which included EFA. This was critical to the modification of variables for multivariate analysis and inference. Multivariate exploratory techniques were used to identify patterns in multivariate data sets. The analysis sequentially employed PFA, CFA and hierarchical factor analysis to identify the underlying relationships and come up with key concepts to be used in the model and programme development.

5.4.2.1 Factor analysis

To assess the scale validity of the research instrument and reduce the data dimensions, the study used the analytical method recommended by Pallant (2016), known as EFA. As a result, EFA was utilised to break down and arrange variables into smaller, more manageable factors, making it easier to analyse the data, despite having a small sample size of 35 respondents. To analyse the factorial structure of scales and clarify the general characteristics of data, the researcher utilised principal component analysis (PCA) with direct oblique rotation. This was followed up with Gaskin's technique for CFA in SPSS AMOS, which utilises a maximum likelihood estimation approach to determine the underlying structure among the variables (Gaskin, 2017).

The study employed a two-step CFA analysis with the first stage of the analysis involving the data imputation. In SPSS AMOS version 23, the data imputation function is used to replace each missing value in a dataset with an approximation termed an *imputed value*. After each missing value has been imputed, the resultant full dataset may be analysed using data analysis methods built for complete data. In the first stage, the researcher used a regression imputation model to predict the unobserved values for the five emerging factors as a linear combination of the observed questionnaire items that reflectively combine under the individual factor. The data file containing imputed values was then saved and used to come up with the final CFA model. Figure 5.1 presents the IBM AMOS path graphics of the two-step CFA analysis.

Figure 5.1 presents the results of the CFA path analysis for the structural equation model framework for this research. The figure presents the resulting causal measurement framework displaying the standardised regression coefficients. The final model fitness measurements used in the study include the ratio of the standardised chi-square and degrees of freedom (CMIN/DF), the goodness-of-fit index (GFI) and the standardised root mean square residual (SRMR). The model fit measures were calculated using Gaskin and Lim’s (2016) model fit measures: AMOS 23 Plugin.

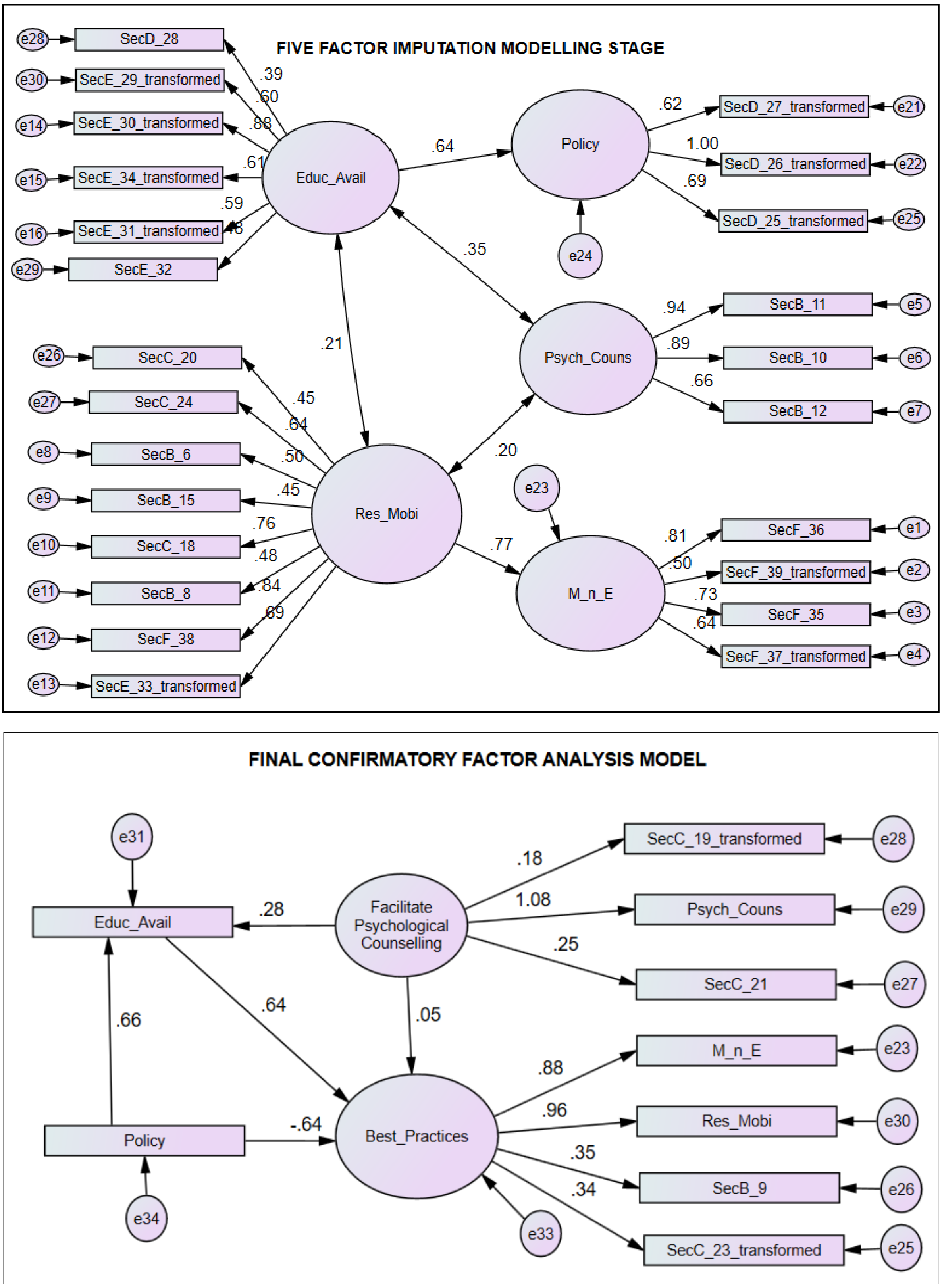


Figure 5.1: Two-step CFA modelling for facilitating the supportive care of men diagnosed with PCa and their families model

The model fitness measures are presented in Table 5.8.

Table 5.8: Model fitness measures and cut-off criteria for the CFA measurement model

Measure	**Estimate**	**Threshold**	**Interpretation**
CMIN	23.122	—	—
DF	23	—	—
CMIN/DF	1.005	Between 1 and 3	Excellent
CFI	0.999	> 0.95	Excellent
SRMR	0.126	< 0.08	Terrible
RMSEA	0.012	< 0.06	Excellent
PClose	0.563	> 0.05	Excellent
Recommended cut-off criteria*			
Measure	**Terrible**	**Acceptable**	**Excellent**
CMINDF	> 5	> 3	> 1
CFI	< 0.90	< 0.95	> 0.95
SRMR	> 0.10	> 0.08	< 0.08
RMSEA	> 0.08	> 0.06	< 0.06
PClose	< 0.01	< 0.05	> 0.05

Source: Hu and Bentler (1999)
*Note, Cut-off criteria for fit indexes in covariance structure analysis: Conventional criteria versus new alternatives

Table 5.8 indicates that the model fit measures are significant with excellent measures for CMIN/DF (1.005 > 1.00), CFI (0.999 > 0.95), RMSEA (0.012 > 0.08) and PClose (0.563 > 0.05). The measure for SRMR (0.126 > 0.10) indicates a terrible fit, with regard to the standardised difference between the observed correlation and the predicted correlation. Field (2013) notes that SRMR is a positively biased measure whose bias is greater for small N and for studies with low degrees of freedom (df), as in this study. Accordingly, this poor measure can be overlooked when considering the study sample of 35, which was the entire targeted population for this study.

The conceptualised factor relationships are presented using the output from the standardised total effects of the relationships presented in Figure 5.1. The findings of the relationships are presented in Table 5.9.

Table 5.9: Standardised total effects for the conceptualised factors for facilitating supportive care

Variables	**Policy**	**Educ_Avail**	**Best Practices**	**Fac psych couns**	**Mean**	**Max**	**MMS**
Educ_Avail	**0.69**	0	0	0	0.29	1.05	28%
Best_Practices	-0.178	**0.695**	0	0			
Fac_psych_couns	0.187	**0.359**	**0.092**	0			
SecC_23	-0.06	0.232	**0.334**	0	0.31	1	31%
Res_Mobi	-0.172	0.67	**0.964**	0	1.27	2.14	59%
Psych_Couns	0.241	0.463	0.119	**1.291**	1.65	2.84	58%
SecC_19	0.027	0.052	0.013	**0.144**	0.29	1	29%
SecC_21	0.038	0.073	0.019	**0.204**	1.09	2	55%
SecB_9	-0.062	0.241	**0.347**	0	2.54	3	85%
M_n_E	-0.157	0.613	**0.883**	0	1.43	2.6	55%

Legend

Educ_Avail	Education availability
Best_Practices	Best practices in facilitating support care
Fac_psych_couns	Facilitating psychological counselling
Res_Mobi	Resources and mobilisation
Psych_Couns	Psychological counselling
M_n_E	Monitoring and evaluation
SecC_23	Orientation programme on supportive care in place for newly recruited registered nurses
SecC_19	Registered nurses are trained in supportive care for men diagnosed with prostate cancer and their families
SecC_21	Registered nurses are trained in counselling men diagnosed with prostate cancer and their families
SecB_9	The department offers supportive care for men diagnosed with prostate cancer and their families

*Note: The bolded values represent direct effects, while numbers in regular font represents indirect effects.

The factors related to best practices in facilitating supportive care for men diagnosed with PCa for nurses working in the oncology departments are summarised in Table 5.9. The table depicts the overall beta weight impact of the elements linked to policies and guidelines and the best practices factor. The findings reveal both the direct and indirect linear regression effects of the linkages in the final measurement model presented in Figure 5.1. For example, the findings reveal conceptual linkages between policy and the guidelines factor and the education availability factor (0.69). This means that if education availability improves by one standard deviation, then policy and guidelines will improve by a standard deviation of 0.69. Furthermore, the findings demonstrate that a one-standard-deviation increase in best practices results in a 0.64 standard-deviation increase in education availability; however, a corresponding and equal standard deviation decrease of 0.64 will be experienced in the policy and guidelines factor. The findings suggest that the facilitation of psychological counselling in the department will significantly depend on the availability of programmes for educational materials, orientation, training and resource mobilisation.

5.4.2.2 Summary of the assessment of underlying factors relating to nurses' experiences in facilitating supportive care in the oncology departments

This section addresses the objective of assessing the oncology departments in terms of facilitating the supportive care of men diagnosed with PCa and their families. Additionally, the study uses the conceptualised factors of best practices by means of a cross tabulation with nurses' views on the capacity of their department to offer supportive care to men diagnosed with PCa and their families. The findings are presented in Table 5.10.

Table 5.10: Findings on the performance of oncology departments in facilitating supportive care for men diagnosed with PCa.

Variable	**The department offers supportive care to men diagnosed with prostate cancer and their families (SecB_9)**											
	Disagree				**Agree**				**Disagree**		**Agree**	
	Oncology ward (OW)		**UOPD**		**Oncology ward (OW)**		**Oncology clinic (OC)**		**OW**	**UOPD**	**OW**	**OC**
	Mean	**Max**	**Mean**	**Max**	**Mean**	**Max**	**Mean**	**Max**	**MMS**	**MMS**	**MMS**	**MMS**
Mean Age	**N = 11**		**N = 1**		**N = 22**		**N = 1**		**44**	**22**	**42**	**50**
SecC_23	0	0	0	0	0.45	1	1	1	0%	0%	45%	100%
SecC_21	1	1	1	1	1.14	2	1	1	50%	50%	57%	50%
Psych_Couns	1.35	2.84	1.85	1.85	1.73	2.8	2.82	2.82	48%	65%	61%	99%
Educ_Avail	0.35	1.05	0.1	0.1	0.24	0.9	0.94	0.94	33%	10%	23%	90%
Policy	0.14	0.51	0	0	0	0	0.5	0.5	27%	0%	0%	98%
Educ_Avail	0.35	1.05	0.1	0.1	0.24	0.9	0.94	0.94	33%	10%	23%	90%
Res_Mobi	1.15	1.86	0.65	0.65	1.39	2.14	0.76	0.76	54%	30%	65%	36%
Psych_Couns	1.35	2.84	1.85	1.85	1.73	2.8	2.82	2.82	48%	65%	61%	99%
Policy	0.14	0.51	0	0	0	0	0.5	0.5	27%	0%	0%	98%
M_n_E	1.23	1.95	0.71	0.71	1.6	2.6	0.75	0.75	47%	27%	62%	29%

Legend

SecC_23	There is an orientation programme on supportive care (for men diagnosed with prostate cancer and their families) in place for newly recruited registered nurses
SecC_21	Registered nurses are trained in counselling men diagnosed with prostate cancer and their families
Psych_Couns	Psychological counselling
Educ_Avail	Education availability
Policy	Policies and guidelines
Educ_Avail	Education availability
Res_Mobi	Resources and mobilisation
Psych_Couns	Psychological counselling
Policy	Policies and guidelines
M_n_E	Monitoring and evaluation

Table 5.10 presents the findings on the performance of oncology departments in facilitating supportive care for men diagnosed with PCa. This performance was assessed using a mean to max ratio score (MMS) reported as a percentage. The findings show that there is a significant difference ($p < 0.05$) between the age distributions of the nurses in the three departments. The results show that the nurses working in the UOPD were younger with a mean age of 22 years, while the oncology clinic had an older nurse aged 50 years. At the same time, the average age in the oncology ward was between 42 and 44 years. The results show that the mean age of the nurses has an impact on the experiences of the nurses in the departments.

The findings further reveal that an orientation programme on supportive care for newly recruited registered nurses (SecC_23) was not in place in the UOPD (0%), although it was partially in place in the oncology ward (45%) and fully in place in the oncology clinic (100%). In addition, the findings suggest that those who were not familiar with the department's offer of supportive care for men diagnosed with PCa, were not privy to the orientation programme on supportive care. In contrast, 45% of the oncology ward nurses and 100% of the oncology clinic nurses who were familiar with the offer of supportive care took part in the orientation programme on supportive care. The findings imply that having undergone the orientation programme will improve the understanding of the department's offering of supportive care for men diagnosed with PCa.

The findings indicated that the registered nurses in the departments were only partially trained in counselling men diagnosed of PCa and their families, with MMS scores for the four groups ranging from 50 to 57%. Consequently, the conceptualised factors then indicated the areas in which the nurses were adequately trained and those areas where gaps still exist. The findings show that nurses in the oncology ward who were not familiar with the supportive care offering of the department were also only partially equipped to provide psychological counselling for patients, with a score of 48%. In contrast, the other group of nurses in the oncology ward had a 61% score on psychological counselling. The oncology clinic had the best score on psychological counselling, which could be influenced by the nurses in the department being more experienced, as seen from the department having a very high MMS score when compared to the other groups. The findings in Table 5.10 further show that the availability of educational materials was a problem for the UOPD (10%) and the oncology ward (23% and 33%) which had very low scores on this factor. Another challenge noted was the lack of policies and guidelines on supportive care in the oncology ward (27%) and the UOPD (0%).

The findings further show that the oncology ward had the best performance with regard to the resources and mobilisation factor scores, with 54% (not familiar group) and 65% (familiar group). The other two departments indicated poor access to resources and mobilisation with the UOPD and the oncology clinic scoring 30% and 36%, respectively. Overall, the findings indicated that the oncology clinic is most suited to handling the supportive care for men diagnosed with PCa, and the UOPD displayed the worst performance. However, the majority of these nurses work in the oncology ward (33), with 66% (22) of the nurses in the oncology ward having enough experience to offer supportive care to men diagnosed with PCa. The next section presents the relationships between the conceptual factors defined and classified using the CFA analysis.

5.4.2.3 Factors associated with the experiences of nurses in facilitating supportive care for men diagnosed with PCa

This section presents the results of the factors associated with nurses' experience extracted and defined at the five-factor data imputation stage (see Figure 5.1). The descriptive statistics pertaining to these component factors and their constituent variables are presented in Table 5.11.

Table 5. 11: Descriptive statistics for factors associated with the experiences of nurses in facilitating supportive care in the oncology departments

Factor	Item	Mean	Std. Dev.	Min	Max	Mean Score	Beta	P-value	Cronbach Alpha
Education availability (Educ Avail)	SecE_30	0.14	0.36	0	1	14%	0.88	0.00	**0.717**
	SecE_34	0.14	0.36	0	1	14%	0.61	0.01	
	SecE_29	0.29	0.46	0	1	29%	0.60	0.01	
	SecE_31	0.37	0.49	0	1	37%	0.59	0.00	
	SecD_28	1.60	0.69	1	3	53%	0.39	0.05	
	SecE_32	1.91	0.82	1	3	64%	0.48	0.02	
Monitoring and evaluation (M_n_E)	SecF_37	0.20	0.41	0	1	20%	0.64	0.00	**0.732**
	SecF_39	0.20	0.41	0	1	20%	0.50	0.01	
	SecF_36	1.80	0.76	1	3	60%	0.81	0.00	
	SecF_35	2.03	0.89	1	3	68%	0.73	0.00	
Policies and Guidelines (Policy)	SecD_25	0.06	0.24	0	1	6%	0.69	0.00	**0.754**
	SecD_26	0.11	0.32	0	1	11%	1.00	0.00	
	SecD_27	0.14	0.36	0	1	14%	0.62	0.00	
Psychological Counselling (Psych_Couns)	SecB_12	1.51	0.78	1	3	50%	0.66	0.00	**0.863**
	SecB_11	1.71	0.75	1	3	57%	0.94	0.00	
	SecB_10	1.91	0.85	1	3	64%	0.89	0.00	

Table 5. 12: Descriptive statistics for factors associated with the experiences of nurses in facilitating supportive care in the oncology departments (continued)

Factor	Item	Mean	Std. Dev.	Min	Max	Mean Score	Beta	P-value	Cronbach Alpha
Resources and Mobilisation (Res_Mobi)	SecE_33	0.40	0.50	0	1	40%	0.69	0.01	**0.815**
	SecC_18	1.57	0.70	1	3	52%	0.76	0.01	
	SecC_24	1.63	0.73	1	3	54%	0.64	0.02	
	SecC_20	1.83	0.86	1	3	61%	0.45	0.04	
	SecB_6	1.94	0.94	1	3	65%	0.50	0.00	
	SecB_15	2.03	0.86	1	3	68%	0.45	0.04	
	SecF_38	2.11	0.93	1	3	70%	0.84	0.01	
	SecB_8	2.37	0.77	1	3	79%	0.48	0.04	

*S.D. – Standard deviation, MMS – mean to max score, Beta – regression coefficient, CA – Cronbach's alpha

Table 5.11 indicates the five factors extracted from the CFA analysis. The study uses the MMS ratio reported as a percentage to measure the level of agreement with the questionnaire item's statement. The findings for the MMS were conditionally formatted in MS Excel 2019 to highlight the positive and negative responses. As the value is close to zero, the red colour indicates that the majority of the responses to the item were negative or the respondents were in disagreement. On the other hand, the green coded items indicate positive responses, agree responses or yes responses.

Reliability tests using Cronbach's alpha (CA) were done and the results are presented in Table 5.11. The results indicate that the questionnaire items on all five factors had good consistency and reliability, with the Cronbach's alpha (CA) values all being above the recommended 0.7. The components with high internal consistency included the Psychological Counselling (Psych_Couns) factor (CA = 0.863), the Resources and Mobilisation (Res_Mobi) factor (CA = 0.820), the Policies and Guidelines (Policy) factor (CA = 0.754), the Monitoring and Evaluation (M_n_E) factor (CA = 0.732), and the Education Availability (Educ_ Avail) factor (CA = 0.717). The study used the questionnaire item loading on the five factors as a way to define, classify and conceptualise the concepts for best practices on the supportive care of men diagnosed with PCa and their families by nurses in the oncology departments. The five factors are described as follows:

Monitoring and evaluation

The effectiveness of the monitoring and evaluation functions is uneven, according to the findings on this factor. Both the monitoring and assessment tools (SecF 37 transformed) and yearly performance awards (SecF 39 transformed) scored a 20% mean agreement in Table 5.6, indicating unfavourable outcomes. Meanwhile, favourable outcomes were found in the frequency of meetings (SecF 35) and assessments of supportive care activities (SecF 36) with scores of 60% and 68%, respectively.

According to Booyens, Jooste and Sibiya (2015), healthcare organisations should provide sufficient and frequent educational sessions aimed at employee development while on the job. Booyens et al. (2015) proposes a three-phased competency-based orientation programme, with phase 1 being a general hospital orientation, phase 2 being nursing rules and procedures, and phase 3 being orientation to the specific unit to which the new employee is assigned. The findings in Table 5.6 suggest that the IHO's department of quality improvement should improve its monitoring and evaluation to ensure that the departmental supportive care programme is kept up to date with nursing advances and new research, particularly in terms of facilitating supportive care for men diagnosed with PCa and their families.

Policies and guidelines

The policies and guidelines factor items averaged at 10%, with item ranges of between 6 and 14%, indicating the lack of availability of policies and guidelines on mechanisms needed for supportive care. The findings in Table 5.4 indicate only 6% agreement on the availability of polices (SecD_25_transformed), and 11% for the availability of guidelines (SecD_26_transformed) for supportive care. Consequently, only 14% of the registered nurses are conversant in the policies and guidelines for supportive care (SecD_27_transformed).

In support, all registered nurse participants interviewed in this study strongly expressed a lack of policies on supportive care in oncology departments. This results in a lack of standardised care and inconsistencies when facilitating supportive care which in turn results from a lack of guidance. Consequently, nurses are not fully informed about the scope of supportive care. There is therefore a need for Namibia to develop and implement such a policy and guidelines.

Literature has it that specialise oncology nurses should have in-depth knowledge of the physical, psychological and social effects of PCa, and thus play a key role in supportive care (De Moraes-Lopes & Higa, 2015). Additionally, a study by King et al. (2015) on PCa and supportive care revealed that men who received care from specialist cancer nurses reported positive experiences of the supportive care received.

In terms of following existing policies and guidelines (SecD 28), the results in Table 5.4 indicate that current procedures were partially followed during the departmental operations on supportive care (53%). These findings are similar to Cowens-Alvarado et al.’s (2013) study which reported that only one-half of primary care providers had confidence in their knowledge and skills when providing follow-up care to cancer survivors.

Psychological counselling

Literature suggests that approximately one-third of all cancer patients suffer from psychological distress (Gerhard et al., 2016). As a result, the Psychological Counselling factor extracted from the experiences of the nurses in the oncology departments provides interesting insights. As the results in Table 5.2 indicate, the degree of agreement on the three questionnaire items loading on this factor scored an average of 57%.

According to the findings in Table 5.2, 64% of the registered nurses thought that oncology departments provide routine psychological counselling for males diagnosed with prostate cancer (SecB 10), with 57% of respondents believing that family members also receive regular psychological counselling (SecB 11). These findings are comparable to those of Chan et al. (2018), who found that 50% of newly diagnosed cancer patients and those with recurring cancer did not receive appropriate psychological care in two oncology wards in a Hong Kong hospital. In addition, a similar study by Salomo et al. (2016) in Namibia found that almost every patient diagnosed with PCa expressed a lack of psychological support from the nurses. Additionally, Wang et al. (2018) observed that emotional support was the most commonly unmet need in the psychological domain for PCa patients.

Consequently, the nurses in the current study might be offering regular psychological counselling that lacks the emotional support and empathy required by the patients. As noted by King et al. (2015), in their study, the majority of men expressed a lack of empathy on the part of health professionals. For most men, their spouses and their families, receiving a PCa diagnosis is a traumatic event (Chambers et al., 2013). Accordingly, the findings in Table 5.2 indicate that half of the nurses (50%) felt that the oncology departments were unsuitable for the psychological counselling of both the males who had been diagnosed and their families (SecB 12).

Education availability

The availability of education for both nurses and their patients is represented by this factor. Oncology nursing is not yet a recognised nursing speciality in Namibia. Therefore, according to the literature, nursing colleges and health institutions should give specific training to guarantee that nurses are empowered in the workplace (Grimes et al., 2014). As such, nurses in Namibia require extra training so as to offer comprehensive supportive care for men diagnosed with prostate cancer and their families, necessitating the establishment of specific education and training programmes for oncology nursing. The findings displayed in Table 5.5 reveal the existence of a partially implemented educational programme (SecE 31 transformed) with a mean score of 37% reported.

In terms of health education, which is rigorously provided to the patients at the first and follow-up visits (SecE 32), that particular programme is effective (64%). The results displayed in Table 5.5 also show that articles or books containing supportive care research (SecE 34 transformed) and IEC materials published in the local language (SecE 30 transformed) both scored 14%, suggesting inadequate availability in the departments. Furthermore, the adequacy of IEC materials (SecE 29 transformed) was determined to be insufficient, with a score of just 29%.

Nursing is a dynamic profession that is subject to rapid changes in healthcare provision; hence the need for in-service training for nurses. Nurses require in-service training in order to update them regarding the latest development in nursing practice. According to research by Røen et al. (2019), family support was not included in any of the health professionals' basic formal education. These findings are confirmed by the interviews conducted in this study, in which registered nurses strongly highlighted a lack of supportive care training to enable them to gain the knowledge and skills required to operate successfully in the cancer environment.

Resources and mobilisation

Kirman et al. (2017) stress that supportive care should include multidisciplinary teams comprised of members who communicate with each other and the patient. Voigt et al. (2014) advocate for cross-departmental collaboration during supportive care in order to ensure the multidisciplinary management of cancer patients, thus highlighting the importance of having the resources and mobilisation factor. The average of the resources and mobilisation factor items was a score of 61% with a range of 40 to 79%.

The findings in Table 5.3 also indicate mixed results, with positive outcomes observed in the support from the MoHSS (SecC_18–52%), in-service training (SecC_24–54%), adequate required resources (SecB_6–65%), and the support from the hospital management (SecB_15–

68%), while negative outcomes were noted in the failure to keep documents and make them accessible for future references (SecE_33_transformed, 40%).

The qualitative interviews with registered nurses in this study support the findings in Table 5.3, with the majority of registered nurses expressing a lack of support from the MoHSS in terms of providing needed resources to oncology departments, while the oncology departments themselves lacked specialised oncology nurses and in-service training in supportive care. As a result, the resources and mobilisation factor results in Table 5.3 highlight the importance of mobilising resources to train nurses in palliative care (SecC 20–61%), having departments led by knowledgeable supervisors (SecB 8–79%), and having proper resources to ensure that palliative care practices are well documented and accessible for future reference (SecF 38–70%). These findings are in line with Kangmennaang et al. (2016), who stress that cancer management requires considerable investment in infrastructure, equipment and personnel. Factors such as inadequate public health infrastructure are consequently likely to undermine the provision of PCa services.

5.5 MERGING OF QUALITATIVE AND QUANTITATIVE RESULTS

The findings in Table 5.13 attempt to merge the key factors from the quantitative analysis with those of the qualitative phase.

Table 5.12 illustrates the way in which the qualitative and quantitative findings were merged by using a side-by-side comparison or parallel database variants, as recommended by Creswell and Creswell (2018). The results were the evidence required to develop the model for nurses to facilitate supportive care for men diagnosed with PCa and their families at the IHO. The study findings reveal inconsistent supportive care by nurses, which resulted in a lack of physical, social, psychological and spiritual support for men diagnosed with PCa and their families. These findings are supported by the results obtained by meeting objectives 1, 2, 3, 4 and 5.

Table 5.13: Merging of qualitative and quantitative results

Findings	**Conclusion**	**Justification of identified concepts (done in line with *Holistic Theory)**	**Proposed central concepts**
Objective 1: Explore and describe best practices for the supportive care of men diagnosed with PCa and their families by nurses in the oncology departments			
Theme 1: Aspects related to management of PCa: National policies on supportive care for men diagnosed with PCa and their families Inclusion/involvement of men and family members in supportive care for men Establishment of certified cancer units at district hospitals **Theme 2:** Aspects related to practising oncology-related matters: Introduction of specialised oncology nursing course at higher institutions of learning Availability of registered specialist cancer nurses in oncology departments Presence of registered specialist cancer nurse when doctor breaks the bad news to men Establishment of advocacy stakeholders meetings for prostate cancer Establishment of community-based face-to-face prostate cancer support groups (PCSGs)[stakeholders and community]	Best practices to support men diagnosed with PCa: National policies [**physical**] Inclusion/involvement of men and family members **[Social/Psychological**] Establishment of certified cancer units [**Physical**] Introduction of specialised oncology nursing course [**Physical**] Specialist registered nurses in oncology departments [**Physical**] Presence of registered specialist cancer nurse when doctor breaking the bad news to men [**Psychologica**l] Establishment of advocacy stakeholder meetings [**Social**] Establishment of community-based support groups [**Social/Psychological**]	Physical, Social, Psychological & Spiritual [Objective: 1]	Physical Social Psychological Spiritual
Objective 2: Explore and describe the experiences of men diagnosed with PCa of the supportive care received from nurses in the oncology departments			
Theme 1: Participants expressed different experiences of supportive care from nurses: Therapeutic nurse-patient relationship during supportive care Unwavering supportive care from nurses Family involvement in treatment and decision-making **Theme 2:** Different experiences of inconsistent supportive care from nurses: Lack of psychological supportive care from nurses Some feelings of lack of health information on prostate cancer from nurses Discussions on sexuality rarely occur	Expected form of supportive care: Therapeutic nurse-patient relationship during supportive care [Social/Psychological] Unwavering supportive care from nurses [Physical/Social/Psychological] Family involvement in treatment and decision-making [Social/Psychological] Challenges regarding supportive care: Lack of psychological supportive care from nurses [Psychological] Lack of health information [Social] Rare discussions on sexuality [Social/Psychological]	Physical, Social, Psychological & S [Objective: 2]	Physical Social Psychological

Table 5.13: Merging of qualitative and quantitative results (continued)

Findings	**Conclusion**	**Justification of identified concepts (done in line with *Holistic Theory)**	**Proposed central concepts**
Objective 3: Explore and describe the experiences of family on the supportive care received from nurses at oncology departments			
Theme 1: Feeling of being devalued by the healthcare system: Lack of family involvement in treatment and decision-making [family and involvement Lack of psychological support from nurses to family] Lack of spiritual support **Theme 2:** Non-conducive environment for counselling men: Lack of privacy	Challenges experienced by family: Feeling of being devalued [**Social/Psychological**] Lack of family involvement in treatment and decision-making [**Social**] Lack of psychological support [**Psychological/Spiritual**] Challenges regarding counselling e environment: • Lack of privacy [**Physical**]	Physical, Social, Psychological & Spiritual [Objective: 3]	Physical Social Psychological Spiritual
Objective 4: Explore and describe the experiences of nurses in facilitating the supportive care of men diagnosed with PCa and their families at oncology departments			
Theme 1: Nurses experience different interventions on supportive care: Good multidisciplinary health team for supportive care for men Patient and family involvement in supportive care for men Usage of basic knowledge as well as learning from others **Theme 2:** Nurses perceive shortage of resources and lack of a conducive environment to facilitate supportive care: Shortage of resources (human and materials) to facilitate supportive care Non-conducive environment for counselling due to lack of counselling rooms **Theme 3:** Nurses expressed different experiences with regard to lack of support system, men, family and community: Lack of support from the family towards men Lack of knowledge on prostate cancer among men and community Men bearing the diagnosis of prostate cancer (denial) Lack of spiritual support	Proposed intervention/approach: Good multidisciplinary health team for supportive care for men [**Physical**] Patient and family involvement on supportive care for men [**Social**] Usage of basic knowledge as well as learning from others [**Social**] Challenges regarding counselling environment: Shortage of resources **[Physical]** Challenges with supportive care: Lack of support from the family towards men [**Social**] Lack of knowledge on prostate cancer among men and community [**Social**] Denial [**Psychological**] Lack of spiritual support [**Spiritual/Psychological**] Lack of clinical policies and guidelines on supportive care [**Physical**] Lack of support from hospital management and Ministry of Health and Social Services for oncology departments [**Physical**] Lack of training for nurses on supportive care [**Physical**]	Physical, Social, Psychological & Spiritual [Objective: 4]	Physical Social Psychological Spiritual

Table 5.13: Merging of qualitative and quantitative results (continued)

Findings	Conclusion	Justification of identified concepts (done in line with *Holistic Theory)	Proposed central concepts
Theme 4: Nurses experienced barriers that influence facilitating supportive care: Lack of clinical policies and guidelines on supportive care Lack of support from hospital management and Ministry of Health and Social Services for oncology departments (human and resources) Lack of training for nurses on supportive care			
Objective 5: Assess the oncology departments in terms of facilitating the supportive care of men diagnosed with PCa and their families			
Section A: Demographic data: No specialist cancer nurses in oncology departments (100%, n = 35) **Section B:** Level of preparedness of oncology department in terms facilitating supportive care: Poorly prepared (45.7%, n = 16) Moderate prepared (14.3%, n = 5) Well prepared (40.0%, n = 14) **Section C:** Level of training for registered nurses in supportive care: Poor training (71.4%, n = 25) **Section D:** Adequacy of IEC materials in oncology department: Inadequate IEC materials (71.4%, n = 25) Adequate IEC materials (5.7%, n = 2) **Section E:** Adequacy of provision of health policies and guidelines on supportive care Adequate policies and guidelines (2.9%, n=1) Inadequate policies and guidelines (94.3%, n=33) **Section F:** Adequacy of monitoring and evaluation of supportive care activities: Adequate monitoring and evaluation (5.7%, n = 2) Inadequate monitoring and evaluation (80%, n = 28)	Unavailability of trained staff: Specialisation Poor training [**Physical**] Level of preparedness: mixed (no clear indication) [**Physical]** Level of training: poor **[Social**] Material [policies and training material]: Inadequate IEC materials [**Physical**] Inadequate policies and guidelines on supportive care [**Physical**] Adequacy of provision of health policies and guidelines on supportive care: Inadequate policies and guidelines [**Physical**] Factors associated with experiences of nurses: Education availability [**Social**] Monitoring and evaluation **[Social]** Policy and guidelines [**Physical**] Psychological counselling **[Psychological/Spiritual**] Resources mobilisation [**Physica**l]	Physical, Social, Psychological & Spiritual [Objective: 1]	Physical Social Psychological Spiritual

Table 5.13*:* Merging of qualitative and quantitative results (continued)

Findings	**Conclusion**	**Justification of identified concepts (done in line with *Holistic Theory)**	**Proposed central concepts**
Factors associated with experiences of nurses Education availability (CA = 0.717) Monitoring and evaluation (CA = 0.732) Policy and guidelines (CA = 0.754) Psychological counselling (CA = 0.863) Resource and mobilization (CA = 0.820)			

In the interviews conducted with registered nurses in this study, most participants expressed a knowledge deficit on facilitating supportive care for men diagnosed with PCa and their families. Moreover, the findings indicate that the registered nurse participants strongly expressed a lack of training on supportive care to enable them to acquire the knowledge and skills needed to practise competently in the oncology setting. These findings are in opposition to the Namibia Vision 2030 (2004), which aims to transform Namibia into an industrialised country by developing diversified, competent and highly productive human resources and institutions that can compete not only nationally but also internationally.

Additionally, the results of this study found inconsistencies with the desired health outcomes outlined in the Namibia’s 5th National Development Plan (NDP5) (2017/18–2021/22); namely, accelerated training of Namibians in specialised health-related fields by 2022 in order for all Namibians to have access to quality healthcare, together with an increase in the Health Adjusted Life Expectancy (HALE) to 67.5 years. It is therefore important for Namibia to introduce specialised oncology nursing programmes at its higher education institutions in order to enable registered nurses to practise competently in the oncology setting.

5.6 SUMMARY

Chapter 5 presented the merging of the quantitative and qualitative results and interpretations based on the five objectives of the study in Phase 1; namely, (1) to explore and describe best practices for the supportive care of men diagnosed with PCa and their family by nurses in oncology departments**,** (2) to explore and describe the experiences of men diagnosed with PCa of the supportive care received from nurses in oncology departments, (3) to explore and describe the experiences of the families of men diagnosed with PCa of the supportive care received from nurses in the oncology departments, (4) to explore and describe the experiences of nurses in facilitating the supportive care for men diagnosed with PCa and their families in the oncology departments, and (5) to assess the oncology departments and associated factors in terms of facilitating supportive care for men diagnosed with PCa and their families. The aim of phase 1 was to identify the concepts for the purpose of developing the model, which required concepts derived from the real situation. Therefore, the identification of the concepts was done in line with Jan Smut's holistic theory (1926).

The findings of objective 1 revealed the best practices for supporting men diagnosed with PCa and their family; namely, the presence of national policies and guidelines on supportive care in oncology departments, the inclusion/involvement of men and family members, the establishment of certified cancer units, the introduction of specialised oncology nursing courses at higher education institutions, the availability of registered specialist nurses in the oncology departments, the presence of registered specialist cancer nurses when doctors break the bad news to men, and the establishment of advocacy stakeholder meetings and community-based support groups.

The findings of objective 2 indicate the forms of supportive care expected and some of the associated challenges; namely, therapeutic nurse-patient relationships during supportive care, unwavering supportive care from nurses, family involvement in treatment and decision-making, lack of psychological supportive care from nurses, lack of health information, and rare discussions on sexuality. The findings of objective 3 revealed the challenges faced by the families of men diagnosed with PCa; namely, feeling of being devalued by the healthcare system, lack of family involvement in treatment and decision-making, lack of psychological supportive care from nurses for families, lack of spiritual support, non-conducive environment for counselling men, and lack of privacy**.** The results of objective 4 revealed approaches to or interventions for supportive care as well as challenges with supportive care; namely, an effective multidisciplinary health team for supportive care, patient and family involvement in the supportive care given to men, the use of basic knowledge, as well as learning from others, shortage of resources, lack of support from the family towards men, lack of knowledge on PCa among both men and the community, lack of spiritual support, lack of clinical policies and guidelines on supportive care, lack of support from hospital management and the MoHSS, and the lack of training for nurses in supportive care, as well as inadequate IEC materials on supportive care.

Similarly, the findings of objective 5 reveal challenges regarding supportive care; namely, the unavailability of trained specialised cancer nurses, and inadequate policies and guidelines on supportive care. The next chapter focuses on the definition, classification and construction of relationship factors for facilitating supportive care, and the application of and the proposed structure for the model.

CHAPTER 6

DEFINITION, CLASSIFICATION, CONSTRUCTION OF RELATIONSHIP STATEMENTS, APPLICATION AND THE PROPOSED STRUCTURE

6.1 INTRODUCTION

Chapter 6 focuses on the results of an analysis of the quantitative data that were gathered. The purpose of this chapter is to conceptualise the main concepts of the central statement in order to describe the conceptual definitions of the concepts. A definition is an explicit meaning that is conveyed for a concept (Chinn & Kramer, 2018). In this study, the definitions of main concepts are required in the development of a model for nurses to facilitate supportive care for men diagnosed with PCa and their families. Walker and Avant (2014) emphasise the importance of clear definitions of concepts in the development of a theory, therefore, for the purposes of developing this model the concepts needed to be clear, precisely defined and explained.

6.2 DEFINITION OF THE IDENTIFIED CONCEPTS

A concept refers to a complex mental formulation of experience, which is a major component of theory that conveys the abstract ideas within the theory (Chinn & Kramer, 2018). Concepts are the basic building blocks of theory. Walker and Avant (2014) stress that the very basis of any theory depends on the identification and explication of the concepts to be considered in it. Concepts are central components that convey the focus and meaning of the theory, therefore making it critical for researchers to identify concepts upon developing a theory. According to Chinn and Kramer (2018), structuring theory requires the researcher to identify the concepts that will form the basic fabric of the theory. Concepts are identified by searching out words or groups of words that represent objects, properties or events within the theory (Chinn & Kramer, 2018). The researcher describes concepts by listing key ideas and tentatively identifying how they seem to interrelate. In this study, the concepts originated from the results obtained on the best practices for the supportive care of men diagnosed with PCa and their families in the oncology departments, the experiences of men diagnosed with PCa of the supportive care received from nurses in these departments, the experiences of family members of the supportive care received from nurses, the experiences of nurses in facilitating supportive care for men diagnosed with PCa, and the assessment of the oncology department in terms of facilitating supportive care for men diagnosed with PCa and their families at the IHO. Table 5.12 in Chapter 5 depicts the concepts identified from the analysis of the research findings, namely, ***support***, ***physical***, ***social***, ***psychological*** *and* ***spiritual***.

Themes that emerged from the experiences of men on supportive care received from nurses in the oncology departments revealed inconsistent supportive care from nurses, as illustrated in Table 4.1, namely: a lack of **psychological** support from nurses, a lack of health information on PCa, and a lack of discussions on sexuality issues. Similarly, themes that emerged from the experiences of families revealed a lack of **spiritual** support for men, a lack of **psychological** support for families from nurses, as well as a lack of family involvement in treatment and decision-making, as illustrated in Table 4.2. The themes that emerged from the experiences of nurses during the facilitation of supportive care revealed a shortage of human and material resources (**physical**) to facilitate supportive care, as well as environment that is unconducive for counselling owing to the poor state of the building that houses men with PCa, as illustrated in Table 4.3. Other challenges experienced by nurses include a lack of **spiritual** support for men, a lack of clinical policies and guidelines (**physical**) in respect of supportive care, a lack of support from hospital management and the MoHSS, and a lack of training for nurses on supportive care. In addition, nurses experienced a lack of support for men from family members (**social**), a lack of knowledge on PCa among men and the community, as well as denial of the PCa diagnosis by men. These experiences of men, family and nurses call for the strengthening of a **support** system during the facilitation of supportive care for men diagnosed with PCa and their families in the oncology departments.

Following the identification of the central concepts of **"support"** – **physical**, **social**, **psychological** and **spiritual** – a comprehensive conceptualisation was executed. Chinn and Kramer (2018) state that concepts may be defined in a list of definitions or in narrative form in the text. In this study, the search was not just limited to the nursing and medical literature, as this might have biased the researcher's understanding of the true nature of the concept (Walker & Avant, 2014). In order for the concepts to yield richer meanings, the researcher carried out extensive reading of as varied sources as possible, such as dictionaries, thesauruses, books, journal articles and internet searches in order to identify as many uses of the concepts as could be found (Walker & Avant, 2014).

6.2.1 Support

The definition of the concept “support” was carried out using dictionary definitions, subject definitions, contextual definitions, the reduction of the identified criteria for the concept and the reduction of the essential and related criteria for the concept.

6.2.1.1 Dictionary definition of the concept support

According to the Oxford Dictionary (2015) support refers to

> bear all part of the weight
> give **assistance, encouragement**, or approval to
> be **actively interested**
> provide with a home or **necessities of life**
> **Corroborate**.

Merriam Dictionary (2014) defines support as

> to **help** someone and be kind to them when they are having a difficult time
> to **hold the weight** of someone or of something such as a building or structure so that they do not move or fall
> to **provide money, food, shelter, or other things** that someone needs in order to live.

Mosby’s Dictionary of Medicine, Nursing and Health Professionals (2013) defines social as

> to **sustain, hold up**, **or maintain in a desired position or condition, or emotionally supporting** a client under stress
> the assistance given to this end, such as physical support, emotional support, or life support.

Merriam Dictionary (2014) refers to social as

> to agree with and give **encouragement** to someone or something because you want them to succeed
> to help someone **emotionall**y or in a practical way
> to provide the right conditions such as enough **food** and **water**, for **life**
> to **hold** something firmly or **carry** its weight, especially from below to stop it from falling

to allow to happen.

According to Oxford Learner's Dictionary (2018) the concept support refers to

help
assist
comfort
guide
keep from falling
carry
uphold
advocate
stand behind
encourage
strengthen
take care of
keep an eye on
attend to
look after

6.2.1.2 Subject definition of the concept "support"

According to Merriam Dictionary (2014) support is of three types, namely, psychological support, social support, and spiritual and chaplaincy support.

Psychological support takes place on three levels:

Psychological support: Level 1 – All health professionals should be able to provide basic psychological support such as, **listening and communicating effectively**, developing **supportive relationships** with **patients** and **carers**, and responding to **distress**.

Psychological support: Level 2 – Professionals with additional **training** and experience may provide more specific or **skilled support**. Thus dealing with adjustment difficulties and loss, offering supportive **counsellin**g, **problem solving** and supporting the patient's ability to **cope**.

Psychological support: Levels 3 and 4 – These levels involve a working knowledge of specific **counsellin**g or **psychotherapy models**, usually done by cancer nurse specialists with additional training.

Oxford English Dictionary (2018) categorise social support into the following elements:

Emotional support. This involves the expression of positive feelings, like concerns and affection, resulting in feeling that one is cared for or **loved**, or **esteemed**. Mostly, patients get this from their families and friends.

Informational support. This is usually sought from professionals in the form of **advice or guidance**, in addition to information about an illness, treatment and side effects.

Instrumental support. This includes **material or financial aid services**.

Social work support. This is the type of support provided for the **family as a system** by trained social workers, and sees to the patients' needs within the **social and family context**.

Cadet et al. (2016) outline the components of support as follows:

It **involves integrated** care with more emphasis on a patient-centred approach.

Support services are provided in a consistent approach across a range of providers, not just one organisation or provider.

Patients should have access to **high quality** supportive care as close to home as possible, assuming the availability of **equipment and resources exist.**

Availability of **support protocol, guidelines, and support pathways to ensure** consistency of **supportive care**.

Comprehensive screening for supportive care needs to ensure **holistic care** for cancer patients.

According to De Moraes-Lopes and Hinga (2014) the key nursing tasks during cancer care include

the **provision** of **support** at the **time** of initial diagnosis
the **provision** of individualised **information**
support with treatment **decision-making**
advice on the **management** of symptoms and the side effects

providing support and assistance for practical issues such as finances and obtaining benefits and/or home assistance
providing **emotional** and **psychological suppo**rt
providing references to specialised services and support services
being a readily available contact for the patient.

According to Cadet et al. (2016), support for people with cancer is actively offered across the six dimension of wellness that include

physical
emotional
intellectual
social
spiritual
occupational

Lavdaniti (2017) states that nurses in oncology departments are required to offer support for the entire course of the cancer patient's illness. This includes

the processes of cancer diagnosis
treatment
possible recurrence
survival period
palliative care and assisting in a peaceful death

According to Oxford English Dictionary (2018) support for cancer patients should

not only focus on treating their disease, but also **manage** the course of their illness.

According to Lavdaniti (2017) the supporting contribution of nurses to cancer patients is crucial throughout the cancer journey because:

the philosophy of nursing is to adopt supportive care that **integrates** all dimensions of life
support is done based on the concept of **holistic** care
support is done based on **continuous** attendance of the patient and family in close **collaboration** with other members of the **multidisciplinary team.**

According to Cadet et al. (2016), a cancer patient should be placed at the centre of support, by enabling the following:

The nursing team consists of skilled cancer care nurses who offer **coordination** of care through assessment, support, identification of needs and referral to appropriate services.

Nursing services assess clients **holistically** and obtain a health history to develop a personalised wellness plan, community and other healthcare **resources** to best support clients.

Cancer nurses assist in the management of a range of cancer-related issues, including **physical** symptom management, understanding the cancer trajectory, treatment options, and treatment **decision-making support**.

Survivorship care planning, support with cancer-related sexual dysfunction and adjustment to hormone therapy or treatment-induced menopause.

Psychology services to offer evidenced-based **psychological care** and interventions provided by certified counsellors and/or clinical psychologists.

Dietician services to provide dietetic and nutritional advice through both individual consultations and group activities.

Exercise physiology classes to be provided in addition to individual **consultations** to develop **personalised** exercise programmes.

Support groups facilitated by cancer nurses and counselling staff, based on supported social interaction, providing an opportunity to meet with others who may be sharing a similar journey.

Lavdaniti (2017) states that support is personalised and designed to meet the following needs of the patient:

Physical
Psychological
Social and
Spiritual needs

6.2.1.3 Contextual definition of the concept “support”

The contextual definition of the concept “support” is deduced from the study findings as illustrated in Table 6.1 in Chapter 6. The findings of this study reveal:

Lack or inadequate **physical** support in terms of provision of resources
  human
  material [equipment, policies, guidelines and training material]
  infrastructure
Lack or inadequate provision of spiritual support in terms of
  enabling peace and well-being
  diminished value, beliefs and culture
  feelings of isolation
  blaming
  unavailability/inadequate or discrimination of religious beliefs.
Lack or inadequate psychological support in terms of
  counselling
  cognitive therapy
  coping mechanism
  self-esteem.
Lack or inadequate **social** support in terms of partnership/involvement
  nurses
  men
  family
  community
  stakeholders
  religious
Feelings of isolation

6.2.1.4 Identification of the criteria of the concept “support”

The following criteria were deduced from the dictionary, subject and contextual definitions of the concept “support”:

provision
comprehensive
holistic

physical
emotional
treatment
collaboration
coordination
consultations
multidisciplinary
management
assistance
encouragement
actively interested
life
corroborate
help
sustain
uphold
maintain
psychological
life support
encouragement
hold
carry
communication
comfort
guide
advocate
stand behind
strengthen
encourage
take control of
keep an eye on
attend to
look after
listening

communication
skilled support
psychotherapy models
counselling
information
instrument
social work
spiritual needs
resources
intergrade
continuous
system
high quality
decision-making-support
equipment
supportive care
provision
advice
providing
personalised
intellectual
social
spiritual
occupational
palliative care

6.2.1.5 Reduction process for the identified criteria for the concept "support"

Table 6.1: Characteristics of essential and related criteria for the concept "support"

Essential criteria	Related criteria
Support **Provision** of a **continuous**, **coordinated**, **integrated**, **holistic,** and **comprehensive** process for **assisting, advocating**, **guiding, advising** and **encouraging** men **physically**, **spiritually**, **psychologically** and **socially** through **communication**, **collaboration** and **consultation** with **stakeholders** through **the management of** the **resources** by a **multidisciplinary** team in a **sustainable** manner	**Physical support** provision of resources human material policies, guidelines and training material infrastructure financial **Psychological support** counselling advice & guidance encouragement problem solving coping mechanism listening effective communication relationships psychotherapy individualised information decision-making information self-esteem **Emotional support** affection loved esteemed **Physical support (instrumental support)** material [policies, guidelines and training material] financial aid services **Social support** family as a system partnership interaction collaboration connection stakeholders **Spiritual support** counselling spiritual wellbeing connectedness with God feeling of belonging

6.2.1.6 Actual definition of the concept "support"

Support refers to the provision of a continuous, coordinated, integrated, holistic and comprehensive process of assisting, advocating, guiding, advising and encouraging men physically, spiritually, psychologically and socially through communication, collaboration and consultation with stakeholders through the management of resources by a multidisciplinary team in a sustainable manner.

6.2.2 The concept “physical” and physical support

The examination of the concept of physical was carried out by dictionary definition, subject definition, contextual definition, reduction of the identified criteria for the concept and the reduction of the essential and related criteria for the concept.

6.2.2.1 Dictionary definition of the concept “physical”

According to Oxford Learner’s Dictionary (2018) the term physical refers to

material
corporeal
visible
tangible
sensible
environmental
palpable
substantial
natural
real
solid
concrete
ponderable
materialistic

According to Nursing Dictionary (2012) the term “physical “refers to

the **body**
natural science
material things
physical science.

The Oxford Dictionary (2015) defines physical as

relating to the body rather than the **mind**
able to be seen, touched, or felt
relating to the way that someone or something looks
used about activities that involve people touching or hitting each other a lot

> existing in the **real world**, rather than in someone's imagination
> relating to physics.

According to the Oxford English Dictionary (2018), physical refers to

> connected to the **body**
> relating to things you see or touch, or relating to the **laws** of nature
> connected with **physics.**

According to Mosby's Dictionary of Medicine, Nursing and Health Professionals (2013), physical means

> **natural.**

According to the Merriam Dictionary (2014), the concept of physical

> relates to the things perceived through the senses as opposed to the **mind**
> relates to **physics** or the operation of natural forces generally.

Oxford Learner's Dictionaries (2018) defines physical as:

> qualities, actions, or things that are **connected** with a person's **body**, rather than with the **mind**
> relating to the **body**, as distinguished from the mind or spirit
> real **things that can be touched and seen**, rather than ideas or spoken words
> **involving** or requiring bodily contact
> someone who physically touches people a lot, either in an **affectionate** way or in a rough way.

6.2.2.2 Subject definition of the concept "physical support"

De Moraes Lopes and Higa (2014) state the following:

> After treatment selection, patients should be followed up to ensure the improvement of their knowledge and ability to **cope** with difficulties that may adversely influence treatment **decisions** and **self-image.**
>
> Besides providing information about the disease and **helping** patients **and their family members** to **cope** with the illness throughout the cancer trajectory, nurses

should help patients manage symptoms and side effects and implement self-care measures.

In addition to the management of self-care, the support provided by a health specialist team should include **guidance** in pre and post-operative pelvic floor exercises and diet to **manage** the bowel effects of radiotherapy.

Physical support should include penile rehabilitation for erectile dysfunction, and **instruction** in exercise programmes to address fatigue caused by hormone **therapy.**

Nurses must **encourage** men with PCa to participate in making the best treatment **decisions.**

Mogotlane et al. (2013) define physical needs as factors required for the optimum physical and physiological functioning of the body. The physical needs include

physiological **processes**

physical activities and **adaptation processes**, all of which enable an individual to function with optimum efficiency and respond appropriately to the **environment.**

Sykes (2013) stresses that in order to address the **physical needs** of patients with cancer, the nurses should

be present at the time the patients is given a PCa diagnosis to ensure timely **continuation** of the dialogue following the patient’s **consultation** with their urologist

contact the patient 72 hours after receipt of referral to ensure that the patient receives adequate information and support at a time they are likely to be experiencing high anxiety

help men with the **decision-making** process following a **diagnosis**, and remain a key contact person for the patient throughout the care **continuum**

ensure that patients have access to the full range of **supportive care** resources open to them in their geographical area.

According to Lavdaniti (2017), caring of the cancer patient on physical level involves

a careful nursing history

assessment of signs and symptoms by using proper tools

designing of an appropriate care plan, and a number of physical nursing **interventions**

According to Chan et al. (2018) good physical supportive care involves:

An effective nurse-patient **communication** which is the key to promoting the psychosocial well-being of patients.

According to Lavdaniti (2017) the needs of patients with cancer generally involve the following:

Physical
Social
Psychological
Financial and **information** needs
Spiritual or **religious** issues
Family relationships
Emotional concerns or other everyday life issues.

Cadet et al. (2016) state that psychological well-being plays a protective role in the dynamic balance between health and disease therefore cancer nurses should physically manage cancer related issues such as:

Physical symptoms **management**
Making patients to understand the cancer trajectory and treatment options
Involving patients in treatment **decision-making**
Providing exercise physiology classes in addition to **individual consultations**
Assisting patients to develop personalised exercise programmes

6.2.2.3 Contextual definition of the concept "physical support"

The contextual definition of the concept physical support is deduced from the study findings as illustrated in table 5.6 in Chapter 5. The study reveals:

Lack or inadequate physical support in terms of the provision of resources such as:
  Human
  Material [equipment, policies and training material]
  Infrastructure

6.2.2.4 Identification of the criteria of the concept “physical support”

The following criteria were deduced from the dictionary, subject and the contextual definition of the concept of “physical”

the body
materials
visible
tangible
environmental
palpable
real
natural
materialistic
concrete
consultation
decision-making
management
relationship
communication
intervention
designing
assessment
continuation
dialogue
physical need
adaptation process
process
decision
guidance
therapy
family
cope
self-image
instruction

6.2.2.5 Reduction process of the identified criteria of the concept “physical support”

Table: 6.2: Characteristics of essential and related criteria of the concept “physical”

Essential Criteria	Related Criteria
Physical A provision of **visible**, **tangible** and **coping environment** through a **continuous relationship, communication** and **consultation** with **management** in terms of **human**, **material**, **infrastructure**, **policies**, **guideline**s and **finance** to meet the **physical needs** of men and **family**	**Human** Cancer nurse specialists Medical Oncologists Radiation Oncologist Onco-geriatrician Urologist Dietician Chaplain Clinical psychologist Social worker Physiotherapist Pharmacist **Material** Diagnostic equipment Medical supplies **Policies, guidelines and training material** Clinical supportive care guideline Training material on supportive care **Infrastructure** certified oncology units counselling rooms enabling environment equipment communication system **Financial** Sufficient budget **Management** Resources Infrastructure Finance Law Consultation **Process** Consultation

6.2.2.6 Actual definition of the concepts physical support

Physical support is a provision of **visible, tangible** and **coping environment** through a **continuous relationship**, **communication** and **consultation** with **management** in terms of **human, material, infrastructure, policies, guidelines** and **finance** to meet the **physical needs** of men and **family**

6.2.3 Psychological & Psychological support

The definition of the concept psychological was carried out by dictionary definition, subject definition, contextual definition, reduction of the identified criteria of the concept and, reduction of the essential and related criteria of the concept.

6.2.3.1 Dictionary definition of the concept psychological

According to the Blackwell's Nursing Dictionary (2012) the term "psychological "relates to:

> Psychology

Merriam Dictionary (2014) defines psychological as

> Connected with the study on how your **mind** works
> Involving or affecting your **mind**

The Oxford Learners Dictionary (2018) refers to psychological as

> Relating to the human **mind and feelings**
> Caused by worry and **sadness**
> Linked to psychology, a scientific study of the way the human mind works and how it **influences behaviour**, or the **influence** of a particular person's character on their behaviour

According to the Oxford Dictionary (2015) the concept psychological refers to:

> **Cerebral**
> Psychical
> Subconscious
> Subjective

According to the Oxford English Dictionary (2018) the concept psychological refers to:

> **Affecting**
> Arising in the **mind**
> **Mental** and **emotional** state of a person
> Psychology

According to Oxford Concise African Dictionary (2010) psychological refers to:

> Affecting or arising in the **mind**, or related to the **mental** and **emotional** state of a person
> An ailment or problem having a **mental** rather than a physical cause

Directed toward, influencing, arising in, or acting through the mind especially in its effective or cognitive functions
Influencing or intended to influence the **mind or emotions**.

6.2.3.2 Subject definition of the concept psychological support

According to Chan et al. (2018) the roles that nurses play in psychological care include

assessing patients' needs
acknowledging patients' distress
managing symptoms of distress
clarifying treatment options
educating the patient about variations in distress during the transition period
building trust
clarifying access to resources
providing assistance with referrals for emotional needs such as counselling.

According to Cheah et al. (2016), psychological support from nurses helps patients with cancer to

cope with psychological and **emotional stress**
overcome the effects of disability caused by illness, ageing, and post-surgery and treatment side-effects.

Chambers et al. (2013) emphasise the screening of men for psychological support because

screening for **psychological distress** is a key component of good cancer care
screening men for **distress** allows for the efficient identification of patients who require more in-depth psychological intervention in order to ameliorate current distress and prevent on-going later distress
screening men for **distress** makes it possible for nurses to refer them to appropriate psychological care services
screening men for **distress** at regular intervals over time enables nurses to monitor their **emotional wellbeing.**

According to Huljev and Pandak (2016,) psychological entails the following:

> Nurses need to promote patients' **psychological and emotional wellbeing** in order to facilitate physical healing.
>
> The patient's feeling and **emotions** of the requires to be known and to be attended to, no less than the symptoms of their diseases. This is in line with Huljev and Pandak (2016) who **stressed** that nurses should **manage** the treatment **environment** using touch, massage, eye contact, voice and other measures to make patients feel more comfortable.

According to Cadet et al. (2016), psychological cancer care means

> shifting from a disease-focused to a holistic approach, in which more attention is given to psychological aspects, quality of life, patients' rights and empowerment, and survivorship.

According to Lavdaniti (2017), psychological support is beneficial in oncology departments in that

> it reduces the psychological **distress** and the **stress** caused to the patient by the physical symptoms
>
> it improves the patient's quality of life

De Moraes Lopes and Higa (2014) stress the following:

> In practice, nurses should pay attention to the feelings and needs of the family members of men undergoing PCa treatment, as the patient's illness may affect the health of his entire family.
>
> Nurses should support patients with PCa in coping with the uncertainties of the disease.
>
> Nurses should assess and continually monitor levels of depressive symptoms, sexual function distress, marital interaction distress, and any other indication for psychosocial interventions in men who have gone radical prostatectomy and their partners.
>
> Nurses must ensure psycho-educational interventions to help partners develop a more positive approach.

> When PCa results are in a terminal diagnosis, nurses must help patients and their families obtain the best end-of-life care.

Chambers et al. (2013) propose the following psychological model with four levels for men with PCa:

> Universal care. This is a care for **mild distress**. Universal care includes care that is based on current evidence and best practice. This type of care should be offered and made available to all men with PCa throughout their cancer experience. This care level includes patient education to promote self-management and effective decision-making, emotional support, practical assistance, peer support that may be in a group setting or one-to-one and face-to-face or remote, physical activity and exercise, as well as screening for distress and referral.
>
> Low intensity care. Low intensity care provides additional support for men who are experiencing mild to moderate **distress** and/or who express the need for additional support. This care level includes psycho-education, stress management and coping skills training, decision support, enhancing support networks, and managing treatment side effects.
>
> Specialised care. Specialised care provides a further and more in-depth level of care for men who are experiencing moderate to severe **distress** and/or who express need for additional support beyond that already provided. This includes specialised therapy for **depression**, **anxiety**, **relationships** or marital distress.
>
> Acute care. Acute care provides high-level **multidisciplinary** mental healthcare for men with severe **distress** and **complex problems**. Men with severe distress may present with depression, anxiety, trauma symptoms or suicidal ideation that may have a serious impact on their ability to function day to day. These men require immediate assessment and intervention and an urgent psychological or psychiatric review is indicated. Specific treatments should be developed according to the particular needs of the patient which potentially include medication as well as psychological treatment.

6.2.3.3 Contextual definition of the concept "psychological support"

The contextual definition of the concept of psychological support was deduced from the following study findings:

Lack or inadequate **psychological** support in terms of

- counselling
- cognitive therapy
- coping mechanism
- self-esteem
- love and affection

6.2.3.4 Identification of the criteria of the concept “psychological”

The following criteria were deduced from the dictionary, subject and contextual definitions of the concept of “psychological support”.

- counselling
- assessing
- acknowledging
- emotional wellbeing
- touch
- feelings
- massage
- feeling of conformability
- holistic approach
- reduction of anxiety
- usage of non-pharmacological methods
- religious and cultural awareness
- mind
- emotion
- distress
- environment
- cerebral
- intellect
- psychological
- advising
- guiding
- encouraging
- support

management

clarification

education

building trust

screening

intervention

monitoring

empowerment

survivorship

diagnosis

screening

referral

6.2.3.5 Reduction process for the identified criteria for the concept “psychological support”

Table 6.3: Characteristics of essential and related criteria for the concept “psychological”

Essential Criteria	**Related Criteria**
Psychological A provision of **education** and **information** through**, counselling, encouraging**, **building trust**, **referral management**, **screening**, **assessment**, **clarification**, **social work, emotional** and **spiritual support** for men in order to **empower** men and enhance **mental** and **emotional** stability for **survivorship**.	**Mental** mind/intellect emotion psychological **Counselling** advising guiding encouraging support **Emotional support** affection loved esteemed **Information support** advice guidance individualised information treatment decision-making information be readily available **Spiritual support** counselling (no peace and well – being) respect (diminished value, believes and culture) boding (feeling of isolation) acceptance (blaming) religious inclusion (unavailability/ inadequate or religious discrimination)

6.2.3.6 Actual definition of the concept “psychological support”

Psychological support entails the provision of **education** and **information** through **counselling, encouraging, building trust, referral management, screening, assessment, clarification, emotional** and **spiritual support** in order to **empower** men and enhance **mental** and **emotional** stability for **survivorship**.

6.2.4 Social and social support

The examination of the concept “social” was carried out by dictionary definition, subject definition, contextual definition, reduction of the identified criteria for the concept and reduction of the essential and related criteria of the concept.

6.2.4.1 Dictionary definition of the concept “social”

According to Merriam Dictionary (2014) the concept “social” refers to

> **worldly**
> **human**
> philanthropic (humanitarian)
> cultural
> eugenical
> **material**
> political
> racial (cultural)
> charitable (helpful/generous)
> altruistic (human).

According to the Oxford Dictionary (2015), social refers to

> **society** or its organisation
> **companionship**
> activities in which people meet each other for pleasure
> an **informal social** gathering **organised** by the members of a particular club or group.

Oxford English Dictionary (2018) defines social as

> relating to **society** and to **people’s lives** in general

> relating to the position that someone has in **society** in relation to other people
> relating to activities that **involve being with other people**
> relating to **rules about behaviour** with other people.

Mosby's Dictionary of Medicine, Nursing and Health Professionals (2013) defines social as

> pertaining to **society** and other **groups of people**.

According to the Oxford English Dictionary (2018) social refers to

> relating to activities in which you meet and spend **time** with other people and which happen during the time when you are not working
> relating to society and **living together** in an organised way.

Oxford South African Concise Dictionary (2018) defines social as

> marked or passed in **pleasant companionship** with friends or associates
> relating to **human society**, the **interaction** of the individual and the group, or the welfare of human beings as members of society
> relating to or involving activities in which people spend time talking to each other or **doing enjoyable things** with each other
> cooperative and **interdependent relationships** with others of one's kind.

6.2.4.2 Subject definition of the concept "social support"

According to Uys and Middleton (2014) social support includes

> early **contact** with the family, early information about the condition of the patient and treatment option
> **listening** to the family in order to **assess** their burden, maintain contact and validate them as people and carers
> **provision of opportunity** by nurses for sharing so that the treatment and **rehabilitation teams** coordinate their efforts with that of family, and information and **planning** is **shared** between the teams and the family
> **counselling** the family in a group, encouraging them to join **support groups** and making sure that they grow in their understanding, assist them as well as the patient.

According to Hinkle and Cheever (2018), social support is composed of the following elements:

Emotional support. This involves the expression of positive feelings, like concerns and affection, resulting in a feeling that one is **cared for**, **loved** or **esteemed**. Mostly, patients get this from their families and friends. Nurses can help by encouraging the open expression of feelings.

Informational support. Informational support is usually sought and **valued** from professionals, and may take the form of advice and **guidance**, in addition to information about illness and treatment, side effects, etc.

Instrumental support. This includes material or financial aid and services. Professionals frequently overlook these areas as they simply attend to and prioritise the medical aspects of the patient’s life when this type of support may be the highest priority for the patient and family.

Social work support. Social workers provide support for the family as a system, and to see to the patient’s needs within the social and family context. They often work as part of the specialist oncology or **palliative care team** in order to provide general psychosocial support.

According to Drennan and Goodman (2014), patients get social support from

family
friends
local **community-based organisations** e.g. **cancer associations**, faith-based organisations, **political parties**, **schools**, community centres, youth clubs, etc
local **support groups** for people in same situation, e.g. carers support groups
local **volunteer organisations** and good neighbour schemes
online and telephone support, e.g. parent line
health, social work, and other public service professionals.

George (2014) states that a nurse is the prime supporter of the ill person by

ensuring that the medical prescriptions are **instituted**
assisting the individual to recovery or providing **support** in dying
serving as a substitute for whatever the patient lacks in order to make him/her complete, whole or independent.

- doing only what the patient cannot do, thus **supporting** the individual in continuing to do as much as possible
- providing support for the patient's **adaptive processes**.

According to Cadet et al. (2016), the risks for major illnesses include social factors such as

- poverty
- **socia**l exclusion
- family level factors such as abuse
- lifestyle factors such as exercise and diet.

Drennan and Goodman (2014) define social support as

- the existence or availability of people on whom you can rely, who let you know that you are cared about, **valued**, and **loved**
- a concept linked to social capital and community approaches to health.

According to Schutt (2019), "social" refers to

- things that are not measured in the gross national product
- a meaningful way of measuring what is important to people.

6.2.4.3 Contextual definition of the concept "social support"

A contextual definition for the concept of social support is deduced from the following study findings:

- Lack of or inadequate **social** support in terms of the **partnership/involvement** of
  - nurses
  - men
  - family
  - community
  - stakeholders
  - religion
- Feelings of isolation

6.2.4.4 Identification of the criteria for the concept “social”

The following criteria were deduced from both the dictionary and the subject definition of the concept “social support”:

family
friends
local community-based organisations/stakeholders (cancer associations, faith-based organisations, political parties, schools, community centres, youth clubs)
support groups
volunteer organisations
worldly
cultural
political
racial (cultural)
altruistic (human)
charitable (helpful/generous)
informal
organised
peoples’ lives
involve
interaction
cooperate
contact
listening
assess
carers
coordinate
counselling
support group
cared for
loved
esteemed
support
valued
guidance
social work support

assisting
online and telephone support
adaptive process
human
society
companionship
activities
social gathering
rules on behaviour
living together
interdependent relationship
lifestyle

6.2.4.5 Reduction process for the identified criteria for the concept “social support”

Table: 6.4: Characteristics of essential and related criteria of the concept “social”

Essential Criteria	Related Criteria
Social It is an **informal**, **partnership**, **collaborative** and **networking** process between **stakeholders (men, nurses, family, community, multidisciplinary team)** through **companionship, listening, interaction, cooperation, coordination, interdependent relationship, guidance, joint decision-making** and **involvement** to provide **support** for men **and their families** regardless of **race, cultural** and **political** aspects of **society**	**Partnership/involvement** interdependent relationship companionship interaction collaboration connection cooperation networking joint decision boding encourage effective communication
	Collaboration working together cooperation partnership involve listening
	Networking interconnection worldly interaction collaboration stakeholders relationship
	Joint decision participation involving together collaboration interdependent relationship connect cooperate

Table: 6.4: Characteristics of essential and related criteria of the concept “social” (continued)

Essential Criteria	Related Criteria
	Stakeholders schools family friends community centres care givers cancer associations support groups volunteer organisations faith-based organisations political parties youth clubs multidisciplinary team

6.2.4.6 Actual definition of the concepts “social support”

Social is an **informal, partnership, collaborative** and **networking** process between **stakeholders (men, nurses, family, community, multidisciplinary team)** through **companionship, listening, interaction, cooperation, coordination, interdependent relationship, guidance, joint decision-making** and **involvement** to provide **support** for **men** and **their families** regardless of **race, cultural** and **political** aspects of **society**

6.2.5 Spiritual and spiritual support

The examination of the concept “spiritual” was carried out by dictionary definition, subject definition, contextual definition, reduction of the identified criteria for the concept and reduction of the essential and related criteria for the concept.

6.2.5.1 Dictionary definition of the concept “spiritual”

According to the Oxford Dictionary (2015), spiritual refers to

> deep **feelings and beliefs**
> spirit of the **soul** rather than body or mind
> people’s **religious beliefs**
> **religious value**
> **inner character** of a person
> nature of **spirit.**

Merriam Dictionary (2018) defines spiritual as

> related to the spiritual instead of the physical world

religious, or related to **religious issues**
connectedness with self, others or **God**
component of **hope.**

Mosby’s Dictionary of Medicine, Nursing and Health Professions (2013) defines spiritual therapy as a form of

counselling
psychotherapy that involves **moral**, **spiritual** and **religious** influences on behaviour and physical health; the use of spiritual and religious **beliefs** and **values** to strengthen the self.

6.2.5.2 Subject definition of the concept “spiritual”

According to Hinkle and Cheever (2014), spirituality comprises the following domains:

How a person derives meaning and purpose from life
One’s **beliefs** and **faith**
Sources of **hope**
Attitudes toward death

According to Surbone et al. (2010), spirituality relates to

culture and **religion**; and how they together influence **perceptions** of health and illness.
broader dimensions and is based on personal authenticity, irrespective of the sources of **authority** and **rituals of worship**.

Hinkle and Cheever (2018) define **spiritual support and chaplaincy** as

an essential and specialist support activity that is undertaken by trained **professionals** such as **chaplains**.

According to Hinkle and Cheever (2014), spirituality helps patients to

discover a purpose in **life**
understand the ever-changing qualities if **life**
develop their **relationship** with **God** or a **higher power.**

Hinkle and Cheever (2014) state that nurses should assess patients’ **spiritual strength** by

- enquiring about the patient’s sense **of spiritual well-being**, **hope,** and **peacefulness**
- assess whether **spiritual beliefs** and **values** have changed in response to illness or loss
- assess the patient’s current and past participation in **religious** or **spiritual practices**
- enquire about the **patient**’s and **family’s** desire for **spiritual support**
- maintain good **communication** and the ability to listen to the patient, and be with them at times of **pain**, **distress** and **fear**
- posing questions that open up the subject of spirituality for the patient, and allowing them space to discuss their concerns
- note the patient’s responses to questions regarding their **spiritual needs.**

According to Surbone et al. (2010), nurses should meet the spiritual needs of patients by

- establishing an **empathetic connection** with patients and their families by **engaging** with them in spiritual discussions or referring and introducing them to members of a **spiritual team**, when available
- creating dedicated **physical spaces** where **patients’ spiritual** concerns can be discussed separately from clinical issues.

6.2.5.3 Contextual definition of the concept “spiritual support”

The contextual definition of the concept “spiritual support” is deduced from the study findings, namely, lack or inadequate provision of **spiritual support** in terms of

- enabling peace and well-being
- diminished values, belief and culture
- feeling of isolation
- blaming
- unavailability/ inadequate or discrimination of religious.

6.2.5.4 Identification of the criteria for the concept “spiritual support”

The following criteria were deduced from both the dictionary and the subject definition of the concept “spiritual”:

- feelings

beliefs
soul
values
religious
connectedness
hope
inner character
counselling
psychotherapy
moral
spirit
spirituality
faith
attitudes
culture
perceptions
authority
ritual of worship
professionals
chaplains
life
relationship
spiritual well-being
peacefulness
spiritual practices
communication
spiritual needs
empathetic connection
engaging
spiritual team
physical spaces
patients’ spiritual

6.2.5.5 Reduction process for the identified criteria for the concept “spiritual support”

Table 6.5: Characteristics of essential and related criteria of the concept “spiritual”

Essential Criteria	Related Criteria
Spiritual This is the **professional** provision of spiritual support by a **spiritual team** or **chaplains** through **engagement**, **communication, counselling** and **psychotherapy** by considering the **feelings, values, beliefs** and **religious perceptions** of men in order to enhance **peace** of **mind**, **soul**, **faith**, **hope, connectedness** and **spiritual well-being** through **empathetic connections, relationships, interconnections** and **partnerships.**	**Connectedness** feelings of belonging partnership relationship interconnection communication **Mind** intellectual understanding psychology **Values** principle worth **Religious** spiritual connectedness with God or religion soul believe

6.2.5.6 Actual definition of the concept “spiritual support”

Spiritual support entails the **professional** provision of spiritual support by a **spiritual team** or **chaplains** through **engagement, communication, counselling** and **psychotherapy** by considering the **feelings, values, belief,** and **religious perceptions** of men in order to enhance **peace** of **mind, soul, faith, hope, connectedness** and **spiritual well-being** through **empathetic connections, relationships, interconnections** and **partnerships**.

6.3 FINAL REDUCTION OF THE IDENTIFIED CRITERIA FOR THE MAIN CONCEPTS OF PHYSICAL, SOCIAL, PSYCHOLOGICAL AND SPIRITUAL

Chinn and Kramer (2018) stress the importance of further reducing the identified criteria for the main concept in order to clearly reflect its intended meaning. The final reduced essential and other related criteria for the concepts “support, physical support, psychological support, social -support, and spiritual support” are illustrated in Tables 6.6, 6.7, 6.8, 6.9 and 6.10, as adopted from Amukugo et al. (2009).

6.3.1 Support

Table 6.6: Final reduced essential and other related criteria for the concept “support”

Essential criteria	Other related criteria
Support Is **a continuous**, **coordinated**, **integrated**, **holistic, comprehensive** and **personalised** process of supporting, **assisting, advocating**, **guiding, advising, encouraging** and **counselling** men **physica**lly, **spiritually**, **psychologically** and **socially** through **communication**, **collaboration**, **consultations** and **decision-making** with **stakeholders** by means of **the management of resources** by a **multidisciplinary** team in a **sustainable** manner.	**Physical support**: The provision of support for men in terms of human, material and financial resources through communication, consultation and collaboration with management, stakeholders and the multidisciplinary team. **Psychological support**: The provision of support in terms of counselling, advising, guiding and encouraging through collaboration with stakeholders and the multidisciplinary team. **Social support:** The provision of support by means of partnerships, collaboration and networking between stakeholders, through companionship, listening, interaction, cooperation, coordination, interdependent relationships, guidance, joint decisions, and involvement to provide support for men and their families regardless of race, cultural and political aspects of society **Spiritual support**: The professional provision of psychotherapy and counselling by chaplains and spiritual teams through empathetic connection, engagement, communication and relationships, bearing in mind the feelings, values and hopes in order to safeguard the spiritual well-being of men.

6.3.2 Physical support

Table 6.7: Final reduced essential and other related criteria for the concept “physical support”

Essential criteria	Other related criteria
Physical-support The provision of a **visible**, **tangible, sensible** and **coping physical environment** through a **continuous relationship, collaboration, communication, consultation, dialogue, guidance** and **joint decision-making** with **management** and **stakeholders** in terms of **human**, **material**, **infrastructure**, **policies**, **guidelines** and **finance** to meet the **physical needs** of men and **family.**	management stakeholders consultation communication collaboration joint-decision continuous consultation relationship dialogue guidance human material infrastructure policies guidelines finance physical needs continuation environment process family dialogue

6.3.3 Psychological support

Table 6.8: Final reduced essential and other related criteria for the concept "psychological support"

Essential criteria	Other related criteria
Psychological-support It is a **holistic, non-pharmacological method** of providing **education** and **information** through **assessment, screening diagnosis, counselling, advising, guiding, monitoring**, **encouraging**, **building trust**, **management**, **referral, clarification**, **social work, emotional** and **spiritual support** for men in order to **empower** men and enhance **coping**, **mental** and **emotional** stability for **survivorship** in a **supportive environment.**	holistic non-pharmacological methods management (assessment, diagnosis, screening, monitoring, planning, intervention, supervision) consultation advise guiding monitoring social mental emotional spiritual support education joint-decision networking collaboration empowerment/ training decision-making building trust survivorship coping boding environment

6.3.4 Social support

Table 6.9: Final reduced essential and other related criteria of the concept "social support"

Essential criteria	Other related criteria
Social-support A **worldly**, **philanthropic (human) charitable**, **informal**, **partnership**, **collaborative** and **networking** process between **stakeholders,** through **involvement, companionship, listening, interaction, cooperation, coordination, interdependent relationship, guidance, joint decision-making** and **involvement** to provide **support** for men **and their families** regardless of **race, cultural** and **political** aspects of **society** in a **valued**, **organised**, **esteemed, caring, loving and friendly manner.**	worldly partnership philanthropic (human) involvement collaboration networking stakeholders companionship listening interaction cooperation coordination interdependent relationship guidance joint decision involvement family race cultural political society valued

Table 6.9: Final reduced essential and other related criteria of the concept "social support" (continued)

Essential criteria	Other related criteria
	organise esteem friendly contact counselling support group care love

6.3.5 Spiritual support

Table 6.10: Final reduced essential and other related criteria for the concept "spiritual support"

Essential criteria	Other related criteria
Spiritual support The **professional** provision of spiritual support by a **spiritual team** or **chaplains for men and their families** through **engagement**, **communication, counselling** and **psychotherapy** by considering the **feelings, inner characters, values, beliefs**, **attitudes** and **religious perceptions** of men in order to enhance **peace** of **mind**, **spirit**, **soul**, **faith**, **hope, morale, connectedness** and **spiritual well-being** through **spiritual practices, empathetic connections, relationships, interconnections** and **partnerships.**	**Spiritual** spiritual team chaplain engagement communication counselling psychotherapy family men feelings values beliefs religious perceptions peacefulness

Table 6.10: Final reduced essential and other related criteria for the concept "spiritual support" (continued)

Essential criteria	Other related criteria
	mind soul faith hope connectedness inner character spiritual well-being empathetic connection relationship interconnections partnership

6.4 DEFINITION OF PHYSICAL, SOCIAL, PSYCHOLOGICAL AND SPIRITUAL SUPPORT

Physical, social, spiritual and psychological support is a **lawful, worldly, organised, integrated, comprehensive, holistic, universal, complex, interdependent, connected** and **non-pharmaceutical continuous process of assessing, diagnosing** and providing **support** for men **physically, socially, psychologically** and **spiritually** through **coordination, networking, engagement, partnership, participation, integration, collaboration, involvement, cooperation, relationships, communication, interconnection, interaction, building trust, joint decision-making, sharing resources** and **consultation** with **management, multidisciplinary team** and **stakeholders** in a **conducive, caring, loving, sustainable** and **friendly environment** with the **resources** required for the **supportive care** and **survivorship** of men.

6.5 ADOPTION OF THEORIES TO GUIDE THE DEVELOPMENT OF THE MODEL

The following theories were adopted to guide the development of the conceptual framework: Dickoff et al.'s (1968) practice oriented theory, Von Bertalanffy's (1930) systems theory, Jan Smuts's (1926) holistic theory and Ida Jean Orlando's (1961) nursing process theory. The survey list provided by Dickoff et al. (1968) was utilised to describe the conceptual framework for the supportive care for men diagnosed with PCa and their families at the IHO. The conceptualisation of the concepts, namely, recipient, agent, context, dynamic, procedure and terminus, is described. Similar concepts are also presented in Figure 6.1. The survey list intends to provide answers to six key questions on supportive care (the activity) (Dickoff et al., 1968):

- The agent (Who performs the activity that facilitates the supportive care for men diagnosed with PCa and their families?)
- The recipient (Who is the recipient of the activity?)
- The context (In what context is the activity performed?)
- The dynamic (What is the energy source, goal or logic of the activity?)
- The procedure (What is the guiding procedure, technique, or protocol of the activity?)
- The terminus (What is the end point of the activity?)

These questions led to the creation of a framework and are described below:

6.5.1 PRACTICE ORIENTED THEORY (DICKOFF ET AL., 1968)

6.5.1.1 Agent

An agent is an individual who engages in activities that meet the required goals of an organisation or institution (Dickoff et al., 1968). In this study, the agents are the nurse and the multidisciplinary team (MDT), as they are involved in the facilitation of supportive care for men diagnosed with PCa and their families. A MDT in oncology is defined as the different specialised professionals who cooperate in order to provide cancer care with the overarching goal of improving treatment efficiency and patient care (Taberna et al.,2020). In this study, the members of the MDT include nurses, medical oncologists, radiation oncologists, urologists, pathologists, oncogeriatricians, pharmacists, social workers, dieticians/nutritionists, psychologists, physiotherapists and chaplains. The benefits of adopting an MDT approach includes the increased survival of men with PCa, shorter timeframes from diagnosis to treatment, greater likelihood of providing supportive care in accordance with clinical guidelines, and educational opportunities for health professionals. The aim is to ensure that all men with PCa receive timely treatment and care from appropriately skilled professionals, that there is continuity of care, and that patients get adequate information and support (Taberna et al., 2020). It has been established from the literature that supporting oncology nurses is vital to ensure that people with PCa are appropriately cared for and guided through their individual journeys in a time of utmost need and vulnerability (Cummings et al., 2018). In this study, the researcher will take the lead and provide guidance and support to nurses in facilitating the supportive care for men diagnosed with PCa and their families in oncology departments of IHO.

Attributes and the roles of the agent

Dickoff et al. (1968) specify the relevant internal and external resources an agent should possess in order to contribute to the realisation of a nursing goal. In this study, the various personal attributes and qualities possessed by an agent will facilitate the successful implementation of the model. It is therefore imperative for an agent to have a combination of internal resources such as values, capacities, skills, education, experience, knowledge and techniques (Shilunga, 2017). Similarly, the external resources that an agent should possess include an ability to maintain, support, develop, protect the recipients. (Dickoff et al., 1968). The agent in this study is discussed according to the following attributes:

Table 6.11: Attributes of an agent as a facilitator of supportive care

Attributes	Description
Vision	A vision refers to a perception of the future, which reveals and points to something new, beyond what is already available and accessible (Namibia Vision 2030, 2004). In this study, the researcher formulated a clear vision statement that he could communicate to nurses, the MDT and stakeholders involved by outlining specific activities to be performed throughout the process. The researcher therefore desired to realise the implementation of the model as essential to facilitate the supportive care for men diagnosed with PCa and their families.
Empathy and warmth	Empathy is the experience of an individual understanding of another person's condition from their perspective (Zibi, 2018). Empathetic people put themselves in the other person's shoes and feel what that person is feeling. By contrast, warmth denotes acceptance and caring about men diagnosed with PCa and their families without judging or controlling them. In this study, empathy and warmth give direction to the facilitator of supportive care in their engagement with men diagnosed with PCa and their families to create a conducive supportive care context. If the facilitators can show that they share a similar emotional state with their patients, patients will regard facilitators as fellow human beings.
Patient and interest	According to Nettina (2014), someone who is patient is able to wait for a long time or deal with a difficult situation without becoming upset or losing interest. In this study, patience enables the agent to help the stakeholders during the implantation of a model until the vision's goal is attained.
Enabling skills	Enabling skills are skills that make something possible, especially by giving someone the ability to make something possible (Zibi, 2018). In this study, enabling skills that should be possessed by the agent include management, communication, listening, guiding, leadership, coordinating, collaboration, consultation, networking, and counselling skills.

Nurse

The nurse coordinates the daily nursing schedule and also the activities of the MDT. The nurse serves as an advocate for men diagnosed with PCa and their families by representing their needs and wishes to other members of the MDT. Mogotlane et al. (2013) stress that nurses should interview the patient and their family to assess the family support system, because a patient with a good family support system copes more effectively than one who does not have such a network. The nurse provides men with information about the diagnosis and the outcome of diagnostic tests in a supportive manner so that the patient is able to make informed decisions regarding treatment. When it is not possible to regain wellness, it is the nurse's function to facilitate a peaceful and dignified death for men (Berman et al., 2016).

Medical oncologist

In PCa, the medical oncologist is often the third doctor to be seen by men after the urologist and radiation oncologist. However, the involvement of the medical oncologist starts from the diagnosis of PCa and remains throughout the course of the disease. A medical oncologist specialises in diagnosing and treating cancer with medical therapies, such as chemotherapy and hormone therapy. He/she establishes a medical diagnosis and prognosis and prescribes treatment, medication and therapeutic aids in collaboration with the MDT (Mogotlane et al., 2013). In addition, the medical oncologist directs the progress of the treatment plan, requests and interprets special investigations, as well as altering treatment accordingly and in collaboration with the MDT. The medical oncologist uses various modalities to treat PCa, and refers cancer patients to surgeons and radiation therapists. Medical oncologists also handle the general medical problems that may arise during the disease.

Radiation oncologist

A radiation oncologist specialises in the use of radiation therapy to treat cancer. They develop the radiation treatment plan, monitor patients while they are receiving radiation therapy, and treat any side effects of the radiation (Taberna et al., 2020).

Urologist

A urologist is most likely to be the first doctor to perform a biopsy, diagnose men with PCa and discuss treatment options such as prostate surgery, since he/she is a surgeon. A urologist treats diseases affecting the urinary tract (kidneys, ureters, bladder and urethra) and disorders of the male reproductive system (Taberna et al., 2020). He/she treats a range of problems such as urination problems, tumours or stones in the urinary system, erectile dysfunction, infertility and others. Some urologists are known as urologic oncologists and are actually surgeons who provide treatment of cancer of the urinary tract and male reproductive organs.

Oncogeriatrician

The oncogeriatrician establishes the frailty profile of elderly men by performing a Comprehensive Geriatric Assessment (CGA) in order to identify the appropriate treatment (Taberna et al., 2020). The CGA helps to identify men who are fit enough to receive standard care of treatment, those who are vulnerable and require adapted treatment, and those unfit to receive any treatment and who should be managed with best supportive care only. Through a CGA, the oncogeriatrician detects geriatric impairments missed by routine oncological clinical assessment especially among men aged 70 years and above. A CGA is an initial frailty assessment which has the ability to help in decision-making but also can improve treatment adherence and tolerance by developing a tailored intervention and a supportive care plan for men during the follow-ups (Taberna et al., 2020).

Social worker

Social workers are particularly familiar with the public and private resources available to patients and families based on their socioeconomic needs (Berman et al., 2016). According to

Mogotlane et al. (2013), the social worker acts as a liaison between the patient, family and community resources by assessing the availability of family members and support networks. A social worker helps men and families to cope with the emotional, physical and financial issues and marital difficulties related to an illness and may also help coordinate services such as housing, transportation, financial assistance, meals, long-term care or hospice care. The social worker also plays a role in expediting the discharge of the patient. Finding suitable housing arrangement is the responsibility of the social worker if the client has no support network in place (Berman et al., 2016).

Dietician

Dieticians in hospitals are concerned with therapeutic diets, supervise the preparation of meals to ensure that patients receive a proper diet, and may design special diets to meet the nutritional needs of individual patients (Berman et al., 2016). A dietician advises on the correct diet for the underlying pathologies as well as on food which prevents digestive complications (Mogotlane et al., 2013). In this study, dieticians assisted in managing nutrition related to PCa and treatment.

Chaplain

The chaplain serves as part of the MDT by attending to the spiritual needs of men and their families (Berman et al., 2016). Chaplains are trained to talk about the major questions of life, death, and existence and may work with patients from different background, including patients with no religious faith. The IHO has a full-time chaplain who offers spiritual services to patients on a regular or on-call basis. The nurses are often instrumental in identifying the men's needs for spiritual support and notify the chaplain. The chaplain may perform religious sacraments or rite such as special blessings, Holy Communion or last rights.

Psychologist

The psychologist evaluates and treats psychological problems associated with terminal illness (Mogotlane et al., 2013). He/she deals with mental processes, especially during times of stress. The psychologist assesses the emotional and cognitive status and treats both man and family with counselling and psychotherapy in order to cope with PCa and treatment.

Physiotherapist

The physiotherapist helps men with the functional restoration of mobility through the application of specific exercises, provides training in mobility using prostheses, crutches, canes, walkers and wheelchairs (Mogotlane et al., 2013). He/she also deals with the range of motion, strength, reflexes, tone, posture, gait, prosthetic fit and function and sensorimotor function.

Pharmacist

A pharmacist prepares and dispenses pharmaceuticals in hospital and the community, and monitors and evaluates the actions and effects of medications on patients (Berman et al., 2016). A pharmacist also works directly with patients and other MDT members to ensure the safe integration of medication into the patients' comprehensive health plan. Similarly, a pharmacist guides primary care providers in prescribing medication.

Pathologist

A pathologist is a physician who works in a laboratory, examining samples of body tissue for diagnostic purposes and pathological staging, so that a patient's disease can be managed appropriately (Washington & Salaria, 2016). Armed with an accurate diagnosis, the treating physician can present the patient with the best therapeutic options. The pathologist plays a tremendously important role in determining a patient's treatment plan, even though they usually do not interact directly with patients.

6.5.1.2 Recipients

Recipients are people on the receiving end of an activity or action from an agent (Dickoff et al., 1968). This study comprises two recipients, namely, the man diagnosed with PCa and his family members, as they receive supportive care from the nurse, as the primary agent, and other members of the MDT.

Man

A man diagnosed with PCa is at risk of deteriorating health and therefore is the beneficiary of the health service – in this study, supportive care from the nurse, as the primary agent, and other members of the MDT.

Family

According to Dickoff et al. (1968), the notion of patient embraces not only the sick person who receives the activity of the nurse or other recognised agents, but also includes any person who receives such activity that contributes to the nursing goal – in this study, family members of men diagnosed with PCa. This implies that much of the activity from the agents is received by the persons other than the ill.

6.5.1.3 Context

The context refers to a setting or location, and the structure of the ward, hospital or medical centre in which supportive care occurs (Dickoff et al., 1968). Smith et al. (2019) define context as the interconnected conditions in which something exists or occur. In this study, systems theory (Von Bertalanffy, 1930) enabled the identification of the context that has an influence on the facilitation of supportive care for men with PCa; namely, the macro (MoHSS, HPCNA, and educational institutions), meso (community, NGOs and support groups) and micro context (health facility, nurse and MDT), as illustrated in Figure 6.1, and Table 6.12 (Smith et al., 2019).

Health facilities

The facilitation of supportive care, in this study, takes place in the health facilities within the micro context influenced by the macro and meso contexts, as illustrated in Figure 7.2. Table 6.12 depicts the application of the micro context in which the facilitation of supportive care for men diagnosed with PCa and their families by nurses and other members of the MDT takes place.

Table 6.12: Application of systems theory to the facilitation of supportive care

Main element	Application to the study
Macro context	National and professional legal frameworks Ministry of Health and Social Services (MoHSS) Health Professions Councils of Namibia (HPCNA) Educational Institutions
Meso context	Community issues that define parameters of service delivery Community Non-governmental organisations (NGOs) Support groups
Micro context	Day-to-day practice Health facility Nurse Multi-disciplinary team (MDT)

Source: Adopted from the systems theory of Von Bertalanffy, 1930

6.5.1.4 Dynamics

According to Dickoff et al. (1968), to consider activity clearly from the aspect of dynamics is to emphasise the power sources for that activity. A holistic theory approach provides an in-depth understanding of patients' needs and enables nurses to develop interventions that are meant to satisfy men's physical, social, psychological and spiritual needs (Jasemi et al., 2017). Huljev and Pandak (2016) maintain that holistic care includes the satisfaction of patients' physical, social, psychological and spiritual needs. In this study, the dynamics were the challenges that hampered nurses in facilitating supportive care for men diagnosed with PCa and their families in the oncology departments at the IHO. Similarly, other dynamics include challenges that prevented men diagnosed with PCa and their families from receiving supportive care from nurses in these departments. The following dynamics were identified in this study: lack of physical support, lack of psychological support, lack of social support and lack spiritual support.

Lack of physical support

Supporting men with PCa physically entails a careful nursing history and the assessment of signs and symptoms using proper tools. Nurses in oncology departments are required to be present at the time the patient is given a PCa diagnosis in order to ensure that men receives adequate information and support at the time they are likely to be experiencing high anxiety and stress. Similarly, nurses should help men with the decision-making process following a diagnosis, and remain the key contact person for the patient throughout the cancer continuum. Men should be made to understand the cancer trajectory and treatment options as well as how to develop personalised exercise programmes. Physical support also implies that nurses should reinforce the importance of cleanliness and ensure adequate hydration and nutrition in the form of nourishing drinks and a well-balanced diet. The physical health of the patients should be monitored carefully. Nurses, in collaboration with other stakeholders, should ensure that men have access to the full range of supportive care open to them within their geographical area. In this study, men expressed a lack of physical support from nurses after being diagnosed with PCa.

Lack of social support

The facilitation of social supportive care for men diagnosed with PCa implies that nurses in oncology departments not only build a relationship with the primary patient, but also with the family or primary caregivers. This relationship should be built on the same competencies as that of the nurse–patient relationship. Men should feel the existence or availability of people on whom they can rely, and who let them know that they are cared about, valued and loved. Nurses should serve as substitutes for whatever the patient lacks in order to make them complete, whole and independent. Nurses should also refer men with PCa to local community-based organisations, for example cancer associations, faith organisations, community centres, youth clubs and the like. Similarly, social workers should provide support for the family as a system, and see to the patient’s needs within the social and family context. In this study, men expressed a lack of social support after being diagnosed with PCa.

Lack of psychological support

The facilitation of psychological supportive care for men with PCa starts with acknowledgement patients' distress, managing symptoms of distress, and providing assistance with referrals for emotional needs such as counselling. Nurses in the oncology departments should screen men for distress in order to allow for the efficient identification of men who require more in-depth psychological intervention in order to ameliorate current distress and prevent ongoing later distress. Screening men for distress enables nurses to promote patients' psychological and emotional wellbeing in order to facilitate physical healing. Similarly, through screening, nurses monitor levels of depressive symptoms, as well as distress linked to sexual function and marital interaction, and any other indication for psychological interventions in men who have undergone a radical prostatectomy and their partners. Men who experience severe distress or who express the need for additional support beyond that already provided should be referred by nurses for specialised care. In this study, most men indicated a lack of counselling from nurses after being diagnosed with PCa.

Lack of spiritual support

In cancer patients, spirituality is beneficial for maintaining self-esteem, providing a sense of meaning and purpose, giving emotional comfort and providing a sense of hope (Lu et al., 2018). It is a strong predictor and promoter of psychological health by improving spiritual well-being and quality of life, as well as reducing the degree of depression, anxiety and hopelessness in patients with cancer. Spiritual support increases resistance against mental health crises following the diagnosis and treatment of cancer in both patients and family. Best et al. (2013) stress that spiritual well-being contributes to cancer patients' quality of life and their ability to cope with terminal illness. When spiritual needs are not met, patients are at risk of depression and have a reduced sense of spiritual meaning and peace. Spiritual care is an therefore important part of healthcare, especially when facing the crisis of advanced cancer. In this study, family members expressed a lack of spiritual support after the diagnosis of PCa in their loved ones. Similarly, registered nurses expressed a lack of spiritual support for men diagnosed with PCa.

6.5.1.5 Procedure

According to Dickoff et al. (1968), a procedure entails the steps, path, rubric or instructions through which the activity is to be performed. It is a blueprint for carrying out an activity. In this study, the procedure refers to the facilitation of supportive care for men diagnosed with PCa and their families through communication, consultation, coordination, collaboration, integration, networking, joint-decision-making, teamwork, partnership, participation, sharing of resources, engagement, involvement, interaction and cooperation.

Communication

Communication is a very important aspect in cancer care (Hinkle & Cheever, 2018). The MDT communicates with each other and the men diagnosed with PCa, enabling them to be confident that their care is coordinated and not disjointed (Kirkman et al., 2017). In supportive care, the team has a responsibility towards one another to have open communication channels and mutual understanding (Huljev & Pandak, 2016). MDT meetings facilitate communication and coordination among professionals in clinical settings to deliver holistic supportive care for men (Hartgerink et al., 2014). Mogotlane et al. (2013) maintain that the families of men with PCa need to be encouraged and counselled by the MDT through communication that is non-threatening, open, honest and acceptable.

Consultation

Consultation with men and family provides healthcare professionals with an opportunity to explore men’s health needs and identify areas of most concern (Paterson & Nabi, 2017). Through consultations, the MDT can improve clinical performance, cut down on medical errors, ease men’s concerns about treatments and procedures, raise efficiency and lower healthcare costs. Consultation is essential at every level of supportive care for achieving harmony of individual efforts, create unity of direction and reconcile conflicting views.

Coordination

Coordination serves as a key to all supportive care activities by ensuring unity of action in the face of various dynamics (Hartgerink et al., 2014). It integrates the work of different units in the health facility and ensures the economic and effective use of physical, financial and human resources. The nurse coordinates the supportive care activities with the MDT and stakeholders to ensure the prudent use of available resources, and limit the overlaps and duplications of work. Members of the MDT consult with each other to implement men’s supportive care plans in order to provide holistic, efficient and patient-centred care

(Nekhlyudov et al., 2014). Similarly, the health systems need to coordinate with other sectors to ensure social determinants are considered when facilitating supportive care.

Collaboration

Multidisciplinary collaboration provides an opportunity to work as part of a united tram in delivering supportive care with inputs from each of the clinicians involved (Hartgerink et al., 2014). Collaboration using available resources enables treatment to be started more quickly and keep things moving faster than when individual physicians or nurses are working independently of one another. Collaboration allows physicians and nurses to speak with a united voice, which is less confusing for the patient and their families and helps reduce anxieties (Crompton, 2016). Clinicians become familiar not only with the patient’s case, but with each other, and know how to reach out for quick feedback when something comes up.

Integration

According to Seely, Weeks and Young (2021) integrative oncology requires that a number of interdisciplinary professionals practice alongside each other and communicate in non-hierarchical and respectful ways to further the goals of treating the whole person. In integrative oncology patients have access to evidence-based care that is safe, comprehensive, and patient-centred throughout the cancer spectrum. Integrative oncology seeks to engage patients and families as active participants in their own care from prevention throughout treatment and survivorship (Latte-Naor & Mao, 2019). In integrative oncology, a safe, knowledgeable, and dynamic cancer management plan is developed cooperatively, ensuring accurate monitoring and evaluation.

The core principles of integrative oncology include individualisation, holism, dynamism, synergism and collaboration by the MDT (Seely, Weeks & Young, 2021). Integration can occur at many levels: individual, clinical, institutional, regulatory and policy. In integrative oncology, the focus of care is on the whole person, and the aim is to meet the needs of cancer patients and their families across the cancer trajectory. In this study, integrative oncology involves applying a range of cancer treatments to address holistic treatment goals as they change over time in accordance to with patients’ needs and values. Evidence suggests that better integrated delivery has the potential to improve the quality and reduce the cost of healthcare, and ultimately improve health outcomes (Haire et al., 2013).

Networking

In order to complete the path of supportive care, nurses are encouraged to network and outsource services, including palliative care therapies and psychological support to entities formally collaborating with PCa units (Crompton, 2016). Networking among professionals improves supportive care delivery by enhancing the exchange of relevant information and by strengthening shared goals and the degree of mutual respect among diverse professionals (Hartgerink et al., 2014). It integrates various activities for the effective achievement of common goals.

Joint decision-making

A decision refers to a choice or judgement that is made after consideration of the best possible option (Oxford Dictionary, 2015). Joint decision-making is a collaborative decision-making process between patients and their clinicians which involves multiple clinically accepted options. It improves the quality of medical or nursing decisions by helping men with PCa to choose options consistent with their own values and in accordance with the best available scientific evidence. Men are made to consult with members of the multidisciplinary health team skilled in the specific treatment modalities relevant to men’s particular needs. Nurses are responsible for creating an environment that will provide men and their families with the opportunities to participate in decision-making.

Teamwork

Supportive care is provided by a diverse team of professionals, including medical oncologists, radiation oncologists, nurse practitioners, psychologists, pharmacists, dieticians, chaplains, rehabilitation workers, social workers and other professionals (Nekhlyudov et al., 2014). Supportive care for chronic diseases is best delivered with a collaborative teamwork effort involving public health specialists, policy and service planners and support personnel (Huljev & Pandak, 2016). Huljev and Pandak (2016) define a healthcare team as the provision of health services to individuals, families or their communities by at least two or more health providers who work collaboratively with patients and their caregivers to accomplish shared goals within and across settings to achieve coordinated and high quality care. In many articles, the outcomes of treatment with a team approach have been reported positively, with no reports of negative consequences of team intervention (Huljev & Pandak, 2016). In this study, the work of the health team on supportive care is interdependent whereby team members share the responsibilities and are accountable for attaining the desired results, in this case, holistic supportive care. Holistic supportive care refers to the consideration of the complete person, physically, psychologically, socially and spiritually (Huljev & Pandak, 2016).

Partnership

A multidisciplinary partnership involves various health professionals from the same sector working together to achieve a common goal (Wolf et al., 2017). Partnership refers to a structured arrangement where health professionals, stakeholders and patients agree to work together to achieve a common goal (Wolf et al., 2017). The key elements required for a successful healthcare partnership are promotion, prevention, cure, support and rehabilitation.

In supportive care, the multidisciplinary health team should cohesively work together and each one's action should always be coordinated for a better outcome. Nurses, medical oncologists, radiation oncologists, psychologists, pharmacists, dieticians, chaplains, rehabilitation workers, social workers and other professionals work together with men and their families in a partnership, referred to as a multidisciplinary partnership (Wolf et al., 2017). Partnerships enable the provision of supportive care for men at an effective cost, consequently boosting the morale of the team members and increasing motivation.

Participation

The attributes of promoting participation among the multidisciplinary team during the facilitation of supportive care includes establishing a relationship between nurses, doctors and other health professionals (Ringdal et al., 2017). Participation of the departments and professionals in the treatment of men with PCa guarantees full and continued supportive care for men during diagnosis, treatment and follow-up periods (Taberna et al., 2020).

Sharing of resources

Cancer management requires a considerable investment in infrastructure, equipment, personnel and other resources (Huljev & Pandak, 2016). Healthcare resources include all materials, personnel, facilities, funds and anything else that can be used to provide healthcare services (Huljev & Pandak, 2016).

The MDT should develop a climate for teamwork, and be willing to provide and share the resources (Hartgerink et al., 2014). By facilitating supportive care, professionals bring the skills of different individuals together in order to address the health needs of both man and family through a team approach (Huljev & Pandak, 2016). The team should also maintain open communication with management in terms of obtaining the required resources such as personnel, equipment, finances and other infrastructure to enable the facilitation of supportive care for men.

Engagement

Engagement is essential at every level of cancer management in order to harmonise individual efforts. Working within an MDT requires all care team members to engage with each other, as well as with men and those who support them, in order to reduce medical errors, improve patients’ experiences and deliver better patient outcomes (Hartgerink et al., 2014).

Involvement

Involving men in their care and treatment means supporting them to manage their own health and wellbeing on a daily basis (Hartgerink et al., 2014). Nurses should support men to become involved, as much as they are able to, in decisions about their care and giving them choice and control over the supportive care services they receive. When men are involved in decisions about their health and care, they tend to choose care, support or treatment packages that align with their personal preferences and goals. In other words, men make decisions and choices that help them optimise their physical, social, spiritual and psychological wellbeing.

Interaction

The MDT meetings facilitate the interaction among health professionals. Interaction among healthcare professionals in the hospital is a useful tool for professionals to share their expertise and consequently reshape care delivery so that it is more responsive to the needs and desires of older patients. As interaction between professionals is influenced by team climate, it is believed to increase coordination by enhancing the quality of relationships, expressed by shared goals, shared knowledge and mutual respect (Hartgerink et al., 2014).

Cooperation

Cooperation involves various healthcare professionals working together by exchanging and sharing information which helps them to act in a holistic manner. Cooperation is successful and effective if two or more independent bodies work collectively to achieve more effective outcomes than they could have if they worked separately (Hartgerink et al., 2014).

6.5.1.6 Terminus

The last aspect of the framework for supportive care is the terminus. Terminus refers to the end point or accomplishment of an activity (Dickoff et al., 1968). In this study, the terminus refers to the desired outcome after the implementation of the model by nurses and other members of the MDT as agents of change. The expected outcome after the implementation of the model in this study is a holistic supportive care for men diagnosed with PCa and their families. Holistic supportive care refers to the consideration of the complete person, physically, socially, psychologically and spiritually, rather than just the symptoms of the disease (Huljev & Pandak, 2016).

Physical support

According to Mogotlane et al. (2013), physical needs refer to factors that are required for the optimum physical and physiological functioning of the body such as physiological processes and physical activities. Nurses should ensure that men are supported physically by making resources in terms of human, material (equipment, policies and training material) and infrastructure available. In addition to physical resources, physical exercise is effective in reducing psychological distress in men with PCa.

Social support

Social support entails early contact with the family, early information about the condition of the patient and treatment options, as well as counselling the family and patients and encouraging them to join support groups (Uys & Middleton, 2014). Men diagnosed with PCa get social support from family, friends, local community-based organisations, local support groups and social workers, as well as online and telephone support.

Psychological support

Psychological support entails the promotion of men’s psychological and emotional wellbeing in order to facilitate physical healing (Huljev & Pandak, 2016). Nurses should provide psychological support for men in terms of encouragement, counselling and information provision, as well as by referring them for spiritual and psychotherapy services. De Moraes Lopes and Higa (2014) stress that nurses should pay attention to the feelings and needs of the family members of men undergoing cancer treatment because the patient’s illness has the potential to affect the health of the entire family. Nurses should therefore ensure psycho-educational interventions to help men’s partners develop a more positive approach to the disease. When PCa reaches terminal stage, nurses should help men and their families to obtain the best end-of-life care.

Spiritual support

Spiritual support is an essential and specialist support activity that is undertaken by trained professionals such as chaplains. According to Hinkle and Cheever (2018), spiritual support helps patients to discover a purpose in life, to understand the ever-changing quality of life, and to develop their relationship with God. Men diagnosed with PCa should be given spiritual support through counselling to ensure spiritual well-being, as well as to instil feelings of belonging in men.

Table 6.13: Application of the terminus in terms of physical, social, psychological and spiritual support

Main element	Application to the study
Physical support	human material policies, guidelines and training material infrastructure financial
Psychological support	counselling advice & guidance encouragement problem solving coping mechanism listening effective communication relationships psychotherapy individualised information decision-making information self-esteem
Social support	family as a system support group men’s club volunteers organisation
Spiritual support	counselling peace of mind overcoming despair and guilt

6.5.2 Systems Theory (Von Bertalanffy, 1930)

Systems theory is a way of assessing the relationships and reactions between individual components of a system and how that relates to the achievement of a goal (Cornell & Jude, 2015). Systems theory can be used to clearly and concisely understand healthcare structures, processes and outcomes, as well as their interaction with the healthcare system. This theory provides a meaningful and useful means of examining challenges in healthcare organisations. In systems theory, an organisation is formed by different departments, sections and units composed of individuals and groups which are independent but working together to achieve a common goal with the aim of turning the organisational vision into reality. Systems theory is best for health issues related to interpersonal relationships. In this study, systems theory enabled the identification of the contexts that have an influence on the facilitation of supportive care for men diagnosed with PCa, namely the macro (MoHSS, HPCNA and Educational Institutions), meso (community, NGO’s and support groups) and micro context (health facility, nurse and MDT), as illustrated in Figure 6.1 (Smith et al., 2019).

6.5.2.1 Macro context

The term “macro context” refers to the major external factors that influence an organisation’s decision-making, performance and strategies (Jacobs et al., 2012). It has to do with the larger influences on healthcare policies at national level. According to Smith et al. (2019), the macro context is comprised of structural, legal, regulatory and economic external conditions that are beyond the influence of individual organisations or practitioners. It incorporates phenomena such as social, political and economic forces in a country, such as the national economy at a given point in time and technological advancement. In this study, the macro context refers to the national and professional legal frameworks; namely, the MoHSS, the HPCNA and educational institutions that influence the facilitation of supportive care for men diagnosed with PCa and their families, as illustrated in Figure 6.1. The results of this study revealed perceptions by several registered nurses that the lack of a national policy on supportive care for men diagnosed with PCa and their families was not in the best interests of providing supportive care in oncology departments. Similarly, there were also perceptions of a lack of support for the oncology departments from the MoHSS, consequently resulting in a lack of training for nurses on supportive care.

6.5.2.2 Meso context

According to Smith et al. (2019), the meso context comprises local institutional factors and influences, as well as community issues that often characterise or define the parameters of service delivery. In this study, the meso context refers to the community, NGOs and support groups, as illustrated in Table 6.12. The study reveals a lack of support from family members for men diagnosed with PCa, as well as a lack of knowledge on PCa by the community.

6.5.2.3 Micro context

The micro context is characterised by day-to-day practice and the attributes or characteristics of individual practitioners and their practice environments that affect the way services are delivered (Smith et al., 2019). It refers to daily nursing practice in which nurses encounter professional challenges from members of the health team or colleagues. In this study, the micro context refers to the health facility, nurses and the MDT in the oncology departments. During the interviews conducted for this study, registered nurses expressed poor understanding by hospital management of nurses' roles in the oncology departments, resulting in a lack of support from management. Others noted stressors associated with the unconducive environment for counselling men, the lack of resources, as well as the lack of specialised or in-service training on supportive care for nurses. The researcher believes that qualifying as a registered nurse is not enough in the context of supportive care for men diagnosed with PCa because the roles of cancer nurses are diverse and require considerable expertise in many specialist areas of clinical cancer supportive care in addition to general nursing skills. Table 6.12 illustrates the application of the micro context to the study.

6.5.3 Nursing Process Theory (Orlando, 1961)

Nursing process theory uses the term “need” to describe patients' problems that require nursing care (Haapoja, 2014). Nursing process theory emphasises that when an individual is not able to meet the needs he/she has, he/she becomes distressed and is in need of nursing care. The theorist emphasised that it is critical not only to meet the patients' needs but first of all find out what those needs are. The theory stresses that the role of the nurse is to discover and meet the patients' needs, which are discovered by interacting with the patient and/or family. According to Berman et al. (2016), a nursing process theory approach requires the nurse to systematically collect data from the patient, family, community or group during the assessment phase. This is done in order to identify health needs, make a nursing diagnosis, establish plans and deliver specific nursing interventions to meet those needs, as well as to evaluate the extent to which the plan was effective in solving the identified needs. In this study, nursing process theory was used to identify the needs of men diagnosed with PCa, namely, physical, social, psychological and spiritual needs. The application of the five elements of nursing process theory to the phases of the model is illustrated in Figure 7.1.

6.5.3.1 Assessment and diagnosis

Berman et al. (2016) define assessment as the systematic and continuous collection, organisation, validation and documentation of data from the patient and/or family. A nursing assessment includes the patient's perceived health needs, health problems, related experience, health practices, values and lifestyle. The nurse is often much closer to the client than other members of the healthcare team. During an assessment the nurse is responsible for the collection of comprehensive data, including physical, social/environmental, psychological, sexual, spiritual and economic. The patient is the primary source of data, while family members or other support persons and relevant literature are secondary or indirect sources. Diagnosis is the second phase of the nursing process (Berman et al., 2016). During the diagnosis phase, nurses use critical thinking skills to interpret assessment data and identify clients' health needs. Activities preceding this phase are directed at formulating the nursing care plan activities. In this study, the nurse as a primary agent, assesses and diagnoses the dynamics of the recipient and the context, as illustrated in Table 6.14.

6.5.3.2 Planning

According to Hinkle and Cheever (2018), the planning component of the nursing process begins once the diagnoses have been identified. All planning is multidisciplinary, involves a number of healthcare providers and interacting with the patient, and includes the patient and family to the fullest extent possible in every step. Planning includes the actions nurses must take to address the patient's health needs and produce the desired outcomes.

6.5.3.3 Implementation

By using data acquired during assessment, the nurse can individualise the care given in the implementing phase, tailoring interventions to fit a specific client rather than applying them routinely to categories of patients. Implementation is an action initiated to accomplish defined goals. The nurse may execute or designate to other capable members of the MDT the interventions that were developed in the planning phase which are required for realising the patient's health goals. Referrals to other members of the MDT should be made when the nurse anticipates that expertise in specialised fields would benefit the patient. The implementation phase of the nursing process ends when the nursing interventions have been completed (Hinkle & Cheever, 2018).

6.5.3.4 Evaluation

According to Berman et al. (2016), to evaluate is to judge or to appraise. This is an important aspect of the nursing process because conclusions drawn from the evaluation determine whether the nursing interventions should be terminated, continued or changed. Evaluation continues until the client achieves the health goals or is discharged from nursing care. Before evaluation, the nurse identifies the desired outcomes that will be used to measure the patient's goal achievement.

Table 6.14: Assessment and diagnosis of the dynamics of the recipient and the context

Phase 1: [Assessment and Diagnosis]			
Recipient		**Context**	
Assessment	**Diagnosis**	**Assessment**	**Diagnosis**
Physical needs Nutritional aspects Hygiene Pain relief Safe environment Physical activity Physiological process (digestive and urinary)	**Physical dynamics** Lack of physical activities Lack of appropriate nutrition Unconducive environment Pain	**Macro enablers** Availability of national policies and guidelines Clear regulatory system Availabilities of resources Specification of funding roles Specification of scope/roles and responsibilities Support for education and endorsement	**Macro barriers** Lack of policies and guidelines Lack of support from the MoHSS Shortage of resources
Psychological needs Autonomy Safety and security Personal significance Connection and acceptance Progress	**Psychological dynamics** Emotional effects: Stress Depression Fear Anxiety Guilty and remorse Isolation Psychosexual issues Psychological distress Lack of support	**Meso enablers [community and families]** Community support Network Involvement Participation Empowerment	**Meso barriers [community and families]** Lack of knowledge on PCa Lack of community involvement and participation
Social needs Food security Housing Safe and secure environment Relationship with others Need to be loved Need to be accepted by others Need for belonging to community	**Social dynamics** Rejection Isolation Stigmatisation Lack of support	**Micro-enablers [Nurse and MDT]** Support from colleagues Inter professional collaboration and coordination Consultation Collaboration Teamwork Capabilities of the stakeholders Negotiation Advocacy Diplomacy & promotion of roles Cooperation Partnership Joint decision-making Networking Communication Sharing of resources Engagement	**Micro-barriers [Nurse and MDT]** Shortage of resources Inadequate training of nurses in PCa Insufficient supportive care for men

Table 6.14: Assessment and diagnosis of the dynamics of the recipient and the context (continued)

Phase 1: [Assessment and Diagnosis]			
Recipient		**Context**	
Assessment	**Diagnosis**	**Assessment**	**Diagnosis**
Spiritual needs Need for meaning and purpose in life Need for love and being loved Feel of sense and belonging Feel of hope and gratitude Need of peace of mind	**Spiritual dynamics** Hopelessness Overwhelm Feeling of being punished Guilty feeling Withdrawal Isolation Angry at God		
Phase 2: [Planning and Implementation of the facilitation process by the agent]			
Identification of the MDT and their roles and responsibility Nurse Urologist Chaplain Psychologist Social worker Dietician Oncogeriatrician Radiation oncologist Medical oncologist Physiotherapist Pathologist Pharmacist			
Identification of mechanism [enablers] for facilitating the dynamics and barriers of the recipient and context [procedure] Communication Sharing resources Integration Networking Coordination Engagement Consultation Collaboration Involvement Cooperation Interaction Partnership Joint-decision-making Team work Participation			
Phase 3: Evaluation of outcome of supportive care [terminus]			
Evaluation of outcome	**Type of supportive care**		
Physical support	Provision of a conducive environment Provision of nutritional aspects Provision of pain relief Encourage physical activities Maintaining physiological processes		
Social support	Maintaining food security Provision of housing Provision of safe and secure environment Maintaining relationships with others Showing of love and acceptance Sense of belonging to the community		

Table 6.14: Assessment and diagnosis of the dynamics of the recipient and the context (continued)

Phase 3: Evaluation of outcome of supportive care [terminus]	
Evaluation of outcome	**Type of supportive care**
Psychological support	Provision of counselling and psychotherapy Autonomy Maintaining safety and security Personal significance Connection and acceptance
Spiritual support	Provision of counselling Sense of purpose and meaning in life Feeling of being loved Feeling of belonging Feelings of hope, peace and gratitude

6.5.4 Holistic Theory (Smuts, 1926)

Jan Smuts (1926, cited in Huljev & Pandak, 2016) defines the term "holism" as a theory which holds that the whole is more than the sum of its systemic parts. The human being consists of body, mind and spirit, integrated into a whole, whose parts are inseparable. According to Jasemi et al. (2017), the philosophy of holistic theory is based on unity and a humanistic view of the patient. The theory describes approaches and interventions that are meant to satisfy a patient's physical, social, psychological and spiritual needs. Providers of holistic care consider the patient as a whole and acknowledge the interdependence among their physical, social, psychological and spiritual aspects. In addition, holistic care emphasises the partnership between nurse and patient and the negotiation of healthcare needs that lead to recovery. According to Cadet et al. (2016), holistic supportive care emphasises a patient-centred approach with a focus on the whole person, which includes emotional, spiritual, social, and lifestyle factors. For this services are provided in a consistent approach across a range of providers and not just one organisation or provider. This also includes advanced training for nurses and the provision of national policies and clinical guidelines to ensure consistency of care and to improve the overall health and quality of life of post-treatment PCa survivors (Cowens-Alvarado et al., 2013). Figure 6.3 illustrates the provision of holistic supportive care (terminus) for men diagnosed with PCa.

6.5.4.1 Physical

According to Chan et al. (2018), physical relates to the things perceived through the senses rather than the mind. Physical complaints of men with PCa include illness and disability, psychological concerns manifested as fear of pain or death and social issues such as family dynamics (Nair et al., 2018). A focus on the physical comfort of the patients enhances their psychological well-being, therefore nurses should consider promoting psychological comfort in patients by improving the quality of their physical care through effective communication during nursing procedures and when providing symptom relief (Chan et al., 2018). Patients must be have access to the full range of supportive care resources open to them within their geographical areas (Mogotlane et al., 2013).

6.5.4.2 Social

A social setting is made up of interpersonal relationships in one's family, peer group, work, neighbourhood, religious organisations and support groups (Ginter & Braun, 2019). It is therefore imperative for the social setting to be assessed for the degree to which it supports or hampers a patient's well-being. According to Berman et al. (2016), understanding the social context in which a patient is living plays an important role in health promotion. Individuals and groups, through interpersonal relationships, can provide comfort, assistance, encouragement and information to patients in need. Social support systems contribute to health by creating an environment that promotes self-esteem and wellness by encouraging healthy behaviours. Social support systems include family, peer support groups and community-organised religious support systems. Ginter and Braun (2019) stress that nurses need to be cognisant of their patients' social setting and whether members of that setting are a source of anxiety or are providing sufficient support for the patients.

6.5.4.3 Psychological

According to Chan et al. (2018), the patients' psychological states change with the physical care that they receive. The risk factors for patients' distress include unrelieved physical symptoms, such as pain, fatigue, sleeplessness, vomiting and constipation. Psychological support from health personnel is imperative because it helps patients to cope with psychological and emotional stress, overcome the effects of frailty caused by the disease post-surgery and treatment side-effects (Cheah et al., 2016).

6.5.4.4 Spiritual

Spirituality is described as an individual and open approach in the search for meaning and purpose in life, and as a search for transcendental truth, which may include a sense of connectedness with others, nature and/or the divine (Büssing & Koenig, 2010). It relates to culture and religion and collectively they influence the perceptions of health and illness. Spirituality is a crucial element of cancer patients' paths toward healing or dying because it helps patients to discover a purpose in life (Surbone et al., 2010). Unmet spiritual needs put cancer patients at risk of hopelessness and a diminished sense of spiritual meaning and peace. According to Berman et al. (2016), spiritual beliefs can affect a person's interpretation of events in his/her life and, therefore, an assessment of spiritual well-being should be part of evaluating the person's overall health. Table 6.15 illustrates the application of holistic supportive care for men diagnosed with PCa in health facilities.

Table 6.15: Holistic supportive care in terms of physical, social, psychological and spiritual

Type of supportive care	
Physical	Provision of an enabling/conducive environment Provision of nutritional aspects Provision of pain relief Encouraging physical activities Maintaining of physiological processes
Social	Maintaining food security Provision of housing Provision of a safe and secure environment Maintaining relationships with others Showing love and acceptance Sense of belonging to the community
Psychological	Provision of counselling and psychotherapy Autonomy Maintaining of safety and security Personal significance Connection and acceptance
Spiritual	Provision of counselling Sense of purpose and meaning in life Feeling of being loved Feeling of belonging Feelings of hope, peace and gratitude

6.6 RELATIONSHIP OF THE STATEMENTS

Chinn and Kramer (2018) define a relationship statement as any statement that sets out a connection or association between two or more phenomena. Relationships are the linkages among and between concepts. In this study, the relationship statements were formulated from essential and related criteria, as well as other concepts.

- Men and family [**recipient**] in the health facilities are diagnosed with needs [assessment].
- Needs [dynamic] are physical, social, physiological and spiritual [diagnosis] and require support [planning].
- Support needs are managed within the **health system [context]** (**macro**, **meso** and **micro**).

- Men in the **health system** are managed by the **MDT [Agent]** (nurses, medical oncologists, radiation oncologists, urologists, pathologists, pharmacists, psychologists, social workers, physiotherapist, chaplains, oncogeriatrician, dieticians/nutritionist).
- The management process [**procedure**] is done through communication, coordination, integration, teamwork, sharing resources, networking, participation, engagement, partnership, collaboration, involvement, cooperation, interaction, joint decision-making and consultation with management, the MDT and stakeholders in a conducive, caring, loving, sustainable and friendly environment with the resources required for supportive care and survivorship of men [implementation].
- Provision of support [evaluation] should be done holistically by an MDT [terminus]

6.7 FINAL PROPOSED STRUCTURES TO BE USED IN THE DEVELOPMENT OF THE MODEL

The structure proposed for the development of the model was derived from the identified central concepts namely: physical, social, psychological and spiritual support (Table 5.12), six elements of Dickoff et al.'s (1968) practice oriented theory, three contexts adopted from Von Bertalanffy's (1930) systems theory, as well as three phases derived from Ida Jean Orlando 's (1961) nursing process theory, as illustrated in Figures 6.1, 6.2, and 6.3.

6.7.1 Proposed structure of phase 1: Initiation

The proposed structure of phase 1 is based on the three identified contexts that have an influence on supportive care as, illustrated in Figure 6.1, namely, the macro, meso, and micro contexts.

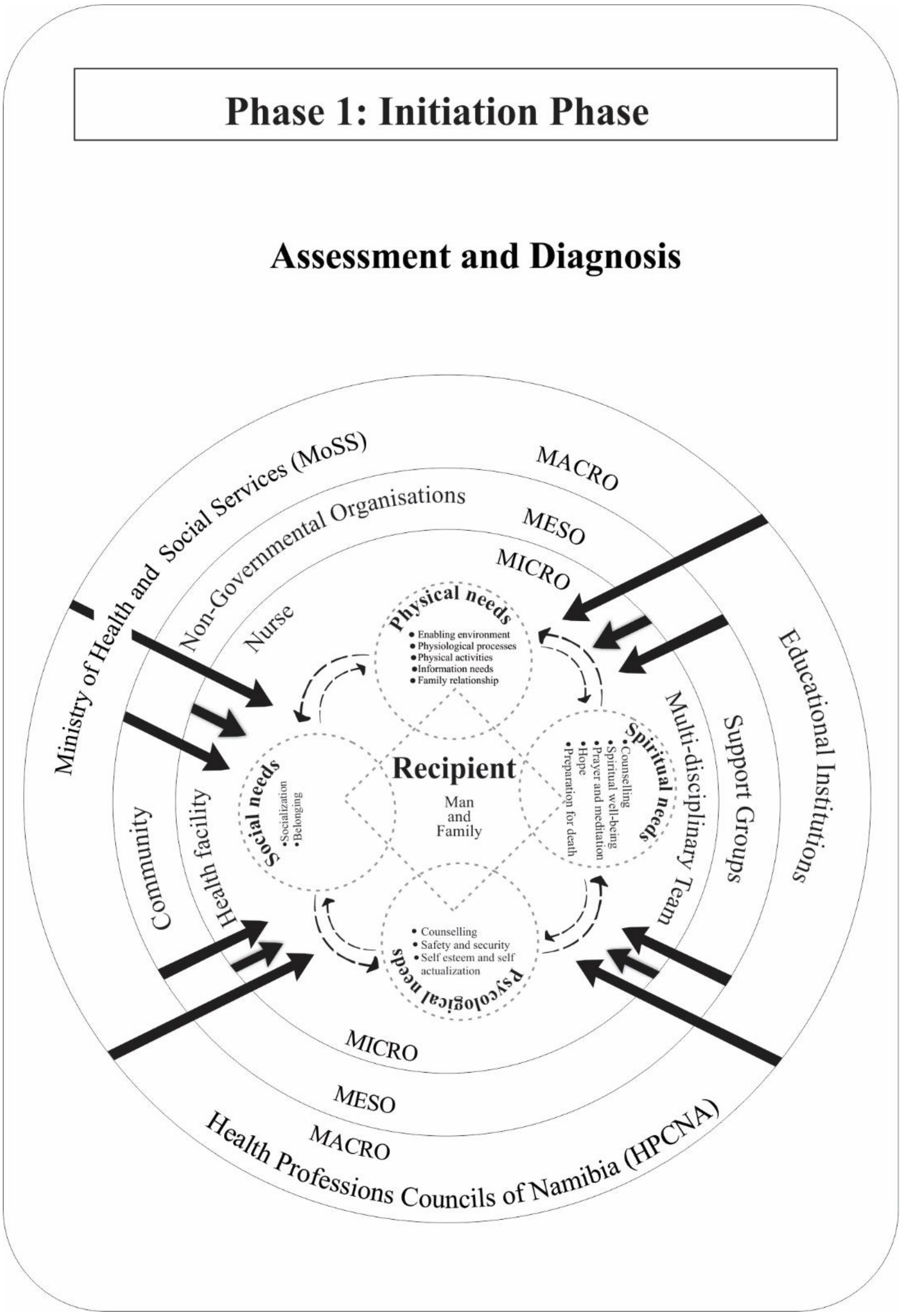


Figure 6.1: Proposed structure of phase 1

6.7.1.1 Macro context

The macro context refers to the national and professional legal frameworks that influence healthcare policies at national level (Smith et al., 2019). Macro contexts are the major external factors that influence the organisation's decision-making, its performance and strategies. In this study, the macro context is made up of the MoHSS, the HPCNA and educational institutions, owing to the influence they have on supportive care for men diagnosed with PCa and their families.

6.7.1.2 Meso context

The meso context comprises local institutional factors and influences, as well community issues that often characterise or define the parameters of service delivery (Smith et al., 2019). In this study, the meso context entails the stakeholders that have an influence on supportive care for men diagnosed with PCa and their families, namely, the community, NGOs and support groups.

6.7.1.3 Micro context

The micro context is characterised by the day-to-day practice and attributes or characteristics of individual practitioners and their practice environments which affect how services are delivered (Smith et al., 2019). Daily nursing practice in which nurses encounter professional challenges from members of the healthcare team or colleagues takes place within the micro context. In this study, the micro context consists of the health facilities in which the facilitation of supportive care activities occurs, and in which the nurse and other members of the MDT carry out such activities.

6.7.2 Proposed structure of phase 2: Working

The proposed structure of phase 2 is made up of a nurse, as a primary agent, and other members of the MDT, namely: urologist, pharmacist, pathologist, physiotherapist, medical oncologist, radiation oncologist, oncogeriatrician, dietician, social worker, psychologist and chaplain. In supportive care for men with PCa, the nurse ‘score function is to bring together a group of healthcare professionals from different fields in order to determine the patient’s treatment plan in a holistic manner (Hinkle & Cheever, 2018; Taberna et al., 2020). A MDT is a group of healthcare workers who are members of different disciplines functioning together to answer a particular clinical problem in a holistic manner. In this phase, the nurse and all members of the MDT aim for holistic supportive care for men with PCa and their families through a facilitation process that consists of communication, consultation, collaboration, engagement, involvement, coordination, interaction, integration, team work, cooperation, participation, networking, partnership, sharing of resources and joint decision-making. Figure 6.2 depicts the proposed structure of phase 2.

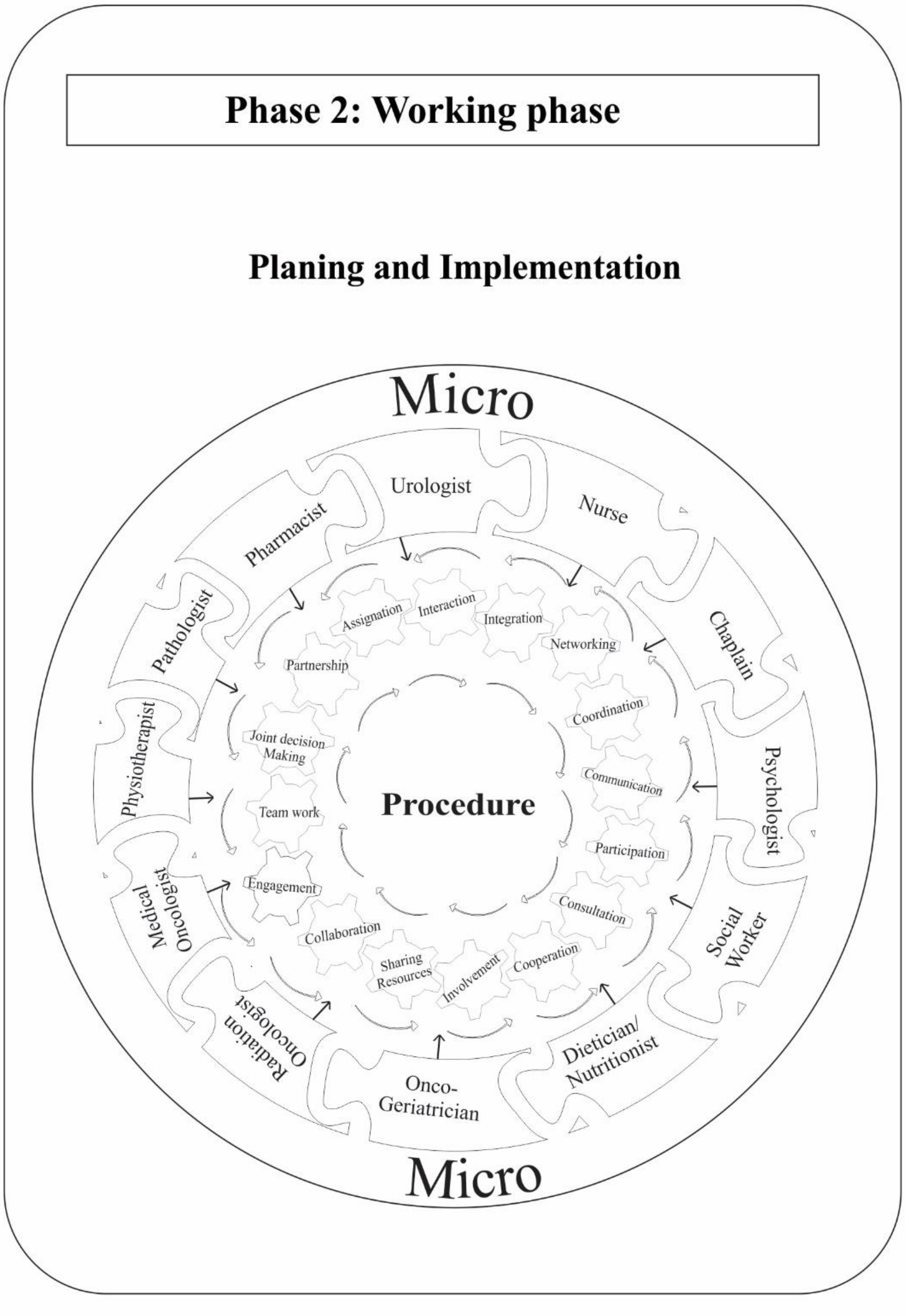


Figure 6.2: Proposed structure of phase 2

6.7.3 Proposed structure of phase 3: Terminus

The proposed structure of phase 3 comprises the terminus. Terminus refers to the end point or purpose of the activity (Dickoff et al., 1968). During this phase, the nurse evaluates whether the implementation of the supportive care activities was effective and whether men’s needs were holistically met through the provision of physical, social, psychological and spiritual support. The provision of holistic supportive care enables men diagnosed with PCa to deal with their illnesses, consequently improving their lives. Figure 6.3 illustrates the proposed structure of phase 3 (terminus).

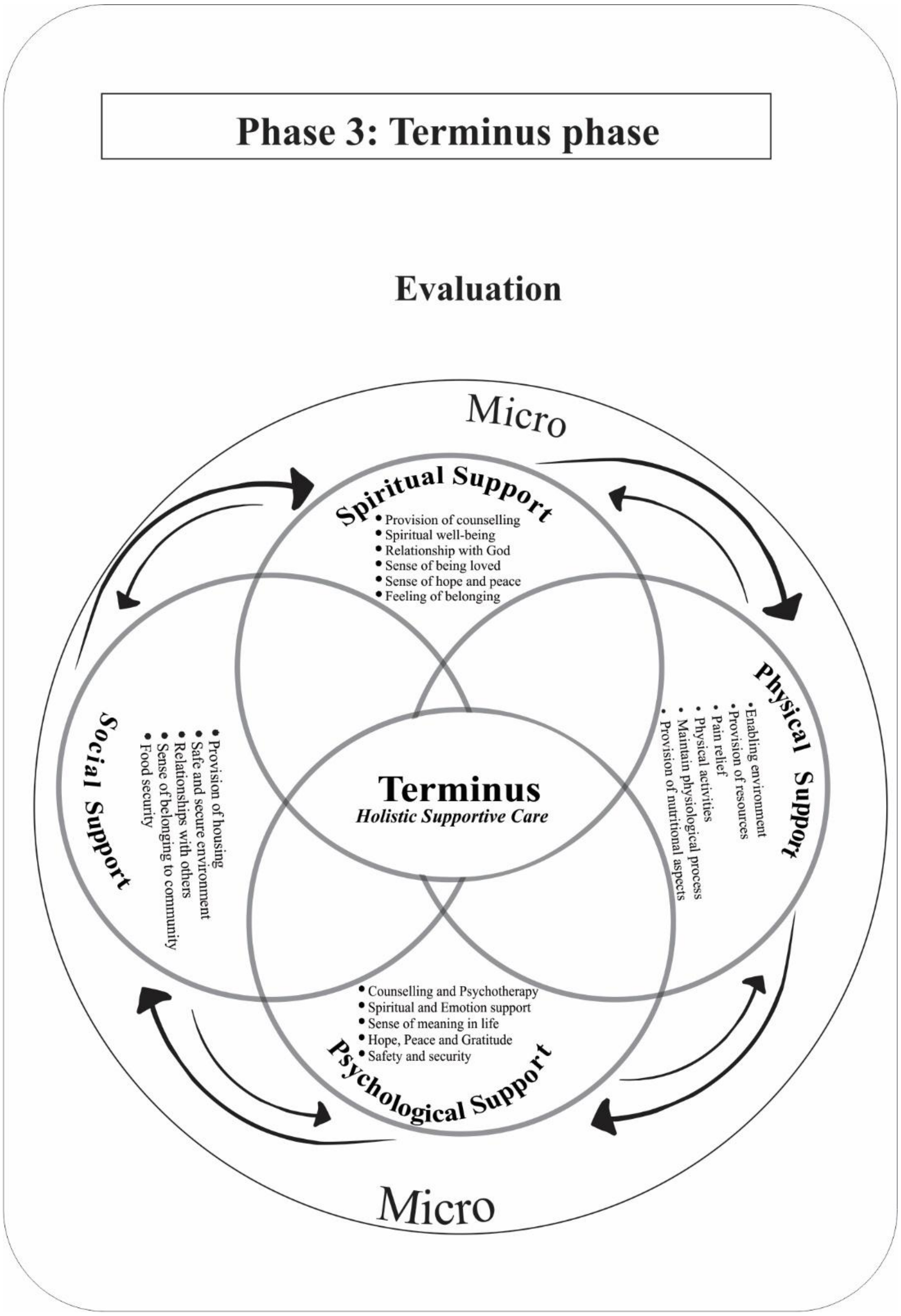


Figure 6.3: Proposed structure of phase 3

6.7.3.1 Physical support

According to Chan et al. (2018), physical support involves effective nurse–patient communication, which is the key to promoting the psychosocial well-being of patients. The delivery of physical support for men diagnosed with PCa and their families includes the provision of resources (human, material and financial), policies and guidelines on supportive care, as well as infrastructure in which the facilitation of supportive takes place. During the provision of physical support, nurses should physically manage cancer-related issues such as physical symptoms management, helping patients to understand the cancer trajectory, involving men and their families in treatment decision-making, providing exercise physiology classes, and assisting men to develop personalised exercise programmes.

6.7.3.2 Social support

Drennan and Goodman (2014) define social support as an existence or availability of people on whom you can rely, who let you know that you are cared about, valued and loved through partnership, interaction, collaboration and connection. Albaugh et al. (2017) stress that support from PCa support groups for men diagnosed with PCa is an important aspect of the healing process and should therefore be considered throughout the disease trajectory. Nurses should introduce men to peer support programmes that afford them with the opportunity to talk to survivors of PCa who may help by normalising the cancer experience, decreasing feelings of self-blame, self-isolation and promoting a hopeful stance. Peer support provides an opportunity for men to share their experiences with other men in similar situations, thus making them feel less alone. The diagnosis of PCa may affect the entire family; therefore nurses should pay attention to the needs and feelings of men’s family members throughout the cancer trajectory.

6.7.3.3 Psychological support

Psychological support is beneficial for men diagnosed with PCa because it improves men’s quality of life by reducing the psychological distress caused to the men by physical symptoms (Lavdaniti, 2017). Nurses should provide psychological support for men through encouragement, emotional support and information support, as well as by referring them for counselling and psychotherapy services. Huljev and Pandak (2016) stress that in order to facilitate physical healing, nurses need to promote men’s psychological and emotional wellbeing through counselling and effective communication and listening. Nurses must also ensure psycho-educational interventions to help partners develop a more positive approach.

Similarly, family members should be given emotional support to assist them to cope with their own fear, uncertainty and feelings associated with the illness of their loved ones.

6.7.3.4 Spiritual support

Spiritual support entails establishing an empathetic connection with patients and their families by engaging with them in spiritual discussions or referring and introducing them to trained professionals such as chaplains, when available. Spiritual support should therefore be provided in the form of spiritual counselling to enable men’s connectedness to God that gives a feeling of belonging.

6.8 SUMMARY

This chapter presented the conceptual framework of the study. The identification and definition of the main concepts were presented, followed by the formulation of the relationship statements. The application of the adopted theories, namely, practice oriented theory (Dickoff et al., 1968), systems theory (Von Bertalanffy, 1930), holistic theory (Smuts, 1926) and the nursing process theory (Orlando, 1961), to the proposed structure of the model for nurses to facilitate supportive care for men diagnosed with PCa and their families was presented. The related and essential attributes identified served as a guide for model development. Using the characteristics of the main concepts identified, a model case was developed. The next chapter focuses on a description of the model together with contributions on model development from the expert researchers who supervised the study.

CHAPTER 7

DESCRIPTION OF A MODEL FOR NURSES TO FACILITATE SUPPORTIVE CARE FOR MEN DIAGNOSED WITH PROSTATE CANCER AND THEIR FAMILIES

7.1 INTRODUCTION

Chapter 7 focuses on the conceptualisation of the main concepts of the central statement in order to present their conceptual definitions. The aim of this chapter is to describe the model for nurses to facilitate supportive care for men diagnosed with PCa and their families in health facilities. The concepts of the central statement are derived from the findings in Chapters 4, 5 and 6 and formed the basis for the model development. The developed model for nurses to facilitate supportive care for men diagnosed with PCa and their families is informed by the following theories: practice oriented theory (Dickoff et al., 1968), systems theory (Von Bertalanffy, 1930), holistic theory (Smuts, 1926) and nursing process theory (Orlando, 1961). Using a concept analysis and derivation process, the researcher identified three phases that guided the development of a facilitation process for men's supportive care. Finally, the model is evaluated in accordance with the criteria for evaluating the nursing model, as proposed by Fawcett (2005) and Parse (2005).

7.2 DESCRIPTION OF THE MODEL

According to Chinn and Kramer (2018), describing a model involves a process comprising the posing of questions about the components of the model. In this study, the description of the model is done in line with the six descriptive components proposed by Chinn and Kramer (2018), namely: purpose, concepts, definitions, relationship, structure and assumptions. Each component of the model is described in terms of the way in which it contributes to the purpose of the model. A schematic representation in Figure 7.1 portrays the structure of a model for nurses to facilitate supportive care for men diagnosed with PCa and their families in health facilities. The model is indicated as follows:

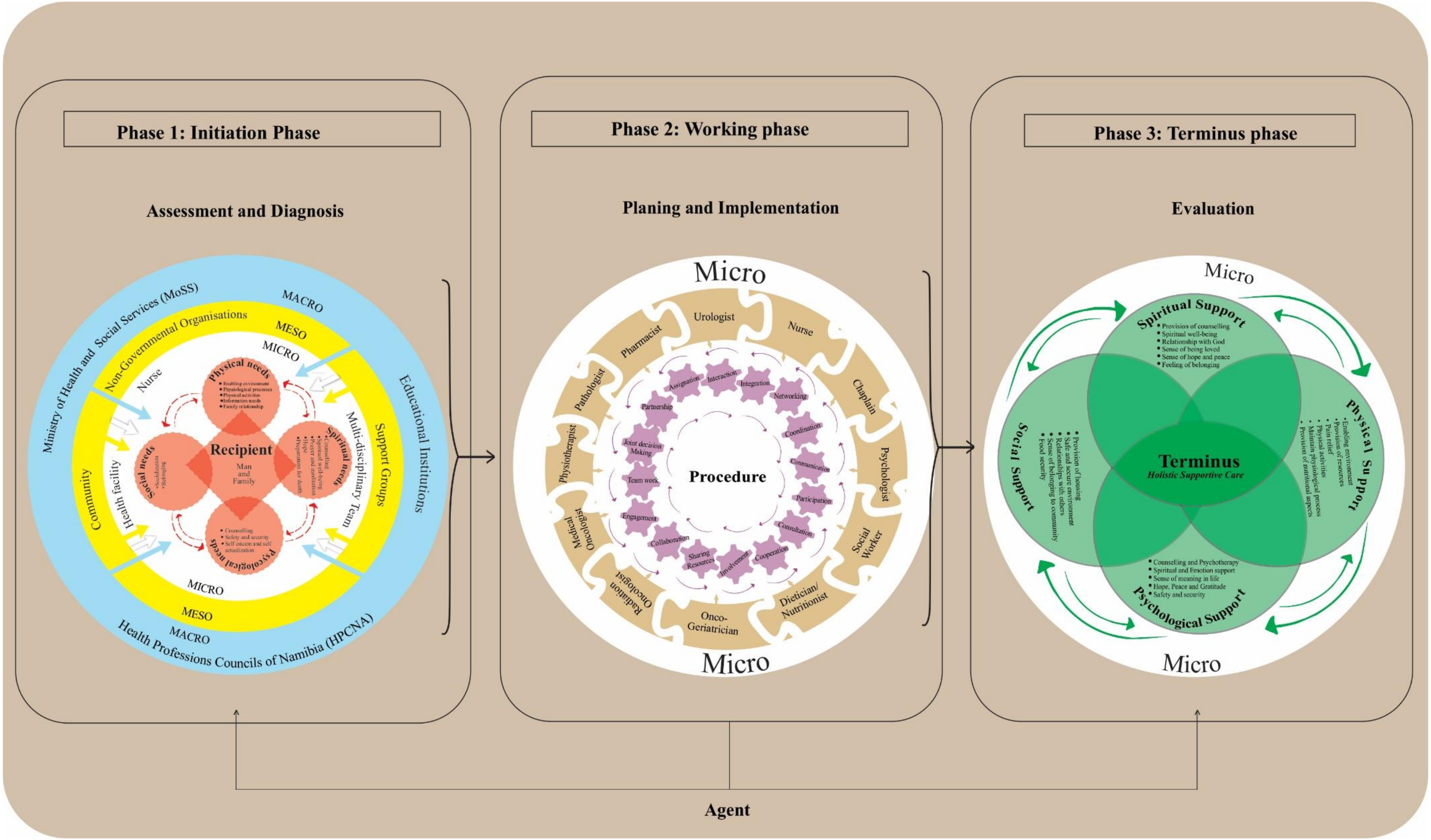


Figure 7.1: A model for nurses to facilitate supportive care to men diagnosed with prostate cancer and their family

7.2.1 Overview of the model

Figure 7.1 illustrates the model and the structures involved in the development of the model. The facilitation of supportive care for men diagnosed with PCa and their families in health facilities requires experienced and expert facilitators, to support men and family. The developed model therefore serves as a frame of reference for the facilitation of supportive care for men with PCa in oncology departments. The findings of the study as highlighted in Chapters 5 and 6 revealed dynamics in the macro, meso, and micro contexts perceived by both men, family and nurses as barriers to the facilitation of supportive care for men and their families in health facilities, namely: a lack of physical, social, psychological and spiritual support. Based on the findings, the researcher concluded that in order for the nurses to facilitate supportive care for men and family at health facilities, there is a need for nurses to collaborate with members of the MDT in order to jointly address the identified barriers.

The schematic representation in Figure 7.1 illustrates the three phases in which nurses, as primary agents in collaboration with other members of the MDT, facilitate the supportive care process for men diagnosed with PCa and their families in the health facility. Each phase of the model is clarified in terms of the manner in which it contributes to the model as a whole. The position of each member of the MDT and their roles are explained in detail in the model process. In addition, guidelines for operationalising such model were developed.

7.2.2 The purpose of the model

Chinn and Kramer (2018) emphasise that the purpose of a model is important because it specifies the context and situations in which the model is useful; therefore, the purpose should be identifiable. The purpose of this model is to provide a framework for nurses to facilitate supportive care for men diagnosed with PCa and their families at health facilities. The proposed activities for each of the three phases of the model serve as guidance for nurses, as the main facilitators, in leading the facilitation process to ensure that the health needs of men diagnosed with PCa and families are addressed. The three phases of the model comprise initiation, that is, (1) focusing on the assessment and diagnosis, (2) working, focusing of planning and implementation, and (3) terminus, focusing on evaluation.

7.2.3 Facilitators of the model

The facilitators of this model are nurses and other members of the MDT, namely: urologist, pharmacist, pathologist, physiotherapist, medical oncologist, radiation oncologist, oncogeriatrician, dietician, social worker, psychologist, and chaplain. During the facilitation process to provide supportive care for men diagnosed with PCa and their families in health facilities, a nurse, as primary agent, and other members of the MDT work as a team applying communication, consultation, collaboration, engagement, involvement, coordination, interaction, integration, team work, cooperation, participating, networking, partnership, sharing of resources, and joint decision-making.

7.2.4 Context for the facilitation of the model

The facilitation of the model will take place within the micro context (health facilities), influenced by both the macro and the meso contexts. The facilitators of the implementation process in health facility are nurses, as primary agents, in collaboration with other members of the MDT namely: urologist, medical oncologist, radiation oncologist, physiotherapist, pathologist, pharmacist, oncogeriatrician, dietician, social worker, psychologist and chaplain. The presence of the MDT allows various specialists to work together and to plan the facilitation of supportive care for a man and his family as recipients.

7.2.5 Structure of the model

The structure of the model is presented in three phases, as adopted from Ida Jean Orlando's (1961) Nursing Process Theory: phase 1 – initiation (assessment and diagnosis), phase 2 – working (planning and implementation), and phase 3 – terminus (evaluation). The three phases of the model are illustrated in Figure 7.2 (phase 1), 7.4 (phase 2), and 7.5 (phase 3).

7.2.5.1 Phase 1: Initiation

Phase 1 (initial) is comprised of three circular contexts as adopted from the Systems theory of Von Bertalanffy (1930) namely: macro, meso, and micro. The schematic presentation of phase 1 is illustrated in Figure 7.2.

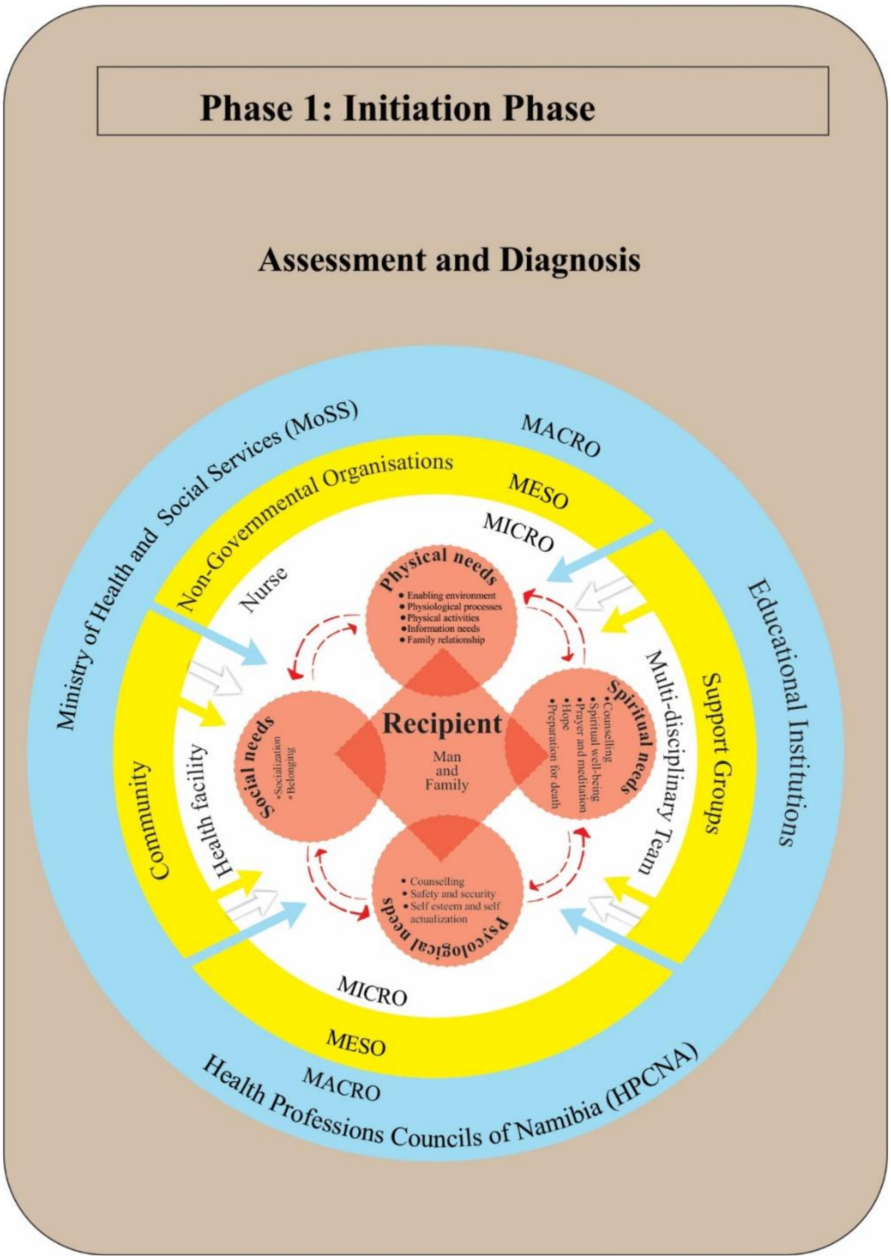


Figure 7.2: Schematic presentation of phase 1

A circle shape suggests protection, comforting, unity and harmony, love, safety, community, holism, and partnership (Fogelström, 2013).

Macro context: The external (outer) circle in blue represents the *macro* context. The macro context symbolises the supra-health system level that directly or indirectly influences the facilitation of supportive care for men diagnosed with PCa in health facilities. The four blue arrows towards the recipients symbolise the influence of the macro context to the facilitation of supportive care for man diagnosed with PCa and his family. Within the macro context are the educational, legal and regulatory frameworks that govern or influence the operations of health facilities namely: Ministry of Health and Social Services (MoHSS), Health Professions Councils of Namibia (HPCNA) and Educational Institutions.

Ministry of Health and Social Services (MoHSS)

The MoHSS was identified as the custodian of the health facilities in which the facilitation of supportive care for men diagnosed with PCa and their families takes place. The MoHSS also avail the resources required for the facilitation of supportive care in health facilities. The results of this study confirmed shortage of resources and non-conducive environment for counselling men in health facilities as the most obstacles to the facilitation of supportive care for men diagnosed with PCa and their families. The results also revealed lack of support from MoHSS and inconsistencies on supportive care for men due to lack of clinical policies and guidelines to inform supportive care at health facilities.

Health Professions Councils of Namibia (HPCNA)

The HPCNA was identified as influential in the facilitation of supportive care for men diagnosed with PCa because it is responsible for controlling and exercising authority over all matters relating to nursing education and training, regulate the practising of the nursing profession by specifying the scope of practice of nurses in Namibia, as well as to ensure that all persons practising such professions are registered or enrolled. Similarly, the HPCNA promote the continuing professional development (CPD) of nurses, and uphold research in the field of the nursing profession. The findings of this study reveal lack of in-service trainings for nurses on supportive care that results in nurses not to be knowledgeable or informed about the scope of PCa care.

Educational Institutions

The educational institutions emerged as important to be involved in the facilitation of supportive care for men diagnosed with PCa and their families because they have been approved by the HPCNA for the purpose of education and training of nurses, midwives and accoucheurs. The results of this study revealed lack of training for nurses on supportive care for men diagnosed with PCa, resulting in reliance on basic training knowledge and learning from others upon facilitating supportive care for men diagnosed with PCa and their families in health facilities. Educational institutions can therefore assist by introducing a post-graduate oncology nursing course as a specialty that offers an intensive training to nurse practitioners as to enable them to provide appropriate and holistic supportive care for men with PCa and their families across the cancer trajectory.

Meso context: The medial circle in yellow represents the *meso* context. The four yellow arrows towards the recipients symbolise the influence of the meso context to the facilitation of supportive care for man diagnosed with PCa and family. In this model, the meso context consists of the community in which family members of men diagnosed with PCa lives, support groups, and the non-governmental organisations.

Community

The community was identified as influential in the facilitation of supportive care for men because following the discharge of men from the health facility, men returns to the community to be under the care of family members and other significant ones in the absence of supportive care from the healthcare team. The family plays a supportive role in the emotional and physical care of the men. The results of this study revealed lack of knowledge on PCa by community, as well as poor supportive care from families for men diagnosed with PCa.

Prostate Cancer Support Groups (PCSGs)

The PCSGs disseminate information on PCa, provide psychological support for men with PCa, reduce feelings of social isolation, and promote an optimistic outlook by helping men and families to come to terms with the disease. The results on best practices on supportive care for men diagnosed with PCa and their families obtained through scoping review of this study reveal that, PCSGs serves as the major source of support that helps men to understand PCa better, provides reassurance, reduces anxiety, and improves positive outlook and the perception of being more involved in treatment decisions.

Non-Governmental Organisations (NGOs)

The NGOs were identified as influential in the facilitation of supportive care for men diagnosed with PCa and their families because of their dedication to reduce the impact of PCa on men, their partners, families and wider communities. The NGO’s offers capacity building in areas such as cancer fundraising, volunteer recruitment, cancer control advocacy, and to mobilise civil societies to work together and advocate governments to develop policies and guidelines on supportive care for men diagnosed with PCa and their families.

Micro context: The internal (inner) circle in white represents the *micro* context. The micro context is about day-to-day practice and attributes or characteristics of individual practitioners and their practice environment that affect how services are delivered. The four white arrows towards the recipients symbolise the influence of the micro context to the facilitation of supportive care for men and family. In this model, the micro context comprises of the nurse, MDT, and the health facilities in which the supportive care of men diagnosed with PCa and family takes place.

Nurse and the multi-disciplinary team (MDT)

Within the health facilities are the *agents* who are the facilitators of the implementation process of supportive care namely; the nurse, as a primary agent, and other members of the MDT such as urologist, medical oncologist, radiation oncologist, physiotherapist, pathologist, pharmacist, oncogeriatrician, dietician, social worker, psychologist and chaplain. The presence of the MDT allows various specialists to work together and to plan the facilitation of supportive care for a man and family as *recipients*, placed at the centre of supportive care services in red diamond. The diamond shape represents the value or precious lives of the recipients. The diamond and the four circles within it are all dotted to indicate the unmet health needs of men diagnosed with PCa. The dotted curved arrows in red between the encircled physical, social, psychological and spiritual needs depict the interrelatedness of such needs. The big bracket in black with an arrow depicts the progression from phase 1 (assessment and diagnosis) to phase 2 (planning and implementation) of the model. In other word, an arrow denotes that phase 1 informs phase 2.

Health facility

The health facility denotes the context in which the facilitation of supportive takes place. A conducive health facility enables the facilitation of supportive care for men diagnosed with PCa and their families to be effective.

Each context in phase 1 of this model namely; macro, meso, and micro are comprises of *dynamics* (barriers that hampers the facilitation of supportive care) and enablers as illustrated in Figure 7.3.

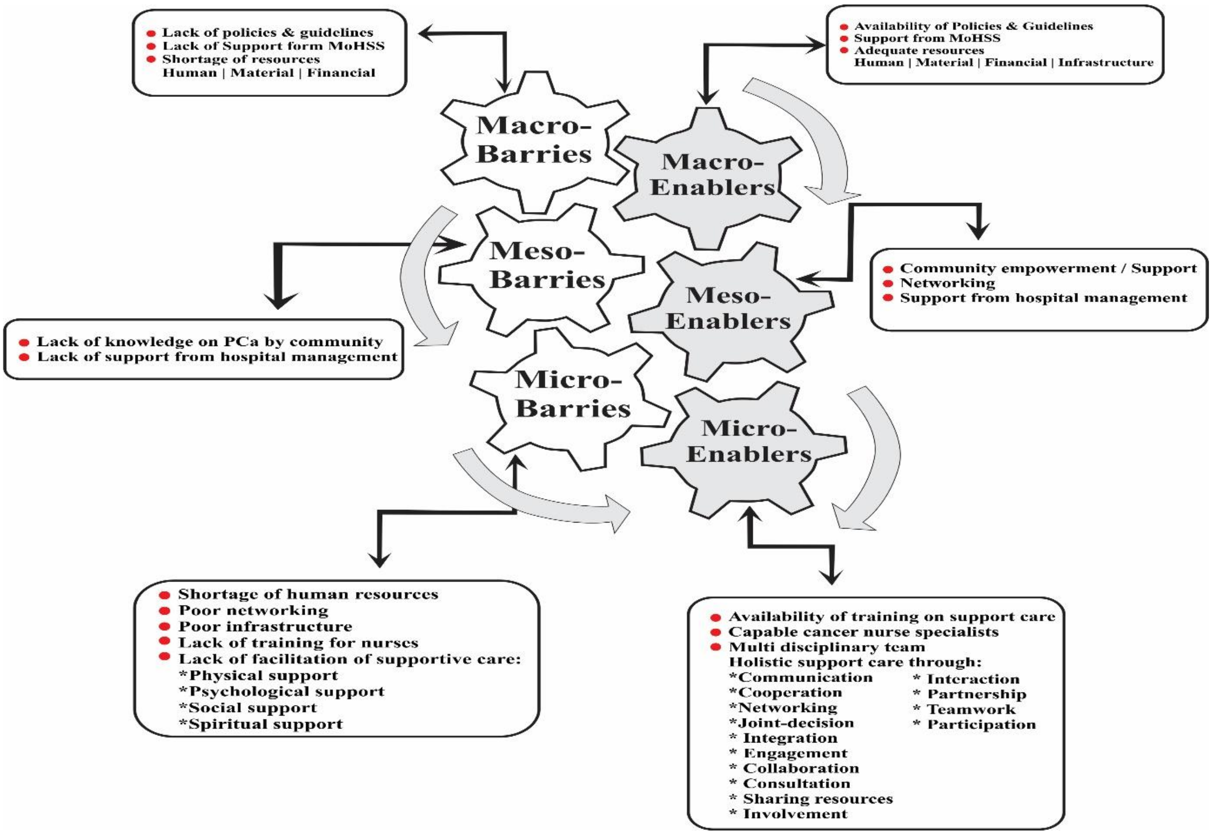


Figure 7.3: Dynamics (barriers) and enablers of the macro, meso and micro contexts

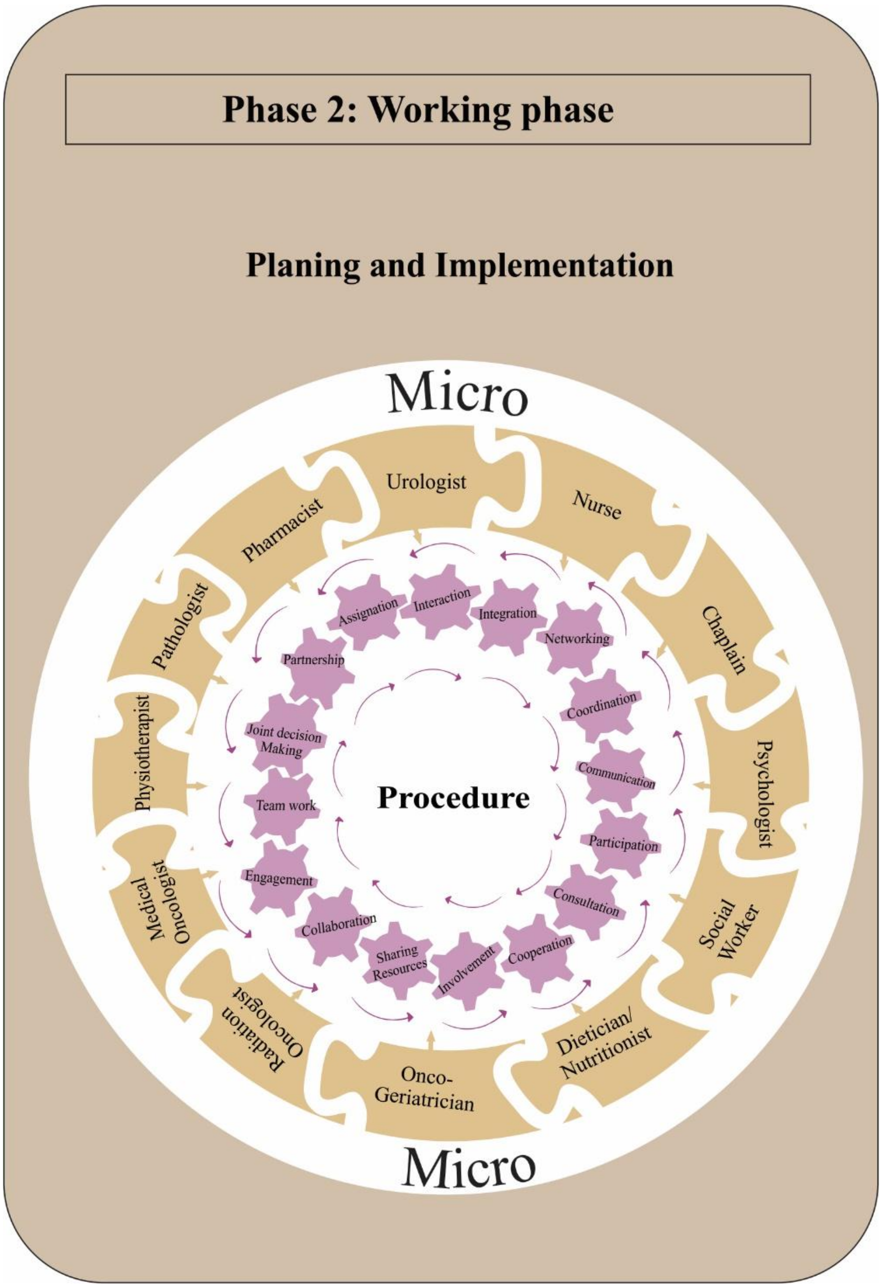
The dynamics (barriers) serves as the challenges against which this model was created. The *dynamics* in respect of *macro context* in this study may be expressed in terms of lack of policies and guidelines on supportive care, lack of support from MoHSS, and shortage of resources in terms of human, financial, material and infrastructures. The macro context *enablers* include the availability of policies and guidelines, support from MoHSS, and adequate resources in terms of human, financial, material and infrastructures. The *dynamics* (barriers) in respect of *meso context* that hinder the facilitation of supportive care for men diagnosed with PCa include lack of knowledge on PCa by community, as well as lack of community based PCa support groups. Meso context enablers are comprised of community empowerment, support and networking as well as an established community based PCa support groups.

With regard to the micro context, the dynamics that hinder the facilitation of supportive care for men diagnosed with PCa includes lack of support from hospital management, shortage of human resources, poor infrastructure, poor networking, lack of training for nurses on supportive care, lack of facilitation of supportive care for men diagnosed with PCa in terms of physical, social, psychological and spiritual support. The micro context *enablers* includes the support from hospital management, availability of trainings for nurses on supportive care, availability of capable cancer nurse specialists, and the availability of the MDT to provide holistic supportive care through communication, networking, integration, engagement, collaboration, consultation, sharing resources, involvement, cooperation, interaction, partnership, participation, teamwork, assignation and joint-decision-making.

7.2.5.2 Phase 2: Working

In phase 2 (working), the nurses, in their capacity as primary agents initiate the *procedure* of facilitating the supportive care for men diagnosed with PCa as illustrated in Figure 7.4.

Figure 7.4 Schematic representation of phase 2



In phase 2, the nurse identifies the members of the MDT (in gold) required for the facilitation of supportive care for men diagnosed with PCa, namely, the urologist, medical oncologist, radiation oncologist, physiotherapist, pathologist, pharmacist, oncogeriatrician, dietician, social worker, psychologist and chaplain. The definitions and roles of the MDT members were described in Chapter 6. Together with the MDT members, the nurse identifies the mechanisms for facilitating supportive care using *communication, networking, integration, engagement, collaboration, consultation, sharing resources, involvement, cooperation, coordination, interaction, partnership, participation, teamwork* and *joint-decision-making,* as illustrated by cogs in purple. The arrows surrounding the cogs symbolise the continuity or ongoing nature of the facilitation process (procedure), in other words, the facilitation process for supportive care for men diagnosed with PCa is never-ending. In this study, the *procedure* refers to the process for facilitating supportive care activities for men diagnosed with PCa and their families.

7.2.5.3 Phase 3: Terminus

Phase 3 (*terminus*) is the last phase of this model. In this study, *terminus* refers to the end point or the accomplishment of the *procedure*; in this case, the facilitation of supportive care activities. After the successful implementation of the facilitation process (*procedure)* in phase 2, the terminus of this model should be holistic supportive care for men diagnosed with PCa and their families, in other words, supporting men as a whole by providing physical, social, psychological and spiritual support as illustrated in Figure 7.5. The green intact arrows between each circle depict the interrelatedness of the physical, social, psychological and spiritual supportive care provided for men diagnosed with PCa and their families. The three arrows pointing upwards underneath each phase, as illustrated in Figure 7.1, symbolise that the entire supportive care facilitation process, from phase 1 to phase 3, is done by the agent.

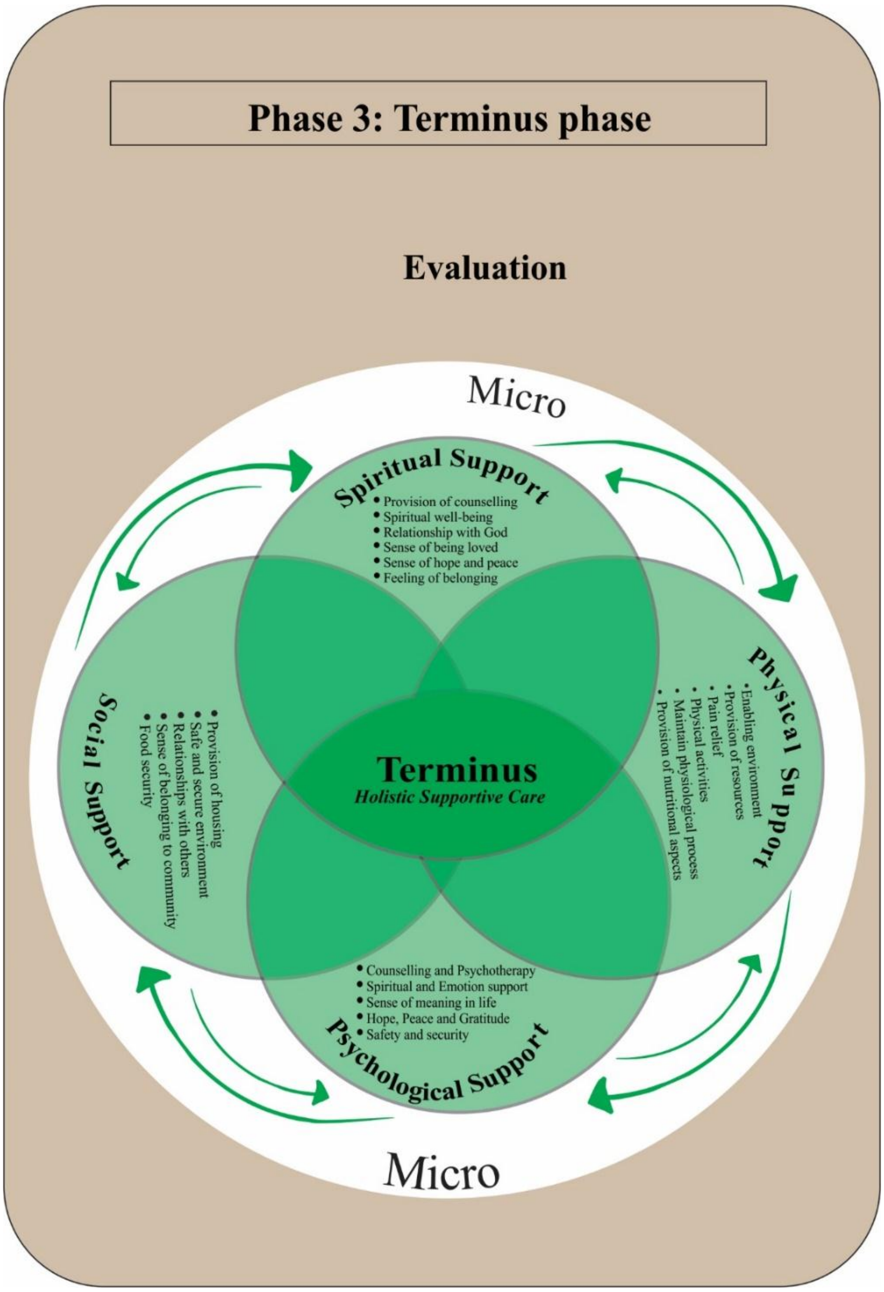


Figure 7.5: Schematic representation of phase 3

The structure of the model is illustrated using different colours, as adopted from Fogelström (2013); namely, brown, blue, yellow, white, red, purple, gold and green. The symbolic representation of the colours is described as follows:

● *Brown*. The brown colour used in the large outer rectangle symbolises earth. The colour was used to symbolise the home planet on which human beings live.

● *Blue*. Blue was used to represent the macro context. Blue symbolises authority, law, order, security, conservatism and responsibility. The colour denotes a plentiful environment, secure feelings and healthcare unity. These features are all associated with the HPCNA which is the regulatory body governing the nursing profession in Namibia, and the MoHSS as the custodian of the health facilities in which the facilitation of supportive care takes place.

🟡 *Yellow*. Yellow was used to represent the meso context. The colour signifies sunshine, brightness, happiness, cheerfulness, fun, hope and optimism. Yellow is strongly associated with originality. These features fit well with the community of which support groups and NGOs form part.

⚪ *White*, White denotes cleanliness, sanitation, transparency and quality. The colour is closely associated with the healthcare industry and is therefore used to represent the micro context that houses the health facilities in which the nurse and other members of the MDT facilitate supportive care for men diagnosed with PCa.

🔴 *Red* was used to represent the unmet health needs of men diagnosed with PCa and their families, that is, physical, social, psychological and spiritual needs. The colour is powerfully associated with complaints, hazard, danger, threat, illness, emotion, anxiety, barriers and lack of hope. The combination of the above features will prompt the nurse, as a primary agent, to conduct an assessment and diagnosis of the dynamics of the recipient and the context in which the facilitation of supportive care occurs.

🟣 *Purple*. Purple was used to symbolise the facilitation process for the supportive care of man and their families (procedure). The colour symbolises vision, creativity, transformation, resourcefulness, teamwork and collaboration. The purple is a manifestation of loyalty, power and motivation. These features closely resemble the facilitation process implemented by the agents.

🟡 *Gold*. Gold signifies charisma, optimism and winning. The colour is strongly associated with the successful implementation of the facilitation process for supportive care by the agents.

🟢 *Green*. Green is the colour of renewal and restoration, self-reliance, peacefulness, emotional balance and calm. The colour was used to symbolise the terminus (outcome) of the facilitation process because of its strong connotations of restored health, new beginnings, transformation, peace, plentiful environments, reduced stress, happiness, joy and feeling.

These features are considered to preserve the outcome, which is the purpose for which the model was developed.

The structure of this model comprises of the assumptions, concepts, definitions of concepts and relationship statements. These are described as follows:

7.2.6 Assumptions of the model

Assumptions are principles or beliefs that the researcher accepts to be true without proof or empirical evidence (Creswell & Poth, 2018). Assumptions determine the researcher's understanding of concepts, definitions, purposes and relationships. In research, assumptions are embedded in the philosophical basis of the framework, the design and the interpretation of findings, and thus have an influence on the logic of a study. According to Creswell and Poth (2018) philosophical assumptions inform the choice of theories that guide our research, in other words, it form the basis from which theoretical reasoning proceeds. In this model, the main assumption is based on facilitating supportive care for men diagnosed with PCa and their families in health facilities. Using Dickoff et al.'s (1968) practice oriented theory, Von Bertalanffy's (1930) systems theory, Jan Smuts's (1926) holistic theory and Ida Jean Orlando's (1961) nursing process theory, the following assumptions were derived by means of deductive reasoning:

- Supporting men diagnosed with PCa and their families requires an MDT approach comprising nurses, urologists, pharmacists, pathologists, physiotherapists, medical oncologists, radiation oncologists, oncogeriatricians, dieticians, social workers, psychologists and chaplain in order to plan, organise, implement and evaluate the supportive care activities.
- The MDT should entail professionals who actively bring the skills of various individuals together and whose work is interdependent, where team members share responsibilities by considering men and their families as their main focus with the aim of addressing the health needs in a holistic manner.
- The agent (registered nurse), as a primary agent, requires assessment and diagnostic skills in order to identify the dynamics of the recipients and the contexts that have an influence on the facilitation of supportive care in health facilities, namely, the macro, meso and micro contexts.

- The agent (registered nurse), as a primary agent, also requires interpersonal skills in order to facilitate supportive care activities for men diagnosed with PCa and their families through communication, networking, integration, engagement, consultation, involvement, cooperation, coordination, interaction, participation, partnership, teamwork and collaboration with other members of the MDT by sharing resources and making joint decisions.
- The context in which the facilitation of supportive care takes place should be enabling, encouraging, conducive and adequately resourced in terms of people and materials.
- The recipients (man and family) should be the central focus of the supportive care activities, and their dynamics and that of the contexts should be assessed and identified by the agent in collaboration, coordination and consultation with other members of the MDT.
- Supporting men with PCa should be done in collaboration with family members.
- As an on-going process, the facilitation of supportive care activities requires monitoring and evaluation in order to determine whether the desired goal has been attained.

7.2.7 Theoretical definition of central concepts

The central statement "facilitation of physical, social, psychological and spiritual support" and related concepts are defined as follows:

The **facilitation of physical, social, psychological and spiritual support** for men is a collaborative, interactive, networking, and continuous process whereby nurses as agents, by virtue of their diversified skills and knowledge, provide supportive care for men in health facility contexts in terms of physical, social, psychological and spiritual support through consultation, involvement, partnership, cooperation, communication, integration, teamwork, engagement, participation, sharing resources and joint decision-making with members of the MDT. The facilitation of supportive care for men with PCa may be achieved by addressing the health needs of men (recipient) as well as the barriers within the macro, meso and micro contexts:

> **Facilitation:** The process that enables the provision of physical, social, psychological and spiritual supportive care for men within the health facility

context. Facilitation implies that nurses consult, communicate, collaborate, interact and engage in joint decision-making with the MDT, through partnerships and cooperation, in order to attain a common and consensual goal which is in the men's best interests. During the facilitation process, nurses and members of the MDT work as a team by sharing resources to address the men's health needs and contextual barriers.

Physical support: Physical support refers to the provision of a visible, tangible and favourable coping environment through a continuous relationship and communication and consultation with management and the MDT in terms of human, material, infrastructure, policies, guidelines and finance to meet the physical needs of men and family

Social support: Social support comprises an informal, partnership, collaborative and networking process between stakeholders (men, nurses, family, community, multidisciplinary team) through companionship, listening, interaction, cooperation, coordination, interdependent relationship, guidance, joint decision-making, and involvement to provide support for men and their families regardless of race, culture and politics.

Psychological support: Psychological support involves the provision of education and information by means of counselling, encouraging, building trust, referral management, screening, assessment, clarification, and emotional and spiritual support for men in order to empower them and enhance their mental and emotional stability for survivorship.

Spiritual support: This refers to the professional provision of support by a spiritual team or chaplains through engagement, communication, counselling and psychotherapy by considering the feelings, values, beliefs and religious convictions of men in order to enhance peace of mind and soul, faith, hope, connectedness and spiritual well-being through empathetic connection, relationships, interconnections and partnerships.

7.2.8 Theoretical definition of the related concepts

The related concepts in this study signify all the activities that should take place for the facilitation of supportive care by the nurse, as a primary agent, and other members of the MDT in health facilities. This facilitation process is done in three phases, therefore the concepts related to this model could include: assessment and diagnosis, planning and implementation, evaluation, agent, recipient, context, dynamics, procedure, terminus.

Assessment and diagnosis: Assessment and diagnosis refers to the systematic and continuous collection, organisation, validation and documentation of data carried out during all phases of the nursing process in order to identify clients' health needs, with the purpose of establishing plans to meet the identified needs and to deliver specific nursing interventions to meet those needs.

Planning and implementation: Planning and implementation refers to the deliberative action that involves decision-making and problem-solving, in which the nurse in consultation together with other members of the MDT perform the nursing interventions that may lead to a desired outcome.

Evaluation: Evaluation refers to the determination of the patient's responses to the nursing interventions and the extent to which the outcomes have been achieved.

Agent: An agent is an individual who engages in the facilitation of supportive care activities with the recipients.

Recipient: Recipient is the individual on the receiving end of the activity from the agent.

Context: Context refers to the setting, location, or structure of the ward in which supportive care occurs.

Dynamics: Dynamics refers to barriers or challenges that hamper the successful implementation of supportive care activities by the agent.

Procedure: Procedure refers to the process of facilitating supportive care by an agent by outlining the activities to be carried out in order to accomplish the intended goal.

Terminus: Terminus refers to the end point or accomplishment of supportive care activities.

7.2.9 Process of the model

The process of the model for nurses to facilitate supportive care for men diagnosed with PCa and their families is presented in three phases, as adopted from the nursing process theory of Ida Jean Orlando (1961). The three identified phases direct the activities of supportive care during the facilitation process in health facilities. The phases are described as follows:

- Assessment and diagnosis of the dynamics for the recipient and context (Phase 1)
- Planning and implementation of the facilitation process (Phase 2)
- Evaluation of the outcome of supportive care activities (Phase 3)

7.2.9.1 Assessment and diagnosis (Phase 1)

The initiation phase consists of the recipient and the three contexts, namely, the macro, meso and micro context, as illustrated in Chapter 6, Table 6.14. During this phase, the nurse as the primary agent, use their skills to conduct an assessment of the recipient and the context in which the facilitation of supportive care takes place. The assessment of the recipient and the context is described as follows:

Assessment and diagnosis of the recipient

In phase 1, the nurse assesses the physical, social, psychological and spiritual needs of the recipient in order to make a diagnosis of the dynamics related to the physical, social, psychological and spiritual aspects, as illustrated in Table 6.14. The dynamics identified during this phase form the basis on which the nurses will plan and implement the facilitation process for supportive care activities (procedure) in phase 2, in order to address the dynamics as identified in the study.

Assessment and diagnosis of the macro context

The assessment of the macro context by the nurse focuses on enablers of supportive care within the macro context such as the availability of national policies and guidelines on supportive care, a clear regulatory system, availability of resources, specification of funding roles, specification of scopes/roles and responsibities of the agent, as well as support for education and endorsement. The assessment of the macro context enables the nurse to diagnose the barriers that affect the facilitation of supportive care for men diagnosed with PCa and their families such as lack of policies and guidelines on supportive care, lack of support from MoHSS, shortage of resources, and lack specification of scopes/roles and responsibities of the agent. The assessment of the macro context is illustrated in Table 6.14.

Assessment and diagnosis of the meso context

The nurse's assessment of the meso context focuses on enablers of supportive care within this context such as community support, networking, as well as community empowerment, involvement and participation in supportive care activities. This assessment enables the nurse to diagnose the existing meso barriers such as a lack of knowledge on PCa by the community, and a lack of community involvement and participation in supportive care activities. Table 6.14 illustrates the application of an assessment and diagnosis of the meso context.

Assessment and diagnosis of the micro context

Within the micro context, the nurse assesses the enablers of supportive care such as support from colleagues, interprofessional collaboration, as well as consultation, collaboration, cooperation, partnerships, networking, communication, engagement and sharing of resources by the members of the MDT. Following the assessment of the micro context, the nurse establishes a diagnosis of the micro barriers that affect the facilitation of supportive care for men diagnosed with PCa in terms of a shortage of resources, inadequate training for nurses on PCa, as well as insufficient supportive care for men with PCa. The application of an assessment and diagnosis of the micro context is illustrated in Table 6.14.

7.2.9.2 Planning and implementation (phase 2)

In phase 2, the nurse's primary responsibility is to identify the members of the MDT and their roles and responsibilities, as well as the mechanisms for facilitating the dynamics and barriers of the recipient and context in order to determine the patient's treatment plan in a holistic manner. In oncology, an MDT comprises a group of healthcare workers who are members of different disciplines, functioning together to address a particular clinical problem with the holistic primary goal of patient care (Hinkle & Cheever, 2014; Huljev & Pandak, 2016; Taberna et al., 2020). The members of the MDT that a nurse should identify in phase 2 include the medical oncologist, radiation oncologist, pathologist, dietician/nutritionist, urologist, chaplain, psychologist, social worker, physiotherapist, pharmacist, and oncogeriatrician. All members of the MDT aim for holistic supportive care for men diagnosed with PCa and their families through the facilitation of communication, consultation, collaboration, engagement, involvement, coordination, interaction, integration, team work, cooperation, participating, networking, partnership, sharing of resources and joint decision-making, as illustrated in Table 6.14.

Evaluation (Phase 3)

Evaluation is the last phase of the model. Following the assessment and diagnosis of the dynamics of the recipients and the context in phase 1, and the facilitation process conducted by the primary agent with members of the MDT in phase 2, the nurse, as a primary agent, evaluates and determines whether the implementation of the supportive care interventions were effective, whether men's needs were met, and whether the desired outcomes have been achieved in phase 3, in this case holistic supportive care for men diagnosed with PCa and their families in terms of physical, social, spiritual and psychological support, as illustrated in Figure 6.14.

7.3 EVALUATION OF THE MODEL

The process of developing the model for nurses to facilitate supportive care to men diagnosed with prostate cancer and their families in health facilities was done under the supervision and guidance of the two study supervisors and experts in model development. Every step involved in model development was closely monitored by the two study supervisors. All inputs and adjustments were incorporated as recommended by the study supervisors. Various stakeholders/specialists such as, oncologists and urologists were also given an opportunity to evaluate the model and give their inputs into the model.

Finally, the model was presented at the School of Nursing and Public Health research seminar at which it was subjected to a joint evaluation by both peers and senior researchers who are also experts in model development. The printout of the developed model (figure 7.1) and its description, evaluation criteria and the developed guidelines to operationalize the model were sent to all sixteen (16) participants to go through prior to the seminar. During the seminar and through the use of power point presentation, the researcher presented the model development process based on the Theory Generation as proposed by Chin and Kramer (2018). The five descriptive components of the model were also presented namely: purpose, concepts, definitions, relationship, structure and assumptions. Among the participants of the seminar were four experts in model development and twelve peers. After the presentation, participants were given an opportunity to evaluate the model in accordance with the criteria for evaluating the nursing model as proposed by Fawcett (2005) and Parse (2005), which address questions regarding its historical evolution, significance, internal consistency, parsimony and testability, as well as its empirical adequacy and pragmatic adequacy. The inputs from the evaluation are presented in Table 7.8 and from part of the final version of the model.

The researcher employed Fawcett's evaluation criteria because they offer detailed mechanisms for analysing and evaluating the model. The evaluation of the model allows for judgements to be made about the level to which nursing theories meet certain criteria. Pertinent questions to be asked during the evaluation of the nursing model were used, as stressed by Fawcett (2005) and Parse (2005). These questions are illustrated in Tables 7.1 to 7.7 respectively. The criteria employed to evaluate the model are as follows:

- Historical evolution of the model
- Significance of the model
- Internal consistency of the model
- Parsimony of the model
- Testability of the model
- Empirical adequacy of the model
- Pragmatic adequacy of the model

7.3.1 Historical evolution of the model

The historical evolution of the model refers to the details of the development of the model, including the philosophical and theoretical antecedents as well as the changes in the model over time (Parse, 2005). Table 7.1 depicts the application of the historical evolution criterion during the development of the model.

Table 7.1: Criterion of the historical evolution of the model

Pertinent questions	Application to the study
How was the model developed?	The development of the conceptual framework was guided by the following theories namely: practice oriented theory (Dickoff et al., 1968), systems theory (Von Bertalanffy, 1930), holistic theory (Smuts, 1926) and the nursing process (Orlando, 1961). Dickoff et al.'s (1968) survey list was used as a mental map for describing the conceptual framework for the supportive care of men and their families, as illustrated in Figure 7.1. In order to ensure the quality of the research findings. the study applied the following philosophical assumptions: meta-theoretical, theoretical and methodological assumptions. The process of developing the model was conducted under the supervision and guidance of two supervisors who are experts in model development and qualitative research. Every stage involved in model development was closely monitored by the two study supervisors. Adjustments to the model were made in line with the supervisors' recommendations. The model was evaluated by a group of expert researchers, supervisors, lecturers from the School of Nursing and the School of Public Health, as well as a group of peers, in order to obtain their input on the model. Consultations were held with the two supervisors, the researcher and five external professors who are all experts in qualitative research and model development in order to solicit inputs and clarify the model.

7.3.2 Significance of the model

According to Fawcett (2005), the criterion of significance focuses on the context of the theory when justifying its importance for the discipline of nursing. The theoretical context refers to both the metaparadigm concepts of nursing and the philosophical assumptions of the theory (Fawcett, 2005). The significance criterion is met when the metaparadigmatic, philosophical and conceptual origins of the model are explicit, when antecedent nursing and adjunctive knowledge is cited, and when the special contributions made by the model are identified. The application of significance to the model in this study is reflected in Table 7.2.

Table 7.2 Criterion of significance

Pertinent questions	Application to the study
Are the metaparadigmatic concepts and propositions addressed by the theory explicit?	Yes, this theory is expressed explicitly through the research articles and textbooks. Concepts: The model aims to be a framework for nurse practitioners to use in everyday practice when facilitating supportive care for men with PCa. The model is derived from practice oriented theory (Dickoff et al., 1968), systems theory (Von Bertalanffy, 1930), holistic theory (Smuts, 1926) and the nursing process (Orlando, 1961). Practice oriented theory (Dickoff et al., 1968) incorporates the paradigm of agent, recipient, context, dynamics, procedure, and terminus; holistic theory incorporates the physical, social, psychological and spiritual needs of men and family; the systems theory incorporates the paradigm of macro, meso and micro contexts; while nursing process theory incorporates the components of assessment, diagnosis, planning, implementation and evaluation. Propositions: The model serves as a tool to enable and empower nurses, the MDT and other relevant stakeholders to provide holistic supportive care for men diagnosed with PCa based on physical, social, psychological and spiritual needs. The significance of this model lies in the fact that it may be utilised in nursing practice, nursing education and research.
Are the philosophical assumptions on which the theory is based explicit?	Yes, to ensure the quality of the study findings, the study applied the following philosophical assumptions: meta-theoretical, theoretical and methodological assumptions. Dickoff et al.'s (1968) survey list was used to describe the conceptual framework for the supportive care for men.
Is the conceptual model from which the model was derived explicit?	Yes, the following theories guided the development of the conceptual framework: practice oriented theory (Dickoff et al., 1968), systems theory (Von Bertalanffy, 1930), holistic theory (Smuts, 1926) and the nursing process (Orlando, 1961).
Are the authors of antecedent knowledge from nursing and adjunctive disciplines acknowledged?	Yes, all sources in the form of articles and books were acknowledged both through in-text citation and in the list of references.
Are bibliographical citation given?	Yes, all the sources used have been acknowledged in the text and the bibliography. The bibliography appears at the end of the dissertation.

7.3.3 Internal consistency of the model

The criterion of internal consistency focuses on both the context and the content of the model (Fawcett, 2005). This criterion requires all elements of the model, including the philosophical claims, conceptual model, and theory concepts and propositions to be congruent. The internal consistency criterion also requires the concepts of the model to reflect semantic clarity and semantic consistency. According to Fawcett (2005), the semantic clarity requirement is more likely to be met when a theoretical definition is given for each concept. Similarly, the semantic consistency requirement is met when the same term and the same definition are used for each concept in all of the author's discussions about the theory. In addition, the internal consistency criterion requires that propositions reflect structural consistency, which means that the linkages between concepts are specified and that no contradictions in relational propositions are evident. The application of the criterion of internal consistency is reflected in Table 7.3.

Table 7.3: Criterion of internal consistency

Pertinent questions	Application to the study
Are the context (philosophical claims and conceptual model) and the content (concepts and propositions) of the model congruent?	Yes, linkages between concepts are specified. No contradictions in relational proportions are evident.
Do the concepts reflect semantic clarity and semantic consistency?	Yes, the main concepts in this model, namely, "physical, social, psychological and spiritual", were examined, defined and described in detail in order to enrich the clarity of the model. Throughout the study, the meaning of the concepts was used consistently during the narrative explanations and the descriptions provided in the model.
Do the propositions reflect structural consistency?	Yes, the researcher used connecting lines and arrows between the boxes in the model to ensure that linkages between concepts were similarly presented throughout the model. This can be assessed by examining the narrative version in relation to the figure of the model. The researcher ensured that concepts in the model are interconnected and organised into a coherent whole (Chinn & Kramer, 2018).

7.3.4 Parsimony of the model

A parsimonious model is conceptually simple, which means that it contains few structural elements but it accounts for a broad range of empiric experiences (Chinn & Kramer, 2018). According to Fawcett (2005) the criterion of parsimony focuses on the content of the model. It requires a theory to be stated in the most economical way possible without oversimplifying the phenomena of interest. This means that the fewer the concepts and propositions needed to fully explicate the phenomena of interest, the better. The parsimony criterion is met when the most parsimonious statements clarify rather than obscure the phenomena of interest. Table 7.4 depicts the application of the criterion of parsimony in the model.

Table 7.4: Criterion of parsimony

Pertinent questions	Application to the study
Is the theory content stated clearly and concisely?	Yes, the development of the conceptual framework was guided by the following theories: practice oriented theory (Dickoff et al., 1968), systems theory (Von Bertalanffy, 1930), holistic theory (Smuts, 1926) and the nursing process (Orlando, 1961). Vagueness in the model was avoided by adopting the six elements of practice theory as recommended by Dickoff et al. (1968) in order to give direction to the description of the model. The structural graph of the model is simple and easy to understand and implement because it clearly shows the contexts (macro, meso and micro) in which supportive care for men diagnosed with PCa should be taking place, the agents or facilitators of the process (nurses and MDT), recipients (man and family), procedure (facilitation process), dynamics (macro, meso and micro barriers) and terminal (holistic supportive care), as illustrated in Figure 7.1 and 7.2 respectively. The concepts used in the model are simple. The three phases involved are clearly numbered to indicate their sequence to the agent. There is a consistent flow of the description of the model, with clear arrows to make it simple to understand the relationship between concepts. Guidelines to operationalise the model were described in accordance with the concluding statements from the conceptualisation process.

7.3.5 Testability of the model

Testability refers to the extent to which the theory can be tested empirically (Fawcett, 2005). This means that the study must have the ability to generate empirical evidence that can be confirmed or refuted. Descriptions of personal experiences may be used to evaluate the testability of the model. The testability criterion is regarded as the major characteristic of a scientifically useful model.

According to Fawcett (2005), the criterion of testability also focuses on the content of the model. This approach requires the specification of an inductive, qualitative research methodology that is in keeping with the philosophical claims and content of the theory. The criterion of testability is met when specific instruments or experimental protocols have been developed to observe the model concepts and statistical techniques that are available to measure the assertions made by the propositions. Table 7.5 depicts the application of the criterion of testability in the model.

Table 7.5: Criterion of testability

Pertinent questions	Application to the study
Does the data obtained from the use of the research methodology represent sufficiently in-depth descriptions of one or more personal experiences to capture the essence of the model?	Yes, a mixed method, which is a research design with philosophical assumptions, guided the direction of the collection and analysis of data. The concept analysis of this study (in Phase 1) comprised five objectives in line of the population of the study: published research materials on PCa, men diagnosed with PCa, family members of men diagnosed with PCa, nurses and oncology departments at the IHO. Stages in appraising the research articles were followed in order to develop themes (Botma et al., 2010). The conceptual framework derived from the conceptual analysis provided a framework for collecting the qualitative data through in-depth individual face-to-face interviews with men diagnosed with PCa, family members and registered nurses working in oncology departments at the IHO.
Are the theoretical concepts observable through instruments that are appropriate indicators of those concepts?	Yes, a questionnaire with a five-point Likert scale was used to collect quantitative data, as illustrated in Annexure E.
Do data analysis techniques permit the measurement of the theory propositions?	Yes, analysis was used in Phase 1 for concept analysis and identification, definition and classification. The researcher conducted a thorough examination and re-examination of the existing experiences of supportive care for men diagnosed with PCa and their families. Analysis was useful during the conceptualisation, concluding statements, clarification of the concepts, and description of the model, as well as guidelines for operationalising the model. The literature review process was conducted by following the stages for appraising the research articles recommended by Botma et al. (2010), namely, reading and re-reading the articles, initial note taking, development of emerging themes (looking for themes), searching for connections across the emergent themes, and development of final themes.

7.3.6 Empirical adequacy of the model

According to Fawcett (2005), the aim of evaluating the empirical adequacy of the model is to determine the degree of confidence warranted by the best empirical evidence, rather than to determine the absolute truth of the model. The outcome of the evaluation of empirical adequacy is a judgment regarding the need to modify, refine, or discard one or more concepts or propositions of the model. The data used to determine the empirical adequacy of a model may come from multiple personal experiences of an individual or the similar experiences of several individuals. The criterion of empirical adequacy requires the assertions made by the theory to be congruent with empirical evidence. Similarly, the extent to which a theory meets that criterion is determined by means of a systematic review of the findings of all studies that have been guided by the theory. Figure 7.6 depicts the application of the criterion of empirical adequacy in the model.

Table 7.6: Criterion of empirical adequacy

Pertinent questions	Application to the study
Are the findings from studies of descriptions of personal experiences congruent with the concepts and propositions of the theory?	Yes, data were carefully examined to determine their congruence with the concepts and propositions of the model.
Are the theoretical assertions congruent with empirical evidence?	Yes, the data used to determine empirical adequacy were obtained from multiple experiences of individuals namely, men diagnosed with PCa, family members and nurses. The specific definitions generated for the model as well as the definitions of related concepts to ensure conceptual meaning serve as evidence of empirical accessibility in the model.

7.3.7 Pragmatic adequacy of the model

The criterion of pragmatic adequacy evaluates the theory’s application in daily nursing practice (Fawcett, 2005). According to Parse (2005), pragmatic refers to the way the theory is used in nursing practice. The pragmatic adequacy criterion requires that nurses have a full understanding of the content of the model, as well as the interpersonal and intellectual skills necessary to apply it. It is therefore important to acknowledge the need for education and special training for nurses before applying the model. The pragmatic criterion also requires that the model is used in the real world of nursing practice. The nurse must be in a setting that is conducive to the application of the model and have the time and training necessary to apply it. Nurses’ cooperation and collaboration of with other members of the healthcare team have to be secured (Fawcett, 2005). The pragmatic criterion also requires the theory-based nursing actions to be socially meaningful by leading to favourable outcomes for those who participate in the actions. The application of the criterion of pragmatic adequacy is illustrated in Figure 7.7.

Table 7.7**:** Criterion of pragmatic adequacy

Pertinent questions	Application to the study
Are education and special skills training required before application of the model in nursing practice?	Yes, in-service training for nurses is to be conducted to enable them to have an understanding of the content of the model, as well as to acquire the interpersonal and psychomotor skills necessary to apply it. With regard to basic nursing training, the model may be used to train student nurses at institutions of higher learning.
Can the theory be applied in the real world of nursing practice?	Yes, the most valuable application of this model for nurses is in oncology departments to facilitate supportive care for men with PCa. The use of this model strengthens the collaboration between nurses and the MDT. The model may also be used in the education of the nursing students.

Table 7.7**:** Criterion of pragmatic adequacy (continued)

Pertinent questions	**Application to the study**
How is the model used as a guide for nursing practice?	Guidelines to operationalise the model for nurses to facilitate supportive care for men diagnosed with PCa and their families were developed. Through the use of guidelines, nurses in collaboration with MDT and other significant stakeholders from the community will be able to facilitate supportive care for men diagnosed with PCa and their families. The model can be used in the real world of oncology nursing practice.
Is it generally feasible to implement practice derived from the theory?	Yes, the development of central concepts using the identified attributes makes it practical to implement the model in nursing practice, nursing education and research. The availability of a conducive environment, and the trained human resources and material resources needed for the implementation of the model makes its implementation feasible.
Does the theory-based nursing lead to favourable outcome?	Yes, this model favours the connection between a nurse and other members of MDT to achieve holistic supportive care in order to address the physical, social, psychological and spiritual needs of men and family. The theoretical concepts of the model have been linked to the empirical indicators to determine the realisation of its purpose (Chinn & Kramer, 2018).
What publications and presentations have emanated from the research findings of the studies and practice projects?	A webinar with researchers and experts in model development was organised at which the researcher presented the model development process by means of a PowerPoint presentation. The content of the presentation included the background of the model development, as well as the purpose, concepts, definitions, structure and assumptions of the model. Following the presentation, participants evaluated the model so as to determine whether it attained the desired outcomes required to meet the objectives of the study. The results of the study will be presented at seminars and national and international conferences. Publication of the study in research articles will be done in reputable journals in order for the research findings to be made known to other researchers. The final version of the dissertation will be sent to the hospital where the study was conducted, as well as to UNAM.
What new knowledge surfaced from the research studies?	An assessment of the oncology departments offered insights into the need for strengthening health facilities for the facilitation of supportive care, as most of oncology departments are unconducive for this. Similarly, an assessment added knowledge to the macro, meso and micro barriers affecting the facilitation of supportive care for men diagnosed with PCa and their families. The exploration and description of the experiences of men with PCa, their families and nurses on supportive care for men has given direction for the improvement of the facilitation of supportive care. The study proposed the introduction of national policies on supportive care for men with PCa and their families, the introduction of a specialised oncology nursing course at a higher institution of learning, the establishment of certified cancer units at intermediate hospitals, and the inclusion of family members during the facilitation of supportive care for men. The study will contribute to the body of knowledge in general nursing, oncology nursing, community nursing, nursing education, research and nursing administration. The model will also be used as a source of reference by scholars intending to conduct research on PCa. This study is the first of its kind in Namibia to develop the model for nurses to facilitate supportive care for men diagnosed with PCa and their families.

Table 7.8: Inputs from the evaluation of the model

Evaluation criteria	Inputs
Historical evolution of the model	▪ *"The development of the conceptual framework was guided by applicable theories as explained by the researcher during the presentation"* ▪ *"The process of developing the model is well explained and followed as proposed by Chinn and Kramer, 2018. It was also good to hear that the model development was done under the close supervision of the experts in model development who gave their inputs"* ▪ *"Holitic Theory should read Holistic Theory"*
Significance of the model	▪ *"The aim of the model is well explained"* ▪ *"Theories from which the model is derived are clearly stated and applied. The model is very appropriate to the nursing fraternity"* ▪ *"This model will serve as frame of reference especially for the nurses caring men with PCa at oncology departments"* ▪ *"Nurses without specialized training in oncology nursing will greatly benefit from the implementation of this model"* ▪ *"An abbreviation MTD should read MDT"*
Internal consistency of the model	▪ *"Linkages between concepts are specified"* ▪ *"The meaning of the concepts was used consistently during the explanations and descriptions of the model"* ▪ *"The three phases of the model are well clarified in terms of the manner in which they contribute to the model as a whole"* ▪ *"The three contexts that influence the facilitation of supportive care are well clarified and very much applicable to the model"* ▪ *"The arrows between the boxes should be made more visible"* ▪ *"The yellow colour used is too bright"*
Parsimony of the model	▪ *"The structural graph of the model is simple to understand"* ▪ *"Concepts used in the model are quite simple"* ▪ *"Guidelines to operationalize the model are clearly explained"* ▪ *"One element (dynamics) of the Practice Oriented Theory is missing. Please incorporate it in the model"*
Testability of the model	▪ *"A mixed methods design with philosophical assumptions that guided the direction of data collection and analysis was well explained during the presentation"* ▪ *"Concept analysis in Phase 1 is well explained"*
Empirical adequacy of the model	▪ *"Multiple experiences obtained from the five populations enabled empirical adequacy"*
Pragmatic adequacy of the model	▪ *"This model is very applicable to the real world of nursing practice. I highly recommend its implementation"* ▪ *"The inclusion of the members of multidisciplinary team in the model enables holistic approach during nursing care"* ▪ *"The developed guidelines are user friendly"* ▪ *"This study contributes to the body of knowledge especially in oncology nursing, research and nursing education"* ▪ *"How will you make the study findings known? Please indicate it"* ▪ *"Do nurses have required skills to implement this model?"* ▪ *"The model is very suitable for nursing. Will there be some in-service training for the agents prior to its implementation?"*

7.4 SUMMARY

This chapter focused on the framework of the model for nurses to facilitate supportive care for men diagnosed with PCa and their families. The chapter provided an overview of the model, the description of the model as well as its purpose and structure. Assumptions on which the model was based and the concept definitions were used to describe the model.

The process of facilitating supportive care for men diagnosed with PCa is carried out in three phases, namely, phase 1 (initiation phase), which has to do with assessment and diagnosis; phase 2 (working phase), which deals with planning and implementation that is done through the identification of MDT members, as well the development of partnerships between the nurse (agent) and the MDT by means of teamwork, participation, communication, networking, integration, engagement, collaboration, consultation, sharing resources, involvement, cooperation, interaction, partnership, and joint decision-making; and phase 3 (terminus phase), which is concerned with evaluating the outcome. The outcome of the facilitation process is holistic supportive care for men diagnosed with PCa.

The evaluation of the model was done based on the criteria for evaluating the nursing model as recommended by Fawcett (2005) and Parse (2005); namely, historical evolution, significance, internal consistency, parsimony, testability, and the empirical and pragmatic adequacy of the model. Pertinent questions to be asked during the evaluation of the nursing model were also used as recommended by Fawcett (2005) and Parse (2005). The next chapter focuses on a description of the guidelines for the operationalisation of the model for nurses to facilitate supportive care for men diagnosed with PCa in health facilities.

CHAPTER 8

DESCRIPTION OF THE GUIDELINES TO OPERATIONALISE THE MODEL FOR NURSES TO FACILITATE SUPPORTIVE CARE FOR MEN DIAGNOSED WITH PROSTATE CANCER AND THEIR FAMILIES

8.1 INTRODUCTION

In Chapter 8, the researcher describes the development and evaluation of the model for nurses to facilitate supportive care for men diagnosed with PCa. This chapter describes the guidelines for the operationalisation of the model for nurses to facilitate supportive care for men diagnosed with PCa in health facilities. According to LoBiondo-Wood and Haber (2010), guidelines are systematically developed practice statements designed to assist clinicians with making healthcare decisions for specific conditions or situations based on research findings. Muller et al. (2011) define guidelines as official advice on how things should be done.

In this chapter, the guidelines were developed based on the findings of the situational analysis in phase 1, objectives 1, 2, 3 and 4 (qualitative data), phase 1, objective 5 (quantitative data) and the conceptual framework as discussed in Chapters 4, 5, 6 and 7. The guidelines are developed as activities to address the challenges or barriers that hinder the facilitation of supportive care for men diagnosed with PCa in health facilities. These guidelines may be implemented in health facilities in which the facilitation of supportive care of men diagnosed with PCa takes place. These guidelines will assist nurses, in collaboration with members of the MDT, to facilitate supportive care for men diagnosed with PCa in health facilities.

Deductive and inductive reasoning were used during the process of developing the guidelines. Deductive reasoning moves from the general to the specific or from a general premise to a particular situation or conclusion (De Vos et al., 2011; Polit & Beck, 2012). It is often referred to as a top-down approach, used mainly in quantitative research studies (Grove, Gray & Burns, 2015). Inductive reasoning involves generalising a theory confirmed in one specific setting to another context as the theory evolves. It is the process of developing generalisations from specific observations (Venkatesh et al., 2016). With inductive reasoning, researchers observe a sample and then draw conclusions about the population from which the sample is drawn. In other words, the researcher begins with a general topic and some vague ideas that he/she then refines and elaborates into more exact theoretical concepts. In this chapter, guidelines are presented for the activities of each of the three phases of the model to provide direction to nurses and members of the MDT involved in the facilitation of supportive care for men diagnosed with PCa.

8.2 GUIDELINES FOR THE FACILITATION OF SUPPORTIVE CARE FOR MEN DIAGNOSED WITH PROSTATE CANCER IN HEALTH FACILITIES

The guidelines to operationalise the model to facilitate supportive care for men diagnosed with PCa were developed in line with the aims of each of the three phases of the model. The sequence of these three phases, together with the aims and activities, in which the guidelines are written are as follows:

- Phase 1: Initiation (assessment and diagnosis)
- Phase 2: Working (planning and implementation)
- Phase 3: Terminus (evaluation)

8.2.1 Guideline for phase 1: Initiation phase

The aim and activities for initiation may be described as follows:

8.2.1.1 Aim

The aim of this guideline is to provide the nurse (main agent) and members of the MDT with assistance on the way in which to conduct an assessment and diagnosis of the dynamics of the agent (nurse), the recipients (men) and the context (macro, meso and micro) in order to identify men’s needs and dynamics as well as the contextual barriers that hinder the facilitation of supportive care for men diagnosed with PCa in health facilities.

8.2.1.2 Activities

The initiation phase entails the assessment process of discovering the needs and dynamics of men with PCa and the barriers within the contexts in which the facilitation of supportive care takes place. Assessment helps nurses to discover the health needs of men which can be addressed with proper nursing interventions in collaboration with members of the MDT during the facilitation of supportive care in health facilities. The assessment and diagnosis of the dynamics will focus on the agent (nurse), the men (recipient) and the context (macro, meso and micro). In this study, the macro context refers to the MoHSS and the HPCNA, the meso context refers to the community, while the micro context refers to the health facility, nurses and members of the MDT. The activities for the assessment and diagnosis of the agent, recipient and context are illustrated in Tables 8.1, 8.2 and 8.3 respectively.

Activities for the assessment and diagnosis of the agent

The activities for the assessment and diagnosis of the agent are illustrated in Table 8.1.

Table: 8.1: Activities for the assessment and diagnosis of the agent

Activities for assessment [Agent]	Activities for diagnosis [Agent]
The nurse manager, in collaboration with nurses as the main agents, is responsible for assessing the agent. The assessment that should be done on the agent should include the following: Skills for and knowledge on facilitating supportive care for men diagnosed with PCa and their families Level of training in oncology nursing Confidence in facilitating supportive care for men with PCa and family Support from colleagues Capabilities of the stakeholders Inter-professional collaboration, coordination, consultation, teamwork, negotiation, advocacy, cooperation, partnership, joint decision-making, networking, communication, sharing of resources, engagement	Following the assessment of the agent, the nurse manager should be able to diagnose the following dynamics: Inadequate skills and knowledge on supportive care Inadequate training of nurses in PCa Lack of confidence in facilitating supportive care Insufficient supportive care for men Inadequate support from colleagues and stakeholders Shortage of resources

Activities for assessment and diagnosis of the recipient

The activities for the assessment and diagnosis of the recipient are described in Table 8.2.

Table: 8.2: Activities for assessment and diagnosis of the recipient

Activities for assessment [Recipient]	Activities for diagnosis [Recipient]
Physical need activities	**Physical dynamics**
The nurse, as a main facilitating agent, in consultation, coordination and collaboration with members of the MDT, is responsible for assessing the physical needs of men with PCa. The members of the MDT to be consulted, engaged and involved by nurses for the assessment of the physical needs of men with PCa include urologist, chaplain, psychologist, social worker, physiotherapist, pharmacist, medical oncologist, radiation oncologist, oncogeriatrician, pathologist and dietician. The physical needs of men diagnosed with PCa to be assessed include the nutritional status, physical activities, hygiene, pain relief, physiological processes, and the safety of the environment.	After an assessment of the physical needs of the recipient (men) in consultation and collaboration with members of the MDT, the nurse as the main facilitator should identify the physical dynamics encountered by men, namely: Inability to perform physical activities Inappropriate nutrition Unconducive environment Pain

Table: 8.2: Activities for assessment and diagnosis of the recipient (continued)

Activities for assessment [Recipient]	Activities for diagnosis [Recipient]
Psychological need activities	**Psychological dynamics**
The nurse, as a main facilitating agent, in consultation, coordination and collaboration with members of MDT, is responsible for assessing the psychological needs of men with PCa. The psychological needs to be assessed include the needs of connection and acceptance, autonomy, safety and security, personal significance, and progress.	Following the assessment of the psychological needs by the nurse in consultation and collaboration with members of the MDT, the nurse as the main facilitator of supportive care should identify the following emotional effects: Stress Depression Fear Anxiety Guilty and remorse Isolation Psychosexual issues Psychological distress Lack of psychological support
Social need activities	**Social dynamics**
The nurse, as a main facilitating agent, in consultation, coordination and collaboration with members of the MDT, is responsible for assessing the social needs of men with PCa. The social needs to be assessed include food security, housing, safe and secure environment, relationship with others, need to be loved, need to be accepted by others and need for belonging to community.	The nurse in consultation and collaboration with members of the MDT, and after the assessment of the social needs of men, should identify the following social dynamics: Rejection Isolation Stigmatisation Lack of support
Spiritual need activities	**Spiritual dynamics**
The nurse, as a main facilitating agent, in consultation, coordination and collaboration with members of the MDT, is responsible for assessing the spiritual needs of men with PCa. The spiritual needs to be assessed include the need for meaning and purpose in life, need for love and being loved, need for feeling sense of belonging, need for feeling of hope and gratitude, and need for peace of mind.	Following the assessment of the spiritual needs of men, the nurse should identify the following spiritual dynamics: Hopelessness Overwhelm Feeling of being punished Guilty feeling Withdrawal Isolation Spiritual distress Angry at God

Activities for the assessment and diagnosis of the context

The context in which the facilitation of supportive care takes place is comprised of the macro (MoHSS, HPCNA, and educational institutions), meso (community, support groups and NGOs) and micro (health facility, nurse and MDT) contexts (Smith et al., 2019). Each context consists of barriers and enablers, as illustrated in Figure 7.2, of which all have an influence on the facilitation of supportive care in health facilities. The activities for the assessment and diagnosis of these contexts are described in Table 8.3.

Table: 8.3: Activities for assessment and diagnosis of the context

Activities for an assessment of the contexts [Macro, Meso and Micro]	
Macro enablers [MoHSS and HPCNA]	**Macro barriers [MoHSS and HPCNA]**
The nurse, in consultation, partnership and collaboration with members of the MDT should conduct an assessment of the macro context in order to identify the following enablers: Availability of the national policies and guidelines on supportive care Availability of a clear regulatory system Availability of resources Specification of funding roles Specification of scope/roles and responsibilities Availability of support for education and endorsement	Following the assessment of the macro enablers, in consultation, partnership and collaboration with members of the MDT, the nurse should conduct a further assessment in order to identify the following macro barriers: Lack of national policies and guidelines on supportive care Lack of support from MoHSS Shortage of resources
Meso enablers [community]	**Meso barriers [community]**
The nurse, as the main facilitator, and in collaboration with members of the MDT, should assess the presence of the following meso enablers: Community support Community network Community involvement Community participation Community empowerment	Following the assessment of the meso enablers, in consultation, partnership and collaboration with members of the MDT, the nurse should conduct a further assessment in order to identify the following meso barriers: Lack of knowledge on PCa by the community Lack of a community network Lack of community involvement and participation Lack of community empowerment
Micro enablers [nurse and MDT]	**Micro barriers [health facility, nurse and MDT]**
The nurse, in collaboration with members of the MDT, should assess the micro context for the following enablers: Support from colleagues Inter-professional communication, collaboration, consultation and coordination Capabilities of the stakeholders Inter-professional teamwork, cooperation, networking, engagement and participation Diplomacy and promotion of roles Advocacy Joint decision-making and sharing of resources	Following the identification of the micro enablers, the nurse, in collaboration with members of the MDT, should further assess the micro context for the following barriers: Shortage of resources [human, material, infrastructure, financial etc.] Inadequate training of nurses in PCa Insufficient supportive care for men Lack of intra-professional communication and collaboration

8.2.2 Guideline for phase 2: Working phase

The aim and activities for the working phase may be described as follows:

8.2.2.1 Aim

The aim of this guideline is to advise registered nurses (main agent) and members of the MDT on ways in which to manage the facilitation of supportive care for men diagnosed with PCa through planning and implementation activities.

8.2.2.2 Activities

The working phase (phase 2) consists of planning and implementing the facilitation process (procedure) for supportive care by the agent. The activities in respect of planning and implementation are described below.

Planning activities:

- During planning, the nurse, as the main agent, should set goals that are realistic by considering the financial and human resources and skills of various members of the MDT.
- During planning, the goals must be set in consultation, coordination and collaboration with members of the MDT.
- The goal-setting should specify both the goal of the programme (supportive care for men diagnosed with PCa) and the goals of each member of the MDT (urologist, chaplain, psychologist, social worker, physiotherapist, pharmacist, medical oncologist, radiation oncologist, oncogeriatrician, pathologist, and dietician).
- Each goal should indicate the outcome, the manner in which outcomes can be achieved, and how they will contribute to the realisation of supportive care for men.
- The nurse should ensure that the activities planned for the facilitation process are achievable, quantifiable and time bound.
- During planning, the nurse, as the main agent should appropriately identify all the members of the MDT, as well as their roles and responsibilities in relation to the facilitation of supportive care for men diagnosed with PCa.
- The members of the MDT that should be identified, consulted, engaged and involved in the planning of the facilitation process include the urologist, chaplain, psychologist, social worker, physiotherapist, pharmacist, medical oncologist, radiation oncologist, oncogeriatrician, pathologist, and dietician.

- To ensure the most efficient use of resources and time, and to safeguard the best results, it is vital for nurses to identify the right level of involvement by members of the MDT when planning the facilitation process.
- To enable the informed involvement of members of the MDT during planning, the nurse should provide sufficient, reliable and transparent information in order to prevent negative perceptions of the facilitation process.
- During planning, the nurse should identify the priority areas in men's needs based on the findings of the study.
- During planning, the nurse should put in place mechanisms to evaluate the goals against the agreed supportive care activities.

Implementation activities:

- Prior to implementation, the nurse as the main facilitator should first identify the mechanisms (enablers) for facilitating the dynamics and barriers of the recipient and context. The enablers, dynamics and barriers are outlined in Chapter 6, Table 6.14.
- The identification of the enablers, dynamics and barriers should always be done in communication, consultation, coordination, engagement, involvement and collaboration with members of the MDT through networking, partnership, participation and teamwork.
- To ensure the implementation of the facilitation process, formal coordination committees should be constituted in health facilities with clear meeting procedures or schedules and reporting mechanisms.
- The coordination committee should also have the following in place: the aims and objectives of the committee, the composition of the committee, the roles and responsibilities of the committee, the scope of the mandate of the committee, as well as the authority of the committee to make joint decisions.
- The role of the committee during implementation, together with the nurse who must also be a member, is to oversee the supportive care facilitation process and to identify the mechanisms (enablers) for facilitating the dynamics and barriers of the recipient and context.
- The committee must ensure the availability of policies and guidelines on supportive care in health facilities that guide the implementation of the facilitation process, and

these should be made known to members of the MDT through interaction, communication, partnership and sharing of resources.

- The nurse should ensure that the environment in which the implementation of the facilitation process takes place is conducive for men, their families and members of the MDT.
- The nurse should promote teamwork, coordination, consultation, collaboration, partnership, participation and joint decision-making with members of the MDT to ensure the successful implementation of supportive care activities in health facilities.
- Members of the MDT should be accorded sufficient time to debate and reach consensus on decisions to be implemented during the facilitation process.

8.2.3 Guideline for phase 3: Terminus phase

The aim and activities for terminus phase may be described as follows:

8.2.3.1 Aim

The aim of this guideline is to evaluate the activities which are aimed at effectively facilitating the supportive care activities towards men diagnosed with PCa in healthcare facilities. In terminus phase the nurse, together with members of the MDT, will evaluate the actual performance of supportive care activities in health facilities against the planned and implemented activities during the facilitation process (procedure) in phase 2 of the model.

8.2.3.2 Activities

During the terminus phase, the nurse together with members of the MDT will evaluate the outcome of the supportive care activities that were suggested in phases 1 and 2 of the model. This phase will enable the nurse and the members of the MDT to determine whether the overall goal of the model is accomplished. In other words, the terminus phase will assist in determining the progress made, areas of improvement if any, the training or resources required and so on.

Evaluation activities for evaluating the supportive care facilitation process:

- The nurse, as the main facilitator and in collaboration with members of the MDT, should set up a written standard indicating the expected level of performance with reference to the assessment and diagnosis of the dynamic of the recipient and the context, planning and implementation of the facilitation process (procedure) to address the health needs of men as well as the evaluation of the outcome of supportive care (terminus).

- A standard should also specify the desired and achievable level of performance against the actual supportive care activities to be evaluated.
- The nurse must ensure that the set standards are relevant, realistic, attainable and measurable.
- Criteria and indicators should be articulated in order to establish whether the set standard has been attained.
- The criteria should specify what is to be evaluated, the responsible person, and the time when the evaluation should take place.
- The process for evaluating the outcomes should be carried out by the nurse, in involvement, engagement, consultation, collaboration and partnership with members of the MDT to determine the progress towards attaining the set goals.
- The outcome to be evaluated includes holistic supportive care in terms of physical, social, psychological and spiritual support for men diagnosed with PCa.
- The expected evaluation outcome in terms of physical, social, psychological and spiritual support includes:
- Physical support:
  Provision of a conducive environment
  Provision of nutritional aspects
  Providing pain relief
  Encouraging physical activity
  Maintaining physiological processes (bowel and bladder care)
- Social support:
  Maintaining food security
  Provision of housing
  Provision of a safe and secure environment
  Maintaining relationships with others
  Showing love and acceptance
  Sense of belonging to the community
- Psychological support:
  Provision of counselling and psychotherapy
  Feelings of autonomy

Maintaining safety and security
Sense of personal significance
Feelings of connection and acceptance
Sense of progress

- Spiritual support:

Provision of counselling
Sense of meaning and purpose in life
Feelings of love and being loved
Sense of belonging
Feelings of hope, peace and gratitude

8.3 SUMMARY

This chapter presented a description of the guidelines to operationalise the model for nurses to facilitate supportive care for men diagnosed with PCa in health facilities. The guidelines were written based on the sequence of the three phases of the model; namely, phase 1 (initiation), phase 2 (working) and phase 3 (terminus). These guidelines were discussed in terms of the aims and activities for each guideline in each of the three phases of the model. The next chapter focuses on the conclusion, contributions, limitations and recommendations of the study.

CHAPTER 9

CONCLUSIONS, CONTRIBUTIONS, LIMITATIONS AND RECOMMENDATIONS OF THE STUDY

9.1 INTRODUCTION

The previous chapter dealt with the description of the guidelines for operationalising the model for nurses to facilitate supportive care for men diagnosed with PCa and their families. This chapter presents the conclusion of the study based on the specific objectives as outlined in each phase of the study, namely: **phase 1** (analysis of concepts), **phase 2** (development of the conceptual framework), **phase 3** (development and description of the model), and **phase 4** (guidelines for operationalising the model). The chapter further discusses the contributions made by the study and the limitations of the study, as well as making recommendations from the findings of the study for nursing education, nursing practice and nursing research.

9.2 PURPOSE OF THE STUDY

The purpose of this study was to develop a model for nurses to facilitate supportive care for men diagnosed with PCa and their families at the IHO. The achievement of the study purpose was based on a scoping review and a triangulation of different data collection methods that included in-depth, individual face-to-face interviews with men, their families and nurses on supportive care for men diagnosed with PCa, as well as the assessment of the oncology departments using a structured questionnaire. Eight objectives were developed to achieve the purpose of the study. These objectives were as follows:

- To explore and describe the best practices for the supportive care for men diagnosed with PCa and their families by nurses in the oncology departments
- To explore and describe the experiences of men diagnosed with PCa on the supportive care received from nurses in the oncology departments
- To explore and describe the experiences of the men’s families on the supportive care received from nurses in the oncology departments
- To explore and describe the experiences of nurses in facilitating supportive care for men diagnosed with PCa and their families at oncology departments
- To assess the oncology departments in terms of facilitating the supportive care of men diagnosed with PCa and their families
- To develop a conceptual framework as a basis for model development

- To develop and describe the model to facilitate supportive care for men diagnosed with PCa and their families at the IHO
- To develop guidelines for operationalising the model to facilitate supportive care for men diagnosed with PCa and their families

9.3 CONCLUSIONS OF THE STUDY

The conclusions in this study are based on the four phases of theory generation within which the study was conducted, namely: **phase 1** (analysis of concepts), **phase 2** (development of conceptual framework), **phase 3** (development and description of the model) and **phase 4** (guidelines to operationalise the model)

9.3.1 Phase 1: Analysis of concepts

The analysis of concepts started with the identification and, subsequently, the definition of concepts. The concepts are described as follows:

9.3.1.1 Identification of concepts

The five main concepts, support, physical, social, psychological and spiritual, as illustrated in Table 5.12 were identified following the conceptual analysis of the findings in Chapters 4, 5 and 6. The first objective explored and described the best practices by nurses for the supportive care of men diagnosed with PCa and their families in the oncology departments by means of a scoping review. The review revealed various aspects related to the management of PCa, such as the availability of national policy on supportive care for men diagnosed with PCa and their families, inclusion of family members in this regard, and the establishment of certified cancer units at district hospitals. The review also revealed aspects related to practising oncology-related matters such as the introduction of a specialised oncology nursing course at higher institutions of learning, the availability of registered nurses specialising in cancer in oncology departments, and the establishment of community-based face-to-face PCa support groups (PCSGs). The second objective explored and described the experiences of men diagnosed with PCa of the supportive care received from nurses in the oncology departments. The findings in this regard were varied and included inconsistent supportive care, lack of psychological and spiritual supportive care, and lack of health information on PCa. The third objective explored and described the experiences of families of the supportive care received from nurses in the oncology departments. It was found that family members felt devalued by the healthcare system owing to a lack of family involvement in treatment and decision-making, as well as an environment that was not conducive to counselling men due to a lack of privacy. The fourth objective explored and described the experiences of nurses in facilitating supportive care of men diagnosed with PCa and their families in the oncology departments. It was revealed that nurses experienced different interventions for supportive care, a shortage of resources to facilitate supportive care, as well as barriers to the facilitation of supportive care. The fifth objective assessed the oncology departments in terms of facilitating supportive care for men diagnosed with PCa and their families. The findings revealed a lack of availability of policies and guidelines on supportive care for men diagnosed with PCa and their families, a lack of training for nurses on supportive care, the lack of a conducive environment for counselling men and families, a lack of tools to monitor and evaluate supportive care activities in the oncology departments, and a lack of support for oncology departments by hospital management.

9.3.1.2 Definition and classification of concepts

The definitions for the concepts, including physical, social, psychological and spiritual support, were devised using dictionary definitions, subject definitions, contextual definitions, the reduction of the identified criteria for the concepts and the reduction of the essential and related criteria for the concepts. These essential and related criteria were merged to form the overall related and essential criteria for the *"facilitation of supportive care".* The essential and related concepts, as well as the dictionary, subject and contextual definitions of the central and other attributes, were utilised to construct a case that represents the experiences that were under investigation in the study. In addition, Dickoff et al.'s (1968) survey list was adopted in the classification of the concepts, namely, agent, recipient, context, dynamics, procedure and terminus.

9.3.2 Phase 2: Construction of relationship statement

The relationship between concepts and statements was constructed by means of definitions and classification. The conceptual framework (in Chapter 6) obtained from the concept analysis formed the basis for the development of the model for nurses to facilitate supportive care for men diagnosed with PCa at the IHO. The six components of practice oriented theory (Dickoff et al., 1968) namely, agent, recipient, context, dynamics, procedure and terminus, were adopted to guide the development of the conceptual framework for the study.

9.3.3 Phase 3: Description and evaluation of the model

The description of the model for nurses to facilitate supportive care for men diagnosed with PCa and their families at IHO was done in Chapter 8, in line with the five descriptive components proposed by Chinn and Kramer (2018): purpose, concepts, definitions, relationship, structure and assumptions. The model was also described based on the six items on Dickoff et al.’s (1968), survey list, the three context levels of systems theory, holistic theory and the five phases of nursing process theory. A schematic representation in Figure 7.1 portrays a structure of the model for nurses to facilitate supportive care for men diagnosed with PCa and their families in health facilities. Each component of the model is described in terms of the way in which it contributes to the purpose of the model.

Furthermore, the content and context of the model was subjected to evaluation by academics and experts in model development, after which the corrections were effected in line with the experts’ recommendations. With regard to the evaluation criteria, the model was evaluated in accordance with the criteria for evaluating the nursing model, as proposed by Fawcett (2005) and Parse (2005), which addressed questions regarding its historical evolution, significance, internal consistency, parsimony, testability, empirical adequacy and pragmatic adequacy, as illustrated in Chapter 7. Pertinent questions to be asked during the evaluation of the nursing model were used as stressed by Fawcett (2005) and Parse (2005).

9.3.4 Phase 4: Guidelines for operationalising the model

The guidelines for operationalising the model were formulated and presented in terms of the activities of each of the three phases of the model to provide direction to nurses and members of the MDT involved in the facilitation of supportive care for men diagnosed with PCa. The guidelines were developed as activities to address the challenges or barriers that hinder the facilitation of supportive care for these men. Deductive and inductive reasoning were used during the process of developing the guidelines.

9.4 CONCLUSION

The conclusion of this study is based on a scoping review and the triangulation of different data collection methods that include the individual face-to-face interviews with men diagnosed with PCa, family members and nurses in oncology departments of IHO, as well as the assessment of the oncology departments using a structured questionnaire. The findings of the mixed method study approach were presented in the form of statistical evidence and the themes and sub-themes were categorised under the following objectives: explore and describe the best practices for the supportive care of men diagnosed with PCa, explore and describe the experiences of men diagnosed with PCa of supportive care from nurses, explore and describe the experiences of family of the supportive care obtained from nurses, explore and describe the experiences of nurses in facilitating supportive care for men diagnosed with PCa, and assess the oncology departments in terms of facilitating the supportive care for men diagnosed with PCa and their families.

The results of the study will be presented at medical seminars at the IHO and to the MoHSS. Efforts will also be made to present the study findings at research seminars at local, regional and international level. The findings of the study will also be made known to other researchers through the publication of the study in the form of research articles in reputable international journals.

The model for nurses and guidelines for operationalising the model to facilitate supportive care for men diagnosed with PCa were developed. The model will empower nurses and members of the MDT during the process of facilitating supportive care for men through communication, networking, coordination, engagement, consultation, collaboration, involvement, cooperation, interaction, partnership, teamwork, participation, joint decision-making and sharing of resources.

9.5 CONTRIBUTION TO THE BODY OF KNOWLEDGE

This study contributes to the body of knowledge on general nursing, oncology nursing, community nursing, nursing education, nursing administration and research. An assessment of the oncology departments offered insights on the need to strengthen health facilities for the facilitation of supportive care, as most oncology departments are unconducive for supportive care. Similarly, an assessment added knowledge to the macro, meso and micro barriers affecting the facilitation of supportive care for men diagnosed with PCa and their families. The exploration and description of the experiences of men with PCa, their families and nurses on supportive care for men and their families has shown the direction for improvement in the facilitation of supportive care. The study proposed the introduction of national policies on supportive care for men with PCa and their families, the introduction of a specialised oncology nursing course at higher institutions of learning, the establishment of certified cancer units at intermediate hospitals, and the inclusion of family members during the facilitation of supportive care for men. A model for nurses to facilitate supportive care for men diagnosed with PCa and their families was developed and described based on three phases derived from nursing process theory. The developed model will also be used as a source of reference by scholars intending to conduct research on PCa. This study is the first of its kind in Namibia to develop a model for nurses to facilitate supportive care for men diagnosed with PCa and their families. The study will therefore provide policymakers with evidence-based data for policy formulation.

9.6 LIMITATIONS OF THE STUDY

According to Brink et al. (2018), the limitations of the study refer to the characteristics or methodology that has affected or influenced the application or interpretation of the results of the study. The findings of this study should be seen in the light of the following limitations:

- The study was restricted to participants from one specific public hospital in Oshana region, namely the IHO, thus this may affect the generalisation of the study findings to other intermediate hospitals in other regions. However, although the findings of this study may not necessarily be applicable to the settings of other intermediate hospitals in Namibia, their transferability to these cannot be doubted. Nevertheless, further studies could be conducted at different intermediate hospitals in other regions of Namibia.
- The use of purposive sampling indicates that the findings are contextual and therefore cannot be representative of all men diagnosed with PCa, their family members or nurses in Namibia. However, the findings will be valuable for reference and future research.
- The model was developed in line with the findings from the IHO only, therefore they may not be applicable to other hospitals in other regions. This necessitates the conducting of further studies at different intermediate hospitals in other regions.
- The researcher (interviewer) was regarded as a colleague by nurse participants and this could result in over-reporting in order to shock the interviewer. In order to obtain relevant data for this study, the researcher used a mixed method design which enabled triangulation.
- Limited literature on supportive care for men diagnosed with PCa in Namibia and other SADC countries was available. This made it hard to validate the findings.
- Enrolled nurses/midwives were not included in this study, therefore their experiences were not explored.

9.7 RECOMMENDATIONS

Bless et al. (2013) stress that, based on the interpretations of the study results, the researcher should draw certain conclusions and make considerable recommendations. The following recommendations were made based on the findings of phases 1, 2, 3 and 4. Recommendations are made in terms of management, nursing education, nursing practice and nursing research aspects.

9.7.1 Recommendations for management

The findings of this study have highlighted a lack of policies and guidelines on supportive care for men diagnosed with PCa and their families in oncology departments. The study also revealed a lack of training for nurses on supportive care for men diagnosed with PCa. It is therefore recommended that:

- The MoHSS should come up with policies and guidelines regarding the facilitation of supportive care for men diagnosed with PCa and their families in the oncology departments in order to enable consistency during patients' care. It is advised that all nurses and other members of the MDT be oriented to the content of the policy and guidelines in order to ensure an effective facilitation process for supportive care. Such policies should also be used during the induction and orientation of the newly recruited nurses as well for the nurses who may find themselves placed in oncology departments as a result of rotations.
- The MoHSS should ensure an adequately staffed, trained and coordinated MDT that facilitates supportive care that is aligned with men's health needs and those of their families.
- The MoHSS should consider establishing an accredited/certified and well-resourced oncology centre at the IHO, characterised by specialisation and multidisciplinary collaboration for the successful facilitation of supportive care for men with PCa. The accreditation should be exclusively based on facility structure, type of services offered by the facility, and the capacity of human resources.
- Formal in-service training for nurses on supportive care for men diagnosed with PCa and their families should be implemented. It is critical that priority should be accorded to nurses working in oncology departments. The model may also be utilised during the facilitation of in-service training. Hospital management should be sensitised to the implementation of in-service training.

- The MoHSS should introduce a community-based awareness programme on PCa in order to create knowledge in the community about the disease and to solicit community support for the programme.
- Upon discharge, nurses should conduct exit interviews with men diagnosed with PCa and their families in order to obtain their opinions with regard to the quality of the supportive care they were given during their admission. Exit interviews are critical for quality improvement.

9.7.2 Recommendations for nursing education

- Cummings et al. (2018) stress that as treatment for cancer evolves, oncology nurses will require postgraduate oncology qualifications in order to provide specialised, holistic and individualised supportive care for those diagnosed with the disease. By contrast, this study established that the micro barriers to supportive care for men diagnosed with PCa were aggravated by a lack of training for nurses on PCa. It is therefore recommended that:
- Institutions responsible for training and certification of nurses should develop relevant core competencies across the cancer care continuum.
- Nursing schools should consider the introduction of a one-year postgraduate oncology nursing course as a speciality in order to prepare nurses to provide comprehensive supportive care for men with PCa and their families across the disease trajectory. The course should aim to address the gaps in nurse practitioners’ training related to the field of oncology. Appropriate oncology training promotes nurses’ confidence in facilitating supportive care for men.
- Nursing schools should consider the introduction of a Master’s in Nursing Science (specialising in oncology nursing) after which one would qualify as a specialist oncology nurse.
- It is imperative that lecturers collaborate with clinical preceptors and members of the multidisciplinary team during the implementation of the guidelines in order to improve and strengthen clinical practice.
- Nursing schools should involve public health facilities in the planning of the micro-curriculum of the nursing programme, and explore the teaching strategies that can reduce the theory-practice gap in nursing education.

9.7.3 Recommendations for nursing practice

Based on the study findings, none of the nurse participants reported feeling comfortable and confident about their knowledge and skills in providing supportive care for men diagnosed with PCa and their families, due to a lack of specialised training in oncology. It is therefore recommended that:

- The MoHSS should require nurses working with cancer patients to have the competencies required to deliver high-quality supportive care, as demonstrated by training, certification and credentials.
- The MoHSS should consider recruiting oncology specialist nurses who will form part of the existing MDT in order to effectively contribute to the facilitation of supportive care for men diagnosed with PCa.
- The specialist oncology nurse should assess the healthcare needs of men using a standardised assessment tool in order to ensure consistency and evidence-based supportive care delivery to all men.
- Nurses should always be present at the time men are given a PCa diagnosis in order to offer health information and support for men and to help them to make decisions. This is because specialist oncology nurses have extensive skills in relation to the effects that a PCa diagnosis has on physical, social, psychological and spiritual aspects in men.
- Nurses should involve men and family members as fully as possible in the decision-making process, so that they do not feel that decisions are being imposed on them.

9.7.4 Recommendations for nursing research

A model for nurses to facilitate supportive care for men diagnosed with PCa and their families at the IHO was developed. Nurses therefore need to play an active role in the implementation of the model, as well as develop a sense of ownership and a positive attitude towards the model to attain its desired goal. The researcher therefore recommends that further research be conducted on the following aspects:

- Nurse Manager should develop questionnaires to evaluate the impact of the model one year after guideline implementation. This will help to determine the effectiveness of the model following its practical implementation in oncology departments.

- The knowledge, attitudes and practices of nurses regarding the facilitation of supportive care for men diagnosed with PCa and their families should be determined.
- The findings of this study are limited in scope and apply only to the IHO in the Oshana region; therefore, similar studies could be conducted in other regions of Namibia to ascertain whether there will be similarities or not in terms of findings.

9.8 WAY FORWARD

On completion of the study, the researcher will disseminate the findings.

The following articles will be extracted for publication in peer-reviewed journals to increase accessibility:

- Best practices for the supportive care of men diagnosed with PCa and their families by nurses in oncology departments (scoping review)
- Experiences of men diagnosed with PCa of the supportive care received from nurses in oncology departments (qualitative)
- Experiences of the families of men diagnosed with PCa on the supportive care received from nurses in oncology departments (qualitative)
- Experiences of nurses in facilitating the supportive care of men diagnosed with PCa and their families in oncology departments-(qualitative)
- Assessment of the oncology departments at the IHO in terms of facilitating supportive care for men diagnosed with PCa and their families (quantitative)
- The conceptual framework as a basis for model development
- A model to facilitate supportive care for men diagnosed with PCa and their families at the IHO
- Guidelines for operationalising the model to facilitate supportive care for men diagnosed with PCa and their families

The following papers are envisaged for presentation on national and international academic platforms:

- Experiences of nurses in facilitating supportive care for men diagnosed with PCa and their families
- A model to facilitate supportive care for men diagnosed with PCa and their families in Namibia

It is envisaged that this dissertation will be converted into a book. The chapters headings will be as follows:

- Chapter 1: Background of men diagnosed with PCa.
- Chapter 2: The challenges inherent in rendering supportive care for men diagnosed with PCa and their families in health facilities.

- Chapter 3: Supportive care services available for men diagnosed with PCa and their families
- Chapter 4: Policies and guidelines on supportive care for men diagnosed with PCa and their families.
- Chapter 5: Stakeholders in the supportive care of men diagnosed with PCa and their families
- Chapter 6: A model for nurses to facilitate supportive care for men diagnosed with PCa and their families in health facilities

9.9 SUMMARY

This chapter presented the purpose of the study, as well as the conclusions, limitations and recommendations. The conclusions were guided by the eight objectives on which the study was built. The chapter outlined the limitations that were encountered during the study, which include the restriction of participants to one public hospital, the limited sample size and the limited literature on supportive care for men with PCa in SADC countries. The study was justified as an original contribution to the existing body of knowledge in nursing practice. Lastly, based on the findings, the study made recommendations in terms of management, nursing education, nursing practice and nursing research. The wish of the researcher is that the implementation of the study recommendations will enable nurses to identify the health needs of men diagnosed with PCa and to successfully facilitate supportive care in oncology departments.

REFERENCES

Addie, W. C., Jo-Anne, A. M., Chisholm, K., David, A. W., Britt, K., McCabe, M., …Anthony, C. J. (2014). Development, feasibility and usability of an online psychological intervention for men with prostate cancer: My road ahead. *Internet Interventions, 1*(4), 188–195.

Adeloye, D., David, R. A., Aderemi, A. V., Iseolorunkanmi, A., Oyedokum, A., Iweala, E. E., Omeregbe, N., & Ayo, C. K. (2016). An estimate of the incidence of prostate cancer in Africa: A systematic review and meta-analysis. *PLoS ONE, 11*(4), 1–18.

Albaugh, J. A., Sufrin, N., Lapin, B. R., Petkewicz, J., & Tenfelde, S. (2017). Life after prostate cancer treatment: A mixed methods study of the experiences of men with sexual dysfunction and their partners. *MBC Urology, 17*(45), 1–9.

Allchorne, P., & Green, J. (2016). Identifying unmet care needs of patients with prostate cancer to assist with their success in coping. *Urologic Nursing, 36*(5), 224–232.

Amukugo, H.J. (2009*). A model to facilitate male partner involvement in the reproductive health context in Oshikoto region in Namibia.* University of Namibia.

Arksey, H., & O'Malley, L. (2005). Scoping studies: Towards a methodological framework. *International Journal of Social Research Methodology, 8*(1), 19-32.

Basketter, V., Benney, M., Causer, L., Fleure, L., Hames., D., Jones., S., Patel., K., & White., l. (2018). Continuous, comprehensive and crucial care: The role of the CNS in the metastatic castration-resistant prostate cancer patient pathway. *British Journal of Nursing, 27*(Sup4b), 61-73.

Begue, A. (2013). Advanced practice nurses training for the geriatric oncology population. *Journal of Geriatric Oncology, 4*(1), S90.

Berman, A., Snyder, S. J., & Frandsen, G. (2016). *Kozier & Erbs's fundamentals of nursing: Concepts, process, and practice* (10th ed.). S4Carlie Publishing Services.

Best, M., Butow, P., & Olver, I. (2013). Spiritual support of cancer patients and the role of the doctor. *Supportive Care in Cancer, 22*(4), 1333–1339.

Biddle, C. (2015). Axiology and anomaly in the practice of mixed methods work: Pragmatism, valuation, and the transformation paradigm. *Journal of Mixed Methods Research, 9*(4), 320–333.

Blackwell's Nursing Dictionary. (2012). Juta & Company Ltd.

Bless, C., Higson-Smith, C., & Sithole, S. L. (2013). *Fundamentals of social research methods: An African perspective* (5th ed.). Juta.

Booyens, S., Jooste, K., & Sibiya, N. (2015). *Introduction to health services management for the unit manager* (4_{th} ed.). Juta & Company Ltd.

Botma, Y., Greeff, M., Mulaudzi, F. M., & Wright, S. C. D. (2010). *Research in health sciences.* Clyson Printers.

Bowen, E. (2019). A qualitative study on psychosexual implications of prostate cancer among black prostate cancer survivors. *Scientific Publishers, 1*(1), 1–12.

Burns, N., & Grove, S. K. (2011). *The practice of nursing research: Appraisal, synthesis, and generation of evidence* (6th ed.). Saunders Elsevier.

Büssing, A., & Koenig, H. G. (2010). Spiritual needs of patients with chronic diseases. *Religions*, *10*(1), 18–27.

Cadet, T., Davis, C., Elks, J., & Wilson, P. (2016). A holistic model of care to support those living with and beyond cancer. *Healthcare, 88*(4), 1–9.

Carter, N., Miller, P. A., Murphy, B. R., Payne, V. J., & Bryant-Lukosius, D. (2014). Healthcare providers' perspective of the supportive care needs of men with advanced prostate cancer. *Oncology Nursing Forum, 41*(4), 241–430.

Chambers, S. K., Dunn, J., Lazenby, M., Clutton, S., Newton, R. U., Cormie, P., Lowe, A., Sandoe, D., & Gardiner, R. A. (2013). *ProsCare: A psychological care model for men with prostate cancer*. Griffith University, Australia.

Chambers, S. K., Hyde, M. K., Laurie, K., Legg, M., Frydenberg, M., Davis, I. D., Lowe, A., & Dunn, J. (2018). Experiences of Australian men diagnosed with prostate cancer: A qualitative study. *BMJ Open, 36*(11), 1–12.

Chan, E. A., Wong, F., Cheung, M. Y., & Lam, W. (2018). Patients' perceptions of their experiences with nurse-patient communication in oncology settings: A focused ethnographic study. *PLoS ONE*, *13*(6), 1–17.

Cheah, W. L., Ling, N. C., & Chang, K. H. (2018). The supportive care needs for prostate cancer patients in Sarawak. *Chinese Clinical Oncology, 15*(1), 1–10.

Chen, R. C., Rumble, B., & Jain, S. (2016). Active surveillance for the management of localized prostate cancer (Cancer Care Ontario Guideline): American Society of Clinical Oncology clinical practice guideline endorsement summary. *American Society of Clinical Oncology, 12*(3), 267–269.

Chetty, P., & Datt, S. (2015). *Reliability test in SPSS using Cronbach alpha.* Project Guru. https://www.projectguru.in/measuring-reliability-questionnaires/

Chinn, P.L., & Kramer, M.K. (2018). *Knowledge Development in Nursing: Theory and Process* (10_{th} ed.). Elsevier Publications.

Cockle-Hearne, J., Charnay-Sonnek, F., Denis, L., Fairbanks, H. E., Kelly, D., Kav, S., Leonard, K., Van Muilekom, E., Fernandez-Ortega, P., Jensen, B. T., & Faithful, S. (2013). The impact of supportive nursing care on the needs of men with prostate cancer: A study across seven European countries. *British Journal of Cancer, 109,* 2121–2130. https://doi.org/10.1038/bjc.2013.568

Cooke, A., Smith, D.M., & Booth, A. (2012). Beyond PICO: The SPIDER tool for qualitative synthesis. *Qualitative Health Research, 22*(10), 1435-1443.

Cooke, H., & Philpin, S. (2008). *Sociology in nursing and healthcare*. Elsevier.

Copi, I.M., & Cohen, C. (2014). *Introduction to Logic Person: New international edition* (14_{th} ed.). Pearson Education Publishers.

Cornell, C., & Jude, N. (2015). The systems theory of management in modern day organisations: A study of Aldgate Congress Report Limited Port Harcourt. *International Journal of Science and Research Publications, 9*(4), 1–7.

Cowens-Alvarado, R., Sharpe, K., Pratt-Chapman, M., & Willis, A. (2013). Advancing survivorship care through the national cancer survivorship resource center: Developing American cancer society guidelines for primary care providers. *CA: A Cancer Journal for Clinicians, 63*(3) 147–150.

Creative Bloq Staff. (2016). Art and design inspiration.

Creswell, J. W. (2014). *Research design: Qualitative, quantitative, and mixed methods approaches* (4th ed.). Sage Publications.

Creswell, J. W., & Clark, V. L. P. (2011). *Design and conducting mixed methods research* (2nd ed.). United Kingdom: Sage Publications.

Creswell, J. W., & Creswell, J. D. (2018). *Research design: Qualitative, quantitative and mixed methods approaches.* Sage Publications.

Creswell, J. W., & Poth, C. N. (2018). *Qualitative enquiry and research design: Choosing among five approaches* (4th ed.). Sage Publications.

Crompton, S. (2016). Pulling together: The case of prostate cancer. *Cancer World, 71*(9), 1–18.

Cummings, G. G., Lee, S. D., & Tate, K. C. (2018). The evolution of oncology nursing: Leading the path to change. *Canadian Oncology Nursing Journal, 28*(4), 314–317.

Cwiklicki, M., & Urbaniak, A. (2018). Methodological rigour in descriptions of case-study research in Polish academic articles on management. *Research Gate, 6*(2), 165–177.

Da Silva, J. M. S., O’Dwyer, G., & Osorio-de-Castro, C. G. S. (2019). Cancer care in Brazil: Structure and geographical distribution. *BMC Cancer, 987*(19), 1–19.

Daudt, H.M.L., Van Mossel, C., & Scott, S.J. (2013). Enhancing the scoping study methodology: A large, inter-professional team’s experience with Arksey and O’Malley’s framework. *BMC Medical Research Methodology, 48*(13), 1-9.

De Moraes-Lopes, M., & Higa, R. (2015). The role of the clinical nurse specialist in caring for patients with prostate cancer: A narrative review. *Nursing Research Review, 4*(2), 77–89.

De Vos, A. S., Strydom, H., Fouche, C. B., & Delport, C. S. L. (2011). *Research at grass roots: For the social sciences and human service professions* (4th ed.). Van Shaik.

Demichelis, F., & Stanfold, J.L. (2015). Genetic predisposition to prostate cancer: Update and future perspectives. *Journal of Oncology, 33*(2), 75-84.

Dickers, M. (2015). What is Scoping Review? *KT Update,* 4(1), 1-5.

Dickoff, J., James, P., & Wiedenbach, E. (1968). Theory in a practice discipline. Part 1: Practice oriented theory. *Nursing Research, 17*(5), 415-435.

Drennan, V. M., & Goodman, C. (2014). *Oxford handbook of primary care and community nursing.* Oxford University Press.

Du Plooy-Cilliers, F., Davis, C., & Bezuidenhout, R. (2014). *Research matters*. Paarl Media Paarl.

Dunn, J., Casey, C., Sandoe, D., Hyde, M. K., Cheron-Chauer, M. C., Lowe, A., Oliffe, L., & Chambers, S. K. (2018). Advocacy, support and survivorship in prostate cancer. *European Journal of Cancer Care, 27*(2), 1–5.

Evans, M. A., Shaw, A. R. G., Sharp, D. J., Thompson, E. A., Falk, S., Turton, P., & Thompson, T. (2007). Men with cancer: Is their use of complementary and alternative medicine a response to needs unmet by conventional care? *European Journal of Cancer Care, 16*(2), 517–525.

Evans, M.P., Duffey, T., & Englar-Carlson, M. (2013). Introduction to special issue: Men in Counselling. *Journal of Counselling and Development, 91*(4), 387-388.

Fawcett, J. (2005). Criteria for evaluation of theory. *Nursing Science Scholarly, 18*(2), 131–135.

Field, A. (2013). *Discovering statistics using IBM SPSS statistics* (4th ed.). SAGE Publications.

Fink, A. (2014). *Conducting research literature reviews: From the internet to paper*. Sage Publications.

Firestone, W. A. (2013). Meaning in methods: The rhetoric of qualitative and quantitative research. *American Educational Research Association Journal, 16*(7), 16–21.

Flynn, K. E., Reese, J. B., Jeffery, D. D., Abenethy, A. P., & Lin, L. (2012). *Patient experiences with communication about sex during and after treatment for cancer*. University of School of Medicine.

Fogelström, E. (2013). *Investigation of shapes and colours as elements of character design*. Sweden: Uppsala University.

Frank, R. C. (2009). *Fighting cancer with knowledge and hope: A guide for patients, families and healthcare providers*. Yale University Press Health and Wellness.

Frankland, J., Brodie, H., Cooke, D., Foster, C., Foster, R., Gage, H., Jordan, J., Mesa-Eguiagaray, I., Pickering, R., & Richardson, A. (2019). Follow-up care after treatment for prostate cancer: Evaluation of a supported self-management and remote surveillance programme. *BMC Cancer, 19*(368), 1–19.

Freshwater, D., & Maslin-Prothero, S.E. (2012). *Blackwell's Nursing Dictionary*. Juta & Company Ltd.

Gamieldien, F., Galvaan, R., Myers, B., & Sorsdahl, K. (2020). Exploration of recovery of people living with severe mental illness (SMI) in low-income and middle-income countries (LMIC): A Scoping Review Protocol. *BMJ Open, 10*(1), 1-7.

Garrett, B. M., Oliffe, J. L., Bottorff, J. L., McKenzie, M., Han, C. S., & Ogrodniczuk, J. S. (2014). The value of prostate cancer support groups: A pilot study of primary physicians' perspectives. *BMC Family Practice, 15*(56), 1–9.

Gaskin, J., & Lim, J. (2016). *Model Fit Measures, AMOS Plugin*. Available at: https://drive.google.com/drive/folders/oB3T1TGdHG9aEbFg1EpqOWtrR3c

Gaskin, J.E. (2017). *Confirmatory Factor Analysis: Validity and Reliability*. Available at: http://statwiki.kolobkreations.com/index.php?title=Confirmatory Factor Analysis

George, J. B. (2014). *Nursing theories: The base for professional nursing practice* (6th ed.). Pearson.

Gerhard, J., Asvat, Y., Lattie, E., O'Mahony, S., Duberstein, P., & Hoerger, M. (2016). Distress, delay of gratification and preference for palliative care in men with prostate cancer. *Psychooncology, 25*(1), 91–96.

Giddens, A., & Sutton, P. W. (2017). *Sociology* (8th ed.). Polity Press.

Ginter, A. C., & Braun, B. (2019). Social support needs of breast cancer patients without partners. *Journal of Social and Personal Relationships, 36*(1), 43–62.

Gliem, J. A., & Gliem, R. R. (2013, October). *Calculating, interpreting, and reporting Cronbach's alpha reliability coefficient for Likert-type scales*. Paper presented at the Midwest Research-to-Practice Conference in Adult, Continuing, and Community Education. Ohio University, Columbus, OH.

Government of the Republic of Namibia. (2004). Nursing Act No. 8 of 2004. *Government Gazette*. Namibia, Windhoek.

Greeff, A.P., & Thiel, C. (2012). Resilience in families of husbands with prostate cancer. *Educational Gerontology, 38*(3), 179-189.

Griffin, K. (2019). Better outcomes, better experiences: Why cancer nursing is a job for specialists. *Cancer World, 86*(11), 1–20.

Grimes, C., Wanless, R. S., & Damonti, J. (2014). New models for elevating the practice and status of community-based nursing across the spectrum of cancer care in Central and Eastern Europe. *European Journal of Oncology Nursing, 18*(2014), S97–S122.

Grove, S. K., Burns, N., & Gray, J. R. (2013). *The practice of nursing research: appraisal, synthesis, and generation of evidence* (7th ed.). Saunders Elsevier.

Grove, S., Gray, J., & Burns, N. (2015). *Understanding Nursing Research: Building an Evidence-Based Practice* (6_{th} ed.). Elsevier Publishers.

Grove, S. K., & Gray, J. R. (2019). *Understanding Nursing Research: Building an Evidence-Based Practice* (7_{th} ed.). Elsevier Publishers.

Guraya, S. Y., London, N. J. M., & Guraya, S. S. (2014). Ethics in medical research. *Journal of Microscopy and Ultrastructure, 3*(2), 121–126.

Gutierrez, M. G. R., Duarte, A. M., & Dias, C. G. (2014). The clinical practice of oncology nursing in Brazil: Realities and challenges in the training of specialist nurses. *Cancer Medical Science, 46*(8), 46.

Haapoja, A. (2014). *The nursing process, a tool to enhance clinical care – a theoretical study.* NOVIA University of Applied Sciences, Finland.

Haire, H., Burton, C., Park, R., Reynolds, J., Stewart, D., & Purushotham, A. D. (2013). Integrated cancer system: A perspective on developing an integrated system for cancer services in London. *London Journal of Primary Care, 5*(1), 29–34.

Haralambos, M., & Holborn, M. (2008). *Sociology: Themes and perspectives* (7th ed.). Harper Collins.

Hartgerink, J. M., Cramm, J. M., Bakker, T. J. E. M., Eijsden, A. M., Mackenbach, J. P., & Nieboer, A. P. (2014). The importance of multidisciplinary teamwork and team climate for relational coordination among teams delivering care to older patients. *Journal of Advanced Nursing, 70*(4), 791–799.

Hays, D. G., & Sigh, A. A. (2011). *Qualitative enquiry in clinical and education setting*. Guilford Press.

Hedden, L. (2018). Development, implementation, and evaluation of a prostate cancer supportive care program. *Community Oncology, 16*(6), e234–e242.

Hilbbard, J. H., & Greene, J. (2013). What the evidence shows about patient activation: Better health outcomes and care experiences: Fewer data on costs. *Health Affairs, 32*(2), 207–214.

Hinkle, J. L., & Cheever, K. H. (2018). *Brunner and Suddarth's textbook of medical-surgical nursing* (13th ed.). Wolters Kluwer Health.

Holloway, S., & Wheeler, I. (2010). *Qualitative research in nursing and healthcare* (3rd ed.). Vivar Printing: Malaysia.

Hornby, A. S. (2015). *Oxford advanced learner's dictionary of current English* (9th ed.). Oxford University Press.

Huljev, D., & Pandak, T. (2016). Holistic and team approach in the healthcare. *Signa Vitae, 11*(2), 66–69.

Jacobs, M., Vakalisa, N.C.G., & Gawe, N. (2012). *Teaching-learning dynamics*. Pearson Education Publishers.

Jacobsen, K. H. (2017). *Introduction to research methods: A practical guide* (2nd ed.). Edwards Brothers Malloy Cover Printing.

Jacobsen, P. B., Holland, J. C., & Steensma, D. P. (2012). Caring for the whole patient: The science of psychosocial care. *Journal of Clinical Oncology, 30*(11), 1151–1153.

Jasemi, M., Valizadeh, L., Zamanzadeh, V., & Keogh, B. (2017). A concept analysis of holistic care by hybrid model. *Indian Journal of Palliative Care, 23*(5), 71–80.

Jolley, R.J., Lorenzetti, D.L., Manalili, K., Lu, M., Quan, H., & Santana, M.J. (2016). Protocol for scoping review study to identify and classify patient-centred quality indicators. *MBJ Open Access, 10*(6), 1-5.

Jooste, K. (2010). *The principles and practice of nursing and health care: Ethos and professional practice, management, staff development, and research.* Van Schaik Publishers.

Kampel, L. J. (2007). *Dx/Rx: Prostate cancer.* Jones and Bartlett.

Kandasamy, S., Khalid, A. F., Majid, U., & Vanstone, M. (2017). Prostate cancer patient perspectives on the use of information in treatment decision-making: A systematic review and qualitative meta-synthesis. *Ontario Health Technology Assessment Series, 17*(7), 1–32.

Kangmennaang, J., Mkandawire, P., & Luginaah, I. (2016). What prevents men aged 40–64 years from prostate cancer screening in Namibia? *Journal of Cancer Epidemiology, 16*(2), 1–7.

Kassianos, A. P., Raats, M. M., & Gage, H. (2016). An exploratory study on the information needs of prostate cancer patients and their partners. *Health Psychology Research, 4*(4786), 19–25.

Kenya Ministry of Health. (2017). *National cancer control strategy 2017–2022.* Nairobi: Kenya.

King, A. J. L., Evans, M., Moore, T. H. M., Paterson, C., Sharp, D., Persad, R., & Huntley, A. L. (2015). Prostate cancer and supportive care: A systematic review and qualitative synthesis of men’s experiences and unmet needs. *European Journal of Cancer Care, 24*(5), 618–634.

Kirkman, M., Young, K., Evans, S., Millar, J., Fisher, J., Mazza, D., & Ruseckaite, R. (2017). Men’s perceptions of prostate cancer diagnosis and care: Insights from qualitative interviews in Victoria, Australia. *BMC Cancer, 2*(6), 1–12.

Kirkman, M., Young, K., Evans, S., Millar, J., Fisher, J., Mazza, D., & Ruseckaite, R. (2017). Men’s perceptions of prostate cancer diagnosis and care: Insights from qualitative interviews in Victoria, Australia. *BMC Cancer, 1*(17), 21–39.

Kirkman, M., Young, K., Evans, S., Millar, J., Fisher, J., Mazza, D., & Ruseckaite, R. (2017). Men’s perceptions of prostate cancer diagnosis and care: Insights from qualitative interviews in Victoria, Australia. *BMC Cancer, 17*(704), 1–12.

Kredo, T., Brnhardsson, S., Machingaidze, S., Young, T., Louw, Q., Ochodo, E., & Grimmer, K. (2016). Guide to clinical practice guidelines: The current state of play. *International Journal for quality in healthcare, 28*(1), 122–128.

Krumwiede, K.A., & Krumwiede, N. (2012). The lived experience of Men Diagnosed with Prostate Cancer. *Oncology Nursing Forum, 39*(5), 443-450.

Latte-Naor, S., & Mao, J.J. (2019). Putting intergrative oncology into practice: Concepts and Approaches. *Journal of Oncology Practice,* 15(1), 7-14.

Lavdaniti, M. (2017). Holistic nursing approach to patients with cancer. *Journal of Nursing and Care, 6*(1), 1–2.

Leedy, P. D., & Ormrod, J. E. (2010). *Practical research: Planning and design* (9th ed.). Pearson Education.

Leis, A. M., Weeks, L. C., & Verhoef, M. J. (2008). Principles to guide integrative oncology and the development of an evidence base. *Current Oncology, 15*(2), s83–s87.

Levac, D., Colquhoun, H., & O’Brien, K.K. (2010). Scoping studies: Advancing the methodology. *Implementation Science, 69*(5), 1-9.

Lewis, S. M., Heitkermper, M. M., & Dirksen, S. R. (2004). *Medical and surgical nursing: assessment and management of clinical problems* (6th ed.). Mosby.

LoBiondo-Wood, G., & Haber, J. (2010). *Nursing research: Methods and critical appraisal for evidence-based practice* (7th ed.). Elsevier.

Lu, X., Xiujing, G., Lu, B., Jiahui, Q., & Jing, C. (2018). Are spiritual interventions beneficial to patients with cancer? A meta-analysis of randomized controlled trials following PRISMA. *Journal of Medicine, 97*(35), 948–955.

Macdonald, G. C. T., Baldassarre, F., Brown, P., Hatton-Bauer, J., Li, M., Green, E., & Lebel, S. (2012). Psychosocial care for cancer: A framework to guide and actionable recommendations for Ontario. *Current Oncology, 19*(9), 209–216.

MacLean, R., & Wilson, S. (2011). *Research methods and data analysis for psychology*. McGraw-Hill Education.

Macmillan English Dictionary for Advanced Learners. (2007). Macmillan Publishers Limited.

Malatji, M., Hafisa, A., & Makhene, A. (2017). Nurses experiences regarding staffing patterns in the surgical wards of a private hospital in Gauteng. *Health SA Gesondheid, 22,* 325–332.

Matthews, B., & Ross, L. (2010). *Research methods: A practical guide for the social sciences*. Pearson Education.

May, A., & Holmes, S. (2012). *Introduction to nursing research: Developing research awareness*. Graphysems Printing.

Merriam Dictionary (2014). *Definition of lack knowledge*. United States of America: Merriam-Webster

Miguel, F., Conceicao, A. V., Lopes, L. V., Bernardo, D., Monteiro, F., Bessa, F., Santos, C., Oliveira, J. B., & Santos L. L. (2014). Establishing of units in low or middle income African countries: Angolan experience – a preliminary report. *The Pan African Medical Journal, 19*(6), 1–10.

Mills, E. G., & Gay, L. R. (2016). *Educational research*. England: Sage Publications.

Ministry of Health and Social Services (2018). *Management Information System*. Oshakati.

Ministry of Health and Social Services (MoHSS). (2011). *Report on need assessment: Screening for reproductive system cancers*. Windhoek: MoHSS.

Ministry of Health and Social Services (MoHSS). (2016). *Patient charter*. Windhoek: MoHSS.

Mitema, A., Maree, L., & Young, A. (2019). Cancer treatment in Africa: The importance of the role of nursing. *Cancer Medical Science, 7*(2), 1–5.

MNT Knowledge Center. (2013). What is prostate cancer? Retrieved October 4, 2018 from http://www.Medicalnewstoday.Com./articles/150086.phpb

Mofolo, N., Betshu, O., Kenna, O., Koroma, S., Lebeko, T., Claassen, F. M., & Joubert, G. (2015). Knowledge of prostate cancer among males attending a urology clinic, a South African study. *Springer Plus, 4*(1), 1–6.

Mogotlane, S. M., Chauke, M. E., Matlakala, M., Mokoena, J. D., & Young, A. (2013). *Juta's complete textbook of medical surgical nursing*. Juta.

Mogotlane, S., Mokoena, J., Chauke, M., Matlakala, M., Young, A., & Randa, B. (2018). *Juta's complete textbook of medical and surgical nursing* (2nd ed.). Juta.

Mogotlane, S.M., Manaka-Mkwanazi, I.M., Mokoena, J.D., Chauke, M.E., Matlakala, M.C., & Randa, M.B. (2015). Juta's Manual of Nursing Volume 2: The Practical Manual (2_{nd}.). Formeset Print.

Moher, D., Liberati, A., Tetzlaff, J., & Altman, D. G. (2010). Preferred reporting items for systematic reviews and meta-analyses: The PRISMA statement. *Medicine Peer-Review Open Access Journal, 6*(7), 1–12.

Mosby's Dictionary of Medicine, Nursing and Health Professions (2013). Elsevier Publications.

Msweli, P. (2011). *Writing a research proposal: Practical guidelines for business students*. Academic Press.

Muller, M., Bezuidenhout, M., & Jooste, K. (2011). Healthcare service management (2nd ed.). Juta.

Nair, S. C., Jaafar, H., Jaloudi, M., Quawasmeh, K., AlMarar, A., & Ibrahim, H. (2018). Supportive care needs of multicultural patients with cancer in the United Arab Emirates. *Cancer Medical Science, 12*(7), 838.

Nakandi, H., Kirabo, M., Semugabo., C., Kittengo, A., Kitayimbwa, P., Kalungi. S., & Maena, J. (2013). Knowledge, attitudes and practices of Ugandan men regarding prostate cancer. *African Journal of Urology, 19*(4), 165-170.

Namibia Vision 2030: Policy Framework for Long-Term National Development. (2014). Namprit.

Negash, W.A. (2020). *Development of an integrated framework for delivery care seeking behaviour among pregnant women in rural Ethiopia.* South Africa.

Nekhlyudov, L., Levit, L., Hurria, A., & Ganz, P. A. (2014). Patient-centered, evidence-based, and cost-conscious cancer care across the continuum: Translating the institute of medicine report into clinical practice. *A cancer Journal of Clinicians, 64*(11), 408–421.

Nelson, C. J., & Kenowitz, J. (2013). Communication and intimacy-enhancing interventions for men diagnosed with prostate cancer and their partners. *Journal of Sexual Medicine, 10*(1), 127–132.

Nelson, C. J., & Kenowitz, J. (2015). *Communication and intimacy-enhancing interventions for men diagnosed with prostate cancer and their partners*. Memorial Sloan-Kettering Cancer Center.

Nettina, S. M. (2014). *Lippincott manual of nursing practice* (10th ed.). Lippincott.

Nevidjon, B., Rieger, P., Murphy, C. M., Rosenzweig, M. Q., McCorkle, M. R., & Baileys, K. (2016). Filling the gap: Development of the oncology nurse practitioner workplace. *Journal Oncology Practice, 10*(6), 1–16.

Nieswiadomy, R. M. (2014). *Foundation in nursing research* (6th ed.). Pearson.

O'Leary, Z. (2014). *The essential guide to doing research project*. Sage Publications.

O'Toole, M. T. (2013). *Mosby's dictionary of medicine, nursing and health professionals* (9th ed.). Elsevier Publications.

Oba, A., Nakaya, N., Saito-Nakaya, K., Hasumi, M., Takechi, H., Arai, S., & Shimizu, N. (2017). Psychological distress in men with prostate cancer and their partners before and after cancer diagnosis: A longitudinal study. *Japanese Journal of Clinical Oncology, 47*(8), 735–742.

Oliffe, J. L., Halpin, M., Bottorff, J. L., Gregory, H. T., McKenzie, M., & Mroz, L. (2015). How prostate cancer support groups do and do not survive: British Columbian Perspective. *American Journal of Men's Health, 2*(2), 143–155.

Oliver, P. (2012). *Succeeding with your literature review: A handbook for students.* CPI Group of Publishers.

Oxford South Africa Concise Dictionary. (2010). ABC Press: South Africa.

Oxford Dictionary. (2015). *Oxford advanced learner's dictionary: International student's edition* (9th ed.). Oxford University Press.

Oxford English Dictionary (2018). Sv. Process. Retrieved: https://en.oxforddictionaries.com/definition/process

Oxford Learners Dictionary. (2018). *Oxford Learners Dictionaries.* ABC Press: South Africa.

Pallat, J. (2016). *SPSS Survival Manual: A step by step guide to data analysis using SPSS.* Open University Press.

Pang, C., Guan, Y., Li, H., Chen, W., & Zhu, G. (2016). Urologic cancer in China. *Japanese Journal of Clinical Oncology, 46*(6), 497-501.

Parahoo, K. (2014). *Nursing Research: Principles, Process and Issues* (2_{nd} ed.). Palgrave Macmillan.

Parse, R. R. P. (2005). Parse's criteria for evaluation of theory with a comparison of Fawcett's and Parse's approaches. *Nursing Science Scholarly, 18*(2), 135–137.

Paterson, C., & Nabi, G. (2017). A model of consultation in prostate cancer care: Evidence from a systematic review. *Cancer Nursing, 40*(4), 276–288.

Paterson, C., Alashkham, A., Windsor, P., & Nabi, G. (2016). Management and treatment of men affected by metastatic prostate cancer: Evidence-based recommendations for practice. *International Journal of Urological Nursing, 10*(1), 44–55.

Peters, M. D. J., Godfrey, C. M., Mclnerney, P., Soares, C. B., Khalil, H., & Parker, D. (2015). *The Joanna Briggs institute reviewer's manual 2015: Methodology for JBI scoping reviews*. The Joanna Briggs Institute South Australia.

Polit, D. F., & Beck, C. T. (2012). *Nursing research: Generating and assessing evidence for nursing practice* (9th ed.). Lippincott, Williams & Wilkins.

Porrit, K., Gomersall, J., & Lockwood, C. (2014). JBI's Systematic review: Study selection and critical appraisal. *American Journal of Nursing, 114*(60, 47-52.

Pretorius, D., Van Rooyen, M., & Reinbrech-Schutte, A. (2010). *Patient-centred communication and counselling: principles and practice.* Juta.

Primeau, C., Paterson, C., & Nabi, G. (2017). A qualitative study exploring models of supportive care in men and their partners/caregivers affected by metastatic prostate cancer. *Oncology Nursing Forum, 44*(6), E241–E249.

Prinsloo, C. J. (2018). *Self-leadership strategies of nurses in an outreach service at a private hospital group in Gauteng* (Published doctoral dissertation). University of Western Cape, South Africa.

Putt, L., & Jones, P. (2014). The role of the specialist acute oncology nurse in the new acute oncology services. *Clinical Oncology, 26*(3), 125–127.

Ramsey, S. D., Zeliadt, S. B., Blough, D. K., Moinpour, C. M., Hall, I. J., Smith, J. L., … Ekwueme, D. U. (2013). Impact of prostate cancer on sexual relationships: A longitudinal perspective on intimate partners' experiences. *Journal of Sexual Medicine*, *10*(12), 1–12.

Ream, E., Quennell, A., Fincham, L., Faithfull, S., Khoo, V., Wilson-Barnett, J., & Richardson, A. (2008). Supportive care needs of men living with prostate cancer in England: A survey. *British Journal of Cancer*, *28*(7), 1903–1909.

Regan, T., Levesque, J. V., Lambert, S. D., & Kelly, B. (2015). A qualitative investigation of healthcare professionals' patients' and partners' views on psychosocial issues and related interventions for couples coping with cancer. *PLoS ONE, 10*(7), 1–22: e0133837.doi:131/journal.pone.0133837

Renzi, C., Fioretti, C., Oliveri, S., Mazzocco, K., Zerini, D., Alessandro, O., Rojas, D.P., Jereczek-Fossa, B.A., & Pravettoni, G. (2017). A qualitative investigation on patient empowerment in prostate cancer. *Frontiers in Psychology, 8*(1215), 1-9.

Resnick, M.J., Lacchetti, C., Bergman, J., Hauke, R.J., Hoffman, K.E., Kungel, T.M., Morgans, A.K., & Penson, D.F. (2015). Prostate Cancer Survivorship Care Guide: American Society of Clinical Oncology Practice Guideline Endorsement. *Journal of Clinical Oncology, 33*(9), 1078-1085.

Ringdal, M., Chaboyer, W., Ulin, K., Bucknall, T., & Oxelmark, L. (2017). Patient preferences for participation in patient care and safety activities in hospitals. *MBC Nursing, 16*(9), 1–8.

Røen, I., Stiffoss-Hansen, H., Grande, G., Kaasa, S., Sand, K., & Knudsen, A.K. (2019). Supporting carers: health care professionals in need of system improvements and education – a qualitative study. *MBC Palliative Care, 54*(18), 1-11.

Salomo, S., Amukugo, H. J., & Pretorius, L. (2016). Experiences of men diagnosed with prostate cancer in the four northern regions of Namibia. *European Journal of Pharmaceutical and Medical Research, 3*(5), 662–673.

Salomo, S., Pretorius, L., & Amukugo, J. H. (2016). Experience of men diagnosed with prostate cancer in the four northern regions of Namibia. *European Journal of Pharmaceutical and Medical Research, 3*(5), 662–675.

Schalkwyk, E., Gay, S., Miller, J., Mathee, E., & Gerber, B. (2020). Perceptions of mothers with preterm infants about early communication development: A scoping review. *South African Journal of Communication Disorders, 67*(1), 1-8.

Schear, R. M., Manasco, L., McGoldrick, D., Kajana, K., Rosenthal, L., McMikel, A., & Lins, N. (2015). International framework for cancer patient advocacy: Empowering organisations and patients to create a national call to action on cancer. *Journal of Global Oncology, 1*(2), 83–91.

Schutt, R. K. (2019). *Investigating the social world: The process and practice of research* (9th ed.). Sage Publications.

Scotland, J. (2012). Exploring the philosophical underpinnings of research: Relating ontology and epistemology to the methodology and methods of the scientific, interpretative, and critical research paradigms. *English Language Teaching, 5*(9), 9-16.

Searle, C. (2010). *Professional Practice: A Southern African Nursing Perspective* (4_{th} ed.). Heinemann Publishers.

Searle, C., Human, S., & Mogotlane, S. M. (2010). *Professional practice: A Southern-African nursing perspective* (5th ed.). Heinemann.

Seely, D.M., Weeks, L.C., & Young, S. (2021). A systematic review of integrative oncology programs. *Current Oncology,* 19(6), e436-e461.

Senelow, J. S., Joubert, H. E., Lee, H., & Fairhurst, B. R. (2018). Coping and adjustment in men with prostate cancer: A systematic review of qualitative studies. *Journal of Cancer Survivorship, 12*(1), 155–168.

Shallal, G. (2011). Job satisfaction among women in the United Arab Emirates. *Journal of International Women Studies, 12*(8) 114–134.

Shallwani, S. M., King, J., Thomas, R., Thevenot, O., De Angelis, G., Aburub, A. S., & Brosseau, L. (2019). Methodological quality of clinical practice guidelines with physical activity recommendations for people diagnosed with cancer: A systematic critical appraisal using the AGREE 11 tool. *PLoS ONE, 14(*4), 1–16.

Shilunga, A. (2017). *Management of sanitation and hygiene practices amongst primary schools in Ohangwena region, Namibia: Model development*. University of Namibia.

Shumba, T.W., & Iipinge, S.N. (2019). Learning style preferences of undergraduate nursing students: A systematic Review. *Africa Journal of Nursing and Midwifery, 22*(1), 1-25.

Siegel, R. L., Miller, K. D., & Jemal, A. (2018). American Cancer Society. *CA: A cancer Journal for Clinicians,* 68(1), 7–30. https://doi.org/10.3322/caac.21442

Sinfield, P., Baker, R., Casomosso-Stefinovic, J., Colman, A. M., Tarrant, C., Mellon, J. K., Steward, W., Kockelbergh, R., & Agarwal, S. (2010). Men's and carers' experiences of care for prostate cancer: A narrative literature review. *Health Expectations, 12*(3), 301–312.

Skolarus, T. A., & Wolf, A. M. D. (2014). American Cancer Society prostate cancer survivorship care guidelines. *CA: A Cancer Journal for Clinicians, 64*(4), 225–234.

Smeltzer, S. C., Bare, B. G., Hinkle, J. L., & Cheever, K. H. (2010). *Brunner and Suddarth's textbook of medical-surgical nursing* (12th ed.). Wolters Kluwer Health.

Smith, T., McNeil, K., Mitchell, R., Boyle, B., & Ries, N. (2019). A study of macro, meso, and micro barriers and enablers affecting extended scopes of practice: the case of rural nurse practitioners in Australia. *BMC Nursing, 18*(14), 1-12.

South African Concise Oxford Dictionary. (2002). Oxford University Press.

Stacey, D., Green, E., Ballantyne, B., Skrutkowski, M., Why not, A., Tardif, L., Trasuk, J., & Carley, M. (2016). Patient and family experiences with accessing telephone cancer treatment symptom support: A descriptive study. *Supportive Care in Cancer, 24*(2), 893–901.

Surbone, A., Baider, L., Weitzman, T. S., Brames, M. J., Rittenberg, C. N., & Johnson, J. (2010). Psychosocial care for patients and their families is integral to supportive care in cancer: MASCC position statement. *Support Care Cancer, 18*(1), 255–263.

Sutton, E., Hackshaw-McGeagh, L. E., Aning, J., Bahl, A., Koupparis, A., Persad, R., Martin, R. M., & Lane, J. A. (2017). The provision of dietary and physical activity advice for men diagnosed with prostate cancer: A qualitative study of the experiences and views of healthcare professionals, patients and partners. *Cancer Causes and Control, 28*(4), 319–329.

Sykes, J. (2013). *Practice framework and competency standards for the prostate cancer specialist nurse*. Prostate Cancer Foundation of Australia.

Taberna, M., Moncayo, F. G., Jane-Salas, E., Antonio, M., Arribas, L., Vilajosana, E., Torres, E. P., & Mesia, R. (2020). The multidisciplinary team (MDT) approach and quality of care. *Frontiers in Oncology, 85*(10), 1–16.

Tappen, R. M. (2011). *Advanced nursing research: From theory to practice*. Jones & Bartlett Learning.

Tappen, R. M. (2016). *Advanced nursing research: From theory to practice* (2nd ed.). Jones and Bartlett Publishers.

Tappen, R.M. (2011). *Advanced Nursing Research: From Theory to Practice*. Sudbury Printers.

Tarrant, C., Sinfield, P., Agarwal, S., & Baker, R. (2008). Is seeing a specialist nurse associated with positive experiences of care? The role of and value of specialist nurses in prostate cancer care. *MBC Health Services Research, 8*(1), 65.

Tavakol, M., & Dennick, R. (2011). Making sense of Cronbach's alpha. *International Journal of Medical Education, 65*(2), 53–55.

Tobin, G. A., & Begley, C. M. (2004). Methodological issues in nursing research: Methodological rigour within a qualitative framework. *Journal of Advanced Nursing, 48*(4), 388–936.

Torrey, E. F. (2006). *Surviving prostate cancer: What you need to know to make informed decisions.* Clarkson Porter.

Townsend, R. M. (2013). Engaging others in civic engagement through ethnography of communication. *Journal of Applied Communication Research, 41*(2), 202–208.

Turner, D., Adams, E., Boulton, M., Harrison, S., Khan, N., Peter, R., Ward, A., & Watson, E. K. (2013). Partners and close family members of long-term cancer survivors: Health status, psychological well-being and unmet supportive care needs. *Psycho-Oncology, 22*(4), 12–19.

Tylor, R. (2017). *Kielhofner's research in occupational therapy: Methods of enquiry for enhancing practice* (2nd ed.). FA Davis.

Ulla-Sisko, L., Aromaa, A., & Tammela, T. L. (2018). Experiences and psychological distress of spouses of prostate cancer patients at time of diagnosis and primary treatment. *European Journal of Cancer Care, 27,* 1–11. doi.org/10.1111/ecc.12729

Urden, L. D., Stacy, K. M., & Lough, M. E. (2018). *Critical care nursing: Diagnosis and management* (8th ed.). Elsevier Publications.

Uys, L., & Middleton, L. (2014). Mental health nursing: A Southern African perspective (6th ed.). Formset Print.

Van Vuuren, A. (2013). *21^{st} Century Psychology for Nurses: An Introduction*. Van Schaik Publishers.

Venkatesh, V., Brown, S. A., & Sullivan, Y. A. (2016). Guidelines for conducting mixed-methods research: An extension and illustration. *Journal of the Association for Information Systems, 17*(7), 435–495.

Voigt, W., Hoellthaler, J., Magnani, T., Corrao, V., & Valdagni, R. (2014). Act on oncology as a new comprehensive approach to assess prostate cancer centers – method description and results of a pilot study. *PLOS one, 9*(9), 1–7: e106743. https://doi.org/10.1371/journal.pone.0106743

Wagner, C. M., Antillon, F., Uwinkindi, F., Van Thuan, T., Luna-Fineman, S., & Anh, P. T. (2018). Establishing cancer treatment programs in resource-limited settings: Lessons learned from Guatemala, Rwanda, and Vietnam. *Journal of Global Oncology, 17*(1), 1–24.

Walker, L. O., & Avant, K. C. (2005). *Strategies for theory construction in nursing* (4th ed.). Pearson Prentice Hall.

Walker, L. O., & Avant, K. C. (2014). *Strategies for theory construction in nursing*. Prentice Hall.

Wang, T., Molassiotis, A., Chung, B. P. M., & Tan, J. (2018). Unmet care needs of advanced cancer patients and their informal caregivers: A systematic review. *MBC Palliative Care, 7*(96), 1–29.

Wangombe, D.K. (2013). *The Philosophy, Ontology, Epistemology and Methodology of Research in Corporate Environment Reporting Behaviour*. Available from: http://www.cluteinstitute.com/index.html (accessed 17February 2019).

Washington, K., & Salaria, S. N. (2016). Expanding roles for pathologists as members of the multidisciplinary cancer care team*: Personalized Medicine in Oncology, 10*(4), 18–25.

Webster's New World Dictionary. (1999). *The quick and easy access of an A-Z Thesaurus, plus the helpful index of a Roget-Style Thesaurus together in the indispensable resource for speakers and writers.* Wiley.

Weiten, W. (2014). *Psychology: Themes and variations*. China: Donnelly.

Wellam, F. Y. K., Ollife, J. L., Han, C. S., Garret, B., Henwood, T., Tuckett, A. G., & Sofrevardi, A. (2016). Canadian nurses’ perspectives on prostate cancer support groups: A study survey. *Cancer Nursing, 39*(3), 197–204.

Wolf, A., Moore, L., Lydahl, D., Naldemirci, O., Elam, M., & Britten, N. (2017). The realities of partnership in person-centered care: A qualitative interview study with patients and professionals. *BMJ Open*, *7*(4), 1–8.

World Medical Association Declaration of Helsinki (2013). *Ethical Principles for medical research involving human subjects*. Helsinki.

Zelders-Steyn, Y. E., Teule, J. A., & Huizinga, G. A. (2012). Proffered papers: Psychological issues and support. *European Journal of Oncology Nursing, 16S1,* S1–120.

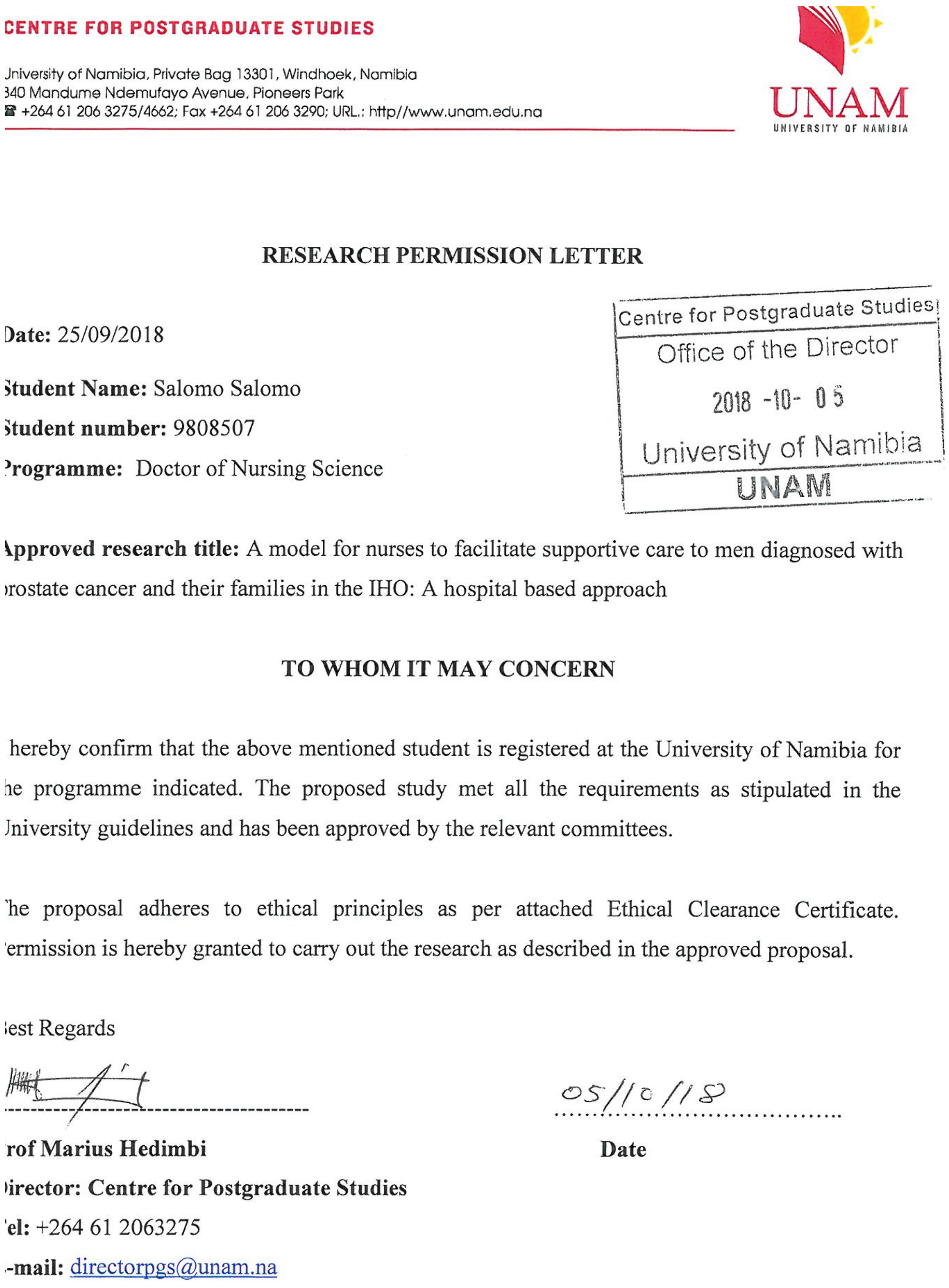
Zhang, Y., & Wildemuth, B. M. (2017). *Qualitative analysis of content: Applications of social research methods to questions in information and library science* (2nd ed.). Libraries of Congress Catalogue.

Zhou, C., Check, D. P., Lortet-Tieulent, J., Laversanne, M., Jemal, A., Ferlay, J., Bray, F., Cook, M.B., & Devesa, S.S. (2016). Prostate cancer incidence in 43 populations worldwide: An analysis of time trends overall by age group. *International Journal of Cancer, 138*(6), 388–1400.

Zibi, P.S. (2018). *A model to facilitate deep learning in nursing students at a University of Gauteng*. South Africa.

Zietsman, A., Pontac, J., Lawrence, S., Horn, L., & Van Schalkwyk, L. (2017). *Namibia national cancer registry (NNR): Cancer incidents in Namibia 2010-2014.* Namibia, Windhoek.

ANNEXURE A: Permission letter from UNAM centre for postgraduate studies



CENTRE FOR POSTGRADUATE STUDIES

University of Namibia, Private Bag 13301, Windhoek, Namibia
340 Mandume Ndemufayo Avenue, Pioneers Park
☎ +264 61 206 3275/4662; Fax +264 61 206 3290; URL.: http//www.unam.edu.na

UNAM
UNIVERSITY OF NAMIBIA

RESEARCH PERMISSION LETTER

Centre for Postgraduate Studies
Office of the Director
2018 -10- 05
University of Namibia
UNAM

Date: 25/09/2018

Student Name: Salomo Salomo
Student number: 9808507
Programme: Doctor of Nursing Science

Approved research title: A model for nurses to facilitate supportive care to men diagnosed with prostate cancer and their families in the IHO: A hospital based approach

TO WHOM IT MAY CONCERN

hereby confirm that the above mentioned student is registered at the University of Namibia for he programme indicated. The proposed study met all the requirements as stipulated in the University guidelines and has been approved by the relevant committees.

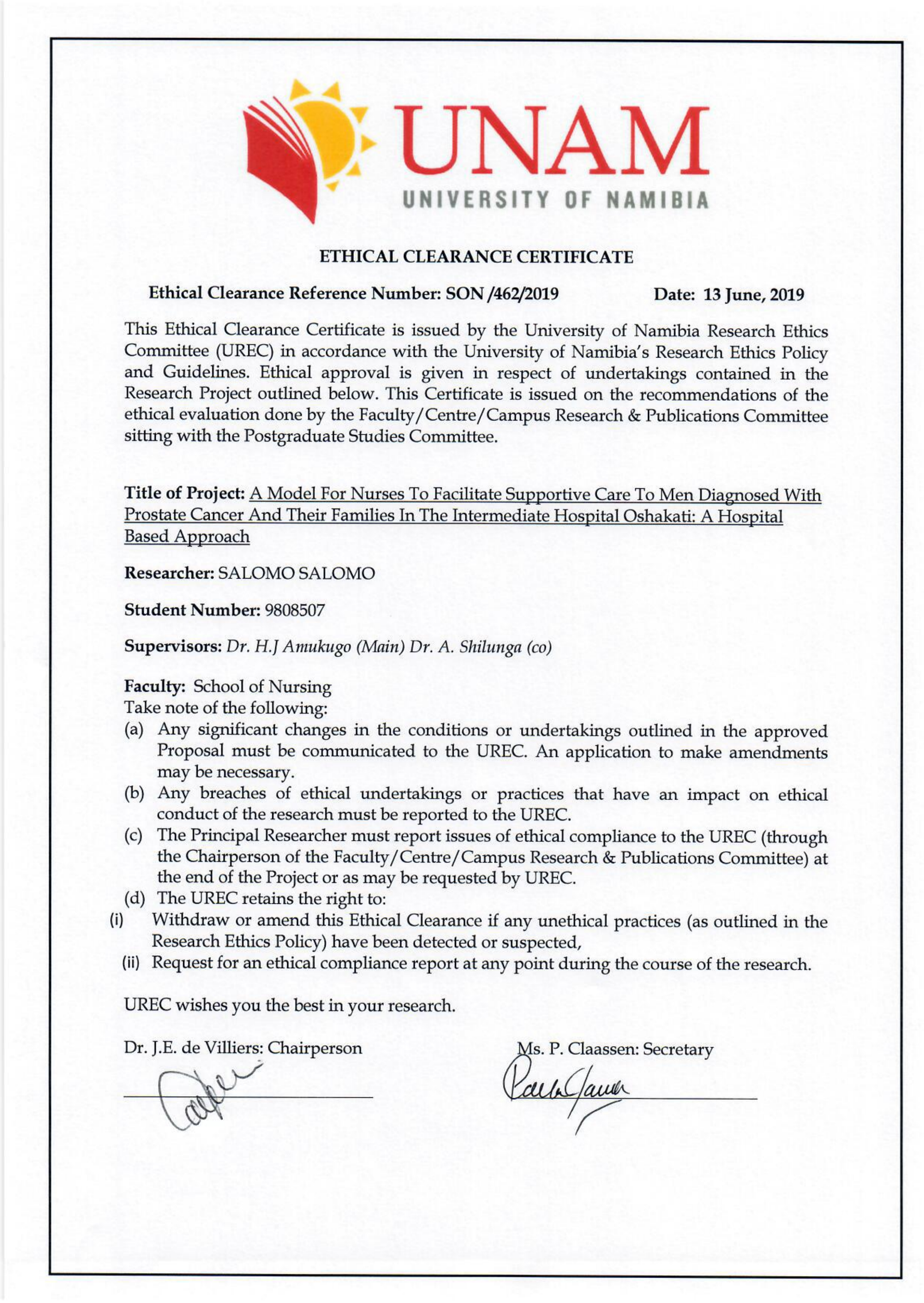
The proposal adheres to ethical principles as per attached Ethical Clearance Certificate. Permission is hereby granted to carry out the research as described in the approved proposal.

Best Regards

05/10/18

rof Marius Hedimbi — **Date**
Director: Centre for Postgraduate Studies
Tel: +264 61 2063275
-mail: directorpgs@unam.na

ANNEXURE B: Ethical clearance certificate from UNAM



UNAM
UNIVERSITY OF NAMIBIA

ETHICAL CLEARANCE CERTIFICATE

Ethical Clearance Reference Number: SON /462/2019 **Date: 13 June, 2019**

This Ethical Clearance Certificate is issued by the University of Namibia Research Ethics Committee (UREC) in accordance with the University of Namibia's Research Ethics Policy and Guidelines. Ethical approval is given in respect of undertakings contained in the Research Project outlined below. This Certificate is issued on the recommendations of the ethical evaluation done by the Faculty/Centre/Campus Research & Publications Committee sitting with the Postgraduate Studies Committee.

Title of Project: A Model For Nurses To Facilitate Supportive Care To Men Diagnosed With Prostate Cancer And Their Families In The Intermediate Hospital Oshakati: A Hospital Based Approach

Researcher: SALOMO SALOMO

Student Number: 9808507

Supervisors: *Dr. H.J Amukugo (Main) Dr. A. Shilunga (co)*

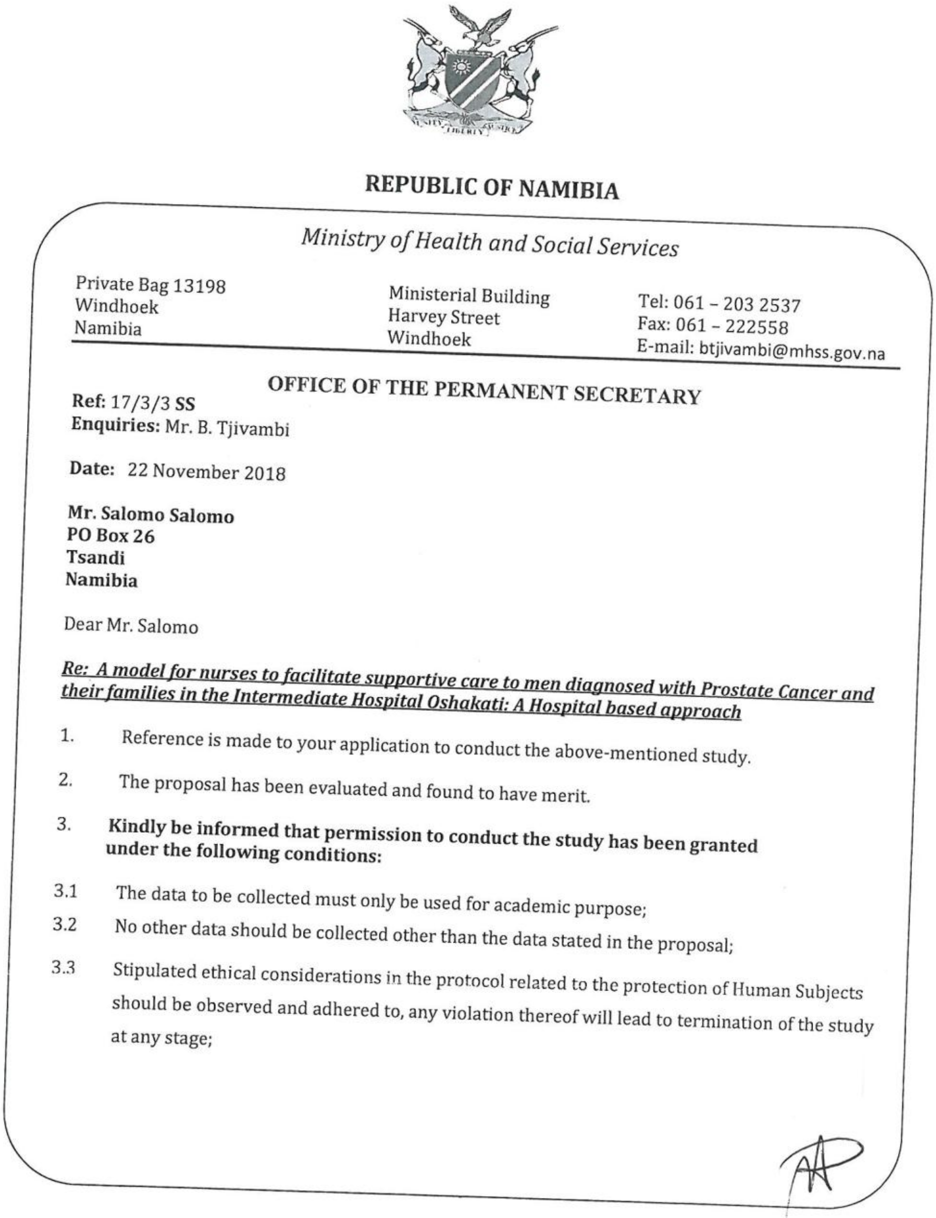
Faculty: School of Nursing
Take note of the following:
(a) Any significant changes in the conditions or undertakings outlined in the approved Proposal must be communicated to the UREC. An application to make amendments may be necessary.
(b) Any breaches of ethical undertakings or practices that have an impact on ethical conduct of the research must be reported to the UREC.
(c) The Principal Researcher must report issues of ethical compliance to the UREC (through the Chairperson of the Faculty/Centre/Campus Research & Publications Committee) at the end of the Project or as may be requested by UREC.
(d) The UREC retains the right to:
(i) Withdraw or amend this Ethical Clearance if any unethical practices (as outlined in the Research Ethics Policy) have been detected or suspected,
(ii) Request for an ethical compliance report at any point during the course of the research.

UREC wishes you the best in your research.

Dr. J.E. de Villiers: Chairperson

Ms. P. Claassen: Secretary

ANNEXURE C: Letter of permission to conduct the study from the MoHSS



REPUBLIC OF NAMIBIA

Ministry of Health and Social Services

Private Bag 13198
Windhoek
Namibia

Ministerial Building
Harvey Street
Windhoek

Tel: 061 – 203 2537
Fax: 061 – 222558
E-mail: btjivambi@mhss.gov.na

OFFICE OF THE PERMANENT SECRETARY

Ref: 17/3/3 **SS**
Enquiries: Mr. B. Tjivambi

Date: 22 November 2018

Mr. Salomo Salomo
PO Box 26
Tsandi
Namibia

Dear Mr. Salomo

Re: A model for nurses to facilitate supportive care to men diagnosed with Prostate Cancer and their families in the Intermediate Hospital Oshakati: A Hospital based approach

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 permission to conduct the study has been granted under the following conditions:**

3.1 The data to be collected must only be used for academic purpose;
3.2 No other data should be collected other than the data stated in the proposal;
3.3 Stipulated ethical considerations in the protocol related to the protection of Human Subjects should be observed and adhered to, any violation thereof will lead to termination of the study at any stage;

3.4 A quarterly report to be submitted to the Ministry's Research Unit;

3.5 Preliminary findings to be submitted upon completion of the study;

3.6 Final report to be submitted upon completion of the study;

3.7 Separate permission should be sought from the Ministry for the publication of the findings.

4. All the cost implications that will result from this study will be the responsibility of the applicant and **not** of the MoHSS.

Yours sincerely,

MR. B.T. NANGOMBE
PERMANENT SECRETARY

ANNEXURE D: Letter of permission from the Chief Medical Superintendent at Windhoek Central Hospital

9 - 0/0001

REPUBLIC OF NAMIBIA
Ministry of Health and Social Services

Private Bag 13215
Tel. No: (061) 2033024
Windhoek **Harvey Street** **Fax No: (061) 2033096**
Namibia **Windhoek**

Enquiries: Ms. S.lipinge **Date: 19 March 2019**

OFFICE OF THE CHIEF MEDICAL SUPERINTENDENT
WINDHOEK CENTRAL HOSPITAL

Mr. Salom Salom
P.O.Box 26
Tsandi
Uukwaluudhi
0812833833

Dear Mr.Salomo

SUBJECT: PERMISSION TO CONDUCT A RESEARCH ON A MODEL FOR NURSES TO FACILITATE SUPPORTIVE CARE TO MEN DIAGNOSED WITH PROSTATE CANCER AND THEIR FAMILIES AT ONCOLOGY UNIT (WARD 8 EAST) WINDHOEK CENTRAL HOSPITAL.

1. Reference is made to your application to conduct the above-mentioned study.

2. This letter serves to inform you that permission has been granted for you to conduct a research on the above mentioned subject as per you request.

3. Patients/Clients information should be kept confidential at all times.

4. Copy of report to be submitted at Chief Medical Superintendent and Customer care office, Windhoek Central Hospital upon completion of the study.

Yours sincerely

18 -03- 2019

DR.D.I.UIRAB
CHIEF MEDICAL SUPERINTENDENT

"Health for All"

ANNEXURE E: questionnaire for assessing Oncology departments at the Intermediate Hospital Oshakati (IHO) in terms of facilitating supportive care for men diagnosed with prostate cancer and their families

Date: ______________________ Interview number:__________
Venue: _____________________ Time: ________to__________

TITLE: A model for nurses to facilitate supportive care for men diagnosed with prostate cancer and their families in the Intermediate Hospital Oshakati: A hospital based approach

Researcher	: Mr Salomo Salomo
Student number	: 9808507
Programme of study	: PhD in Nursing Science
Institution	: University of Namibia Oshakati Campus Eliander Mwatale Street Oshakati

Purpose of the study:
The purpose of this study is to develop a model for nurses to facilitate supportive care for men diagnosed with prostate cancer and their families at the Intermediate Hospital Oshakati. The model will serve as a tool to enable and empower nurses to provide supportive care for men diagnosed with prostate cancer based on the need identified.

Dear participant
Please note the following:

1. The questionnaire consists of six (6) pages, including the front page.
2. Please do not write your name on the questionnaire because this data collection exercise is anonymous.
3. Participation is voluntarily and refusing to participate will not attract any penalty.
4. You have the right to choose not to answer any question that you do not want to answer.
5. All responses will be regarded as confidential.
6. This questionnaire consists of Sections A, B, C, D, E and F.
7. Thank you very much for taking the time to complete the questionnaire.

Instructions:
SECTION A: Please put a cross (x) in the box that corresponds to your answer.
SECTIONS B to F: Please rate by indicating with a cross (×) the extent of your agreement with each one of the statements on the Likert scale 1 (Strongly Disagree) to 5 (Strongly Agree).

SECTION A: Demographic characteristics of the respondents

1. What is your gender?

1		2		3	
Male		Female		Other, please specify	

2. What is your age in years?

1		2		3		4		5	
Younger than 20		20–29		30–39		40–49		50 or older	

3. What is your highest educational qualification?

1		2		3		4	
Undergraduate diploma		Bachelor degree		Postgraduate diploma		Postgraduate degree	

4. Which section of the Oncology Department are you working in?

1		2		3	
Oncology ward		Oncology clinic		UOPD	

5. How many years of working experience do you have as a registered nurse?

1		2		3		4	
Less than 5		5–9		10–14		15 or more	

SECTION B: Statements related to the oncology departments						
No:	Statement	1	2	3	4	5
		Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
6	The Department of Oncology at the IHO is well equipped with required equipment.					
7	The Department of Oncology at the IHO has the capacity to diagnose prostate cancer.					
8	The Department of Oncology at the IHO is headed by knowledgeable supervisors who are committed to the departmental supportive activities.					
9	The department offers supportive care for men diagnosed with prostate cancer and their families.					
10	The Department of Oncology at the IHO offers routine psychological counselling for men diagnosed with prostate cancer.					
11	The Department of Oncology at the IHO offers routine psychological counselling to family members of men diagnosed with prostate cancer.					
12	The Department of Oncology at the IHO is conducive for counselling men diagnosed with prostate cancer and their families.					
13	There are licensed counsellors or specialised therapists (e.g. sex therapist) in the department.					
14	The department collaborates well with other units in the hospital on supportive care activities.					
15	The department receives support from the hospital management by having the required resources for supportive care available, e.g. equipment, etc.					
16	The department receives support from the Ministry of Health and Social Services by having the required resources for supportive care available, e.g. skilled personnel, equipment etc.					
17	The departmental services for supportive care are accessible 7 days a week e.g. Sunday–Saturday.					

SECTION C: Statements related to the training of registered nurses						
No.	Statement	1	2	3	4	5
		Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
18	The department receives support from the Ministry of Health and Social Services by making training opportunities (on supportive care) available to the nursing staff.					
19	Registered nurses are trained on the supportive care of men diagnosed with prostate cancer and their families.					
20	Registered Nurses are trained on palliative care.					
21	Registered Nurses are trained on counselling men diagnosed with prostate cancer and their families.					
22	The department has specialised registered oncology nurses.					
23	There is an orientation programme on supportive care (for men diagnosed with prostate cancer and their families) in place for the newly recruited registered nurses.					
24	The department has an in-service training programme for nurses on supportive care for men diagnosed with prostate cancer and their families.					

SECTION D: Statements related to health policies and guidelines						
No.	Statement	1	2	3	4	5
		Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
25	Policies (with mechanism) on supportive care for men diagnosed with prostate cancer and their families are available in the Department of Oncology at the IHO.					
26	Guidelines (with mechanism) on supportive care for men diagnosed with prostate cancer and their families are available in the Department of Oncology at the IHO.					

27	Registered nurses are conversant in the policies and guidelines on supportive care for men diagnosed with prostate cancer and their families.					
28	Departmental activities on supportive care for men diagnosed with prostate cancer and their families are performed in line with existing policies and guidelines (if any).					
SECTION E: Statements related to information, education and communication materials (IEC)						
No.	Statement	1	2	3	4	5
		Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
29	There are adequate IEC materials on supportive care for men diagnosed with prostate cancer and their families.					
30	IEC materials are written in the local languages that men diagnosed with prostate cancer and their families can understand.					
31	There is an educational programme in place on prostate cancer for men diagnosed with prostate cancer and their families.					
32	Health education is strictly offered to men diagnosed with prostate cancer and their families at initial and follow-up visits					
33	The department conducts community mobilisation and awareness on supportive care for men diagnosed with prostate cancer and their families.					
34	Research articles or books on supportive care for men diagnosed with prostate cancer and their families are available in the department					
SECTION F: Statements related to monitoring and evaluation (M&E)						
No.	Statement	1	2	3	4	5
		Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
35	Nursing staff in the department conduct regular meetings on supportive care for men diagnosed with prostate cancer and their families					

36	The departmental activities on supportive care for men diagnosed with prostate cancer and their families are evaluated on a regular basis.					
37	A tool for monitoring and evaluating the departmental activities on supportive care for men diagnosed with prostate cancer and their families is in place.					
38	Departmental activities on supportive care for men diagnosed with prostate cancer and their families are well documented and accessible for future reference.					
39	Hospital management offers annual awards to the department for exceptional performance in the supportive care of men diagnosed with prostate cancer and their families.					

Thank you very much for your time!

ANNEXURE F: Individual Interview Guide For Men Diagnosed With Prostate Cancer

Title: A model for nurses to facilitate supportive care for men diagnosed with prostate cancer and their families in the Intermediate Hospital Oshakati: A hospital-based approach

Central question:

1. Tell me about your experiences of the supportive care you received from nurses in the oncology departments after being diagnosed with prostate cancer?

Possible probing questions:

1.1 What do you understand by the term “supportive care”?

1.2 How helpful is the supportive care you receive from the nurses in the oncology departments?

1.3 How would you describe the health information you received from the nurses regarding prostate cancer in oncology departments?

1.4 What information did you receive from nurses regarding the side effects of treatment for prostate cancer?

1.5 What information did you receive from nurses regarding the progression of prostate cancer?

1.6 What supportive care did you receive from nurses in order to cope with the diagnosis of prostate cancer?

1.7 What information did you receive from the nurses regarding the long-term consequences of prostate cancer?

1.8 How were you physically supported by the nurses after being diagnosed with prostate cancer?

1.9 How were you psychologically supported by the nurses after being diagnosed with prostate cancer?

1.10 How frequently did you receive counselling from the nurses after being diagnosed with prostate cancer?

1.11 How conducive is the environment in which you usually get counselling?

1.12 What do you think should be done in order for the nurses to give supportive care for men diagnosed with prostate cancer?

1.13 What else would you like to comment on regarding the supportive care you received from nurses in oncology departments?

ANNEXURE G: Transcription of an individual interview with a man diagnosed with prostate cancer in the Intermediate Hospital Oshakati

Men no: 8
Date: 30.07.2019
Time:
Language of Interview: Oshiwambo (translated to English)
Place: Intermediate Hospital Oshakati
Department: Oncology Clinic
Region: Oshana
Age: 74

Researcher: Good afternoon Sir?

Participant: Good afternoon.

Researcher: How are you?

Participant: I am fine

Researcher: Tatekulu, my name is Salomo. I am a postgraduate student at the University of Namibia, conducting a research with regard to prostate cancer. The title of the research is:“ A model for nurses to facilitate supportive care for men diagnosed with prostate cancer and their family in the Intermediate Hospital Oshakati. One of the objectives of the study is to explore and describe the experiences of men diagnosed with prostate cancer on the supportive care received from nurses in oncology departments. This study has been approved by the Research Ethics Committees at University of Namibia and Ministry of Health and Social Services. Your participation in this study is entirely voluntary. You are free to decline to participate. You are also free to withdraw for the study at any time. There will be no need for your details or your name and the confidentiality will be assured as nobody will kink the information to the provider. On the other hand the information will not be shared with unauthorised people apart from the supervisors of the study.

With me I am having a tape recorder that will be used to record our conversation and it will be kept safe after the data collection and nobody will temper with it in terms of the answers. The interview will last for about 45 minutes to 1 hour. The findings of this study will be used to develop the model that will serve as a guiding tool to the Ministry of Health and Social Services which will ultimately lead to an improved supportive care forwards men diagnosed with prostate cancer and their family. Madam, I am kindly requesting you to give your honest opinion as a family member to a man diagnosed with prostate cancer in Intermediate Hospital Oshakati. Based on the objectives of the study that I have explained to you earlier on, do you agree to participate in the study?

Participant: Yes, I agree.

Researcher: Tell me your experiences on the supportive care you received from nurses in oncology departments after being diagnosed with prostate cancer?

Participant: I started getting sick at home without knowing what the problem was, so I came to Oshakati hospital where they did investigations and informed me that I am having prostate cancer. I was then informed that if a person is diagnosed with this disease he has to be operated. I was then operated before I was sent to Windhoek where I was put on the machines. I did not expect to live now, but the healthcare that I received in here and in Windhoek at least I appreciated it. I am getting the medicines here and when they got finish they tell me to come back, so I am getting good care because I was just on a wheel chair but now I can walk on my own. I think I am helped well.

Researcher: You said you have been operated. Was the operation explained to you before you were operated?

Participant: Yes.

Researcher: What did the nurses tell you about the operation?

Participant: They said this disease can spread fast; therefore I need to be operated. They also said I have to go to Windhoek to be put on the machines that can burn the disease so that it cannot spread throughout the body. So they took me to one private oncology centre in Windhoek somewhere close to the mountains, because initially I was admitted in Central hospital but their machines were broken for a long time. They promise to take my blood to see whether the disease is progressing or not.

Researcher: Who explained the operation to you?

Participant: I was informed by the doctor. First the investigations were sent to Windhoek and when the results came back I was informed that I am having prostate cancer and I need to be operated.

Researcher: How did take the message, as a man, that you will be operated whereby your testes will be removed?

Participant: I have accepted not because people forced me to be operated but out of my own will because I was informed that the operation may give me a chance to live longer but if I refuse the disease may progress which result into death.

Researcher: How helpful is the supportive care you receive from the nurses in oncology departments?

Participant: About healthcare?

Researcher: Yes, do you describe the supportive care you receive from the nurses?

Participant: I did really spend many days in the hospital, but the nurses did not really treated ne bad. The only thing that I have a concern with was after an operation, because I was not use to be dressed regularly and that has resulted in prolonged healing of the wound. Initially they even told me that they will give one solution that I can use to clean the wound, but after discharge they never gave it to me. The stitches that I was stitched with were also not removed until now, so I was concerned that how comes they were not removed until now? However, I was informed that there are some stitches that get absorbed therefore cannot be removed.

Researcher: You said you were wheelchair bound before the operation. How physically were you supported by the nurses both during the time you were on a wheelchair and after an operation?

Participant: I was having a person from home in the hospital that usually uses to assist me while on wheelchair. When I use to go to the toilet I did not really get assisted by the nurses, only by my relatives during visiting time. But when it was the time for operation, it was the nurses who took me to theatre and returned me back to the ward. It is also nurses who use to give me water to bath, here in Oshakati. But in Windhoek when I was with nurses, I was just like with my mothers.

Researcher: What makes you say that in Windhoek you were just like with your mother?

Participant: In Windhoek I don't even use to move, but only the nurses who take from the bed to the trolley and take me to see the doctor and return me to my bed again. That is why I was saying it was just like as if I was with my mother. They just help me, so I did not even use to move.

Researcher: What about the nurses in Oshakati? How do you describe the supportive care you receive from them?

Participant: In Oshakati I was not moving, but just on the bed.

Researcher: How do you describe your interaction with the nurses either by communication or any other interactions?

Participant: The only nurse whom I am not thankful with is when I approached her seeking for assistance due to pain on feet and ankles. Instead of helping me she simply told me that this is not where your conditions use to be treated, but to the other department [pointing to the oncology clinic]. That happened at the X-ray department. They just told us that this is not where cancers are being treated, go that side….[pointing at the oncology clinic]. I then came here and I was sent to Windhoek.

Researcher: How old do you think was the nurse who mistreated you?

Participant: It is a middle aged nurse.

Researcher: How does that made you feel as a patient who came to the hospital seeking for healthcare?

Participant: I felt bad because I also do not know where the disease came from, and if the disease was somewhere else and I happen to pick it up, so then that is my unluckiness. But, there is one nurse who use to make jokes with us.

Researcher: What do you understand by the term "supportive care"?

Participant: The nurses know the medicines that can make the patient better, so they should help me to give the correct medicines and if they handle situation then they should refer me somewhere else where I can be assisted, even to the machines that detect whether the virus is going up or is going down. Like now I use to use some pain on my legs and feet. Like when I was in Windhoek I was told to go back, but the nurses here told me that there is no need to go back because I was already there. So, I did not go back until now, because they erased the follow up dates.

Researcher: Was it nurses or doctors who said you should not go back to Windhoek again?

Participant: It was nurses.

Researcher: Did they tell you why they erased your follow up dates?

Participant: They said I was already there, so what else should I go and do?

Researcher: How did that make you feel?

Participant: I felt so bad, because I did not know could have been done in Windhoek may be they wanted to change my treatment or to put me on the machines. So, why can't I go and see what they will do and then come back?

Researcher: How can you describe the health information you received from the nurses regarding prostate cancer, after being diagnosed?

Participant: At least they gave the information because informed me that I was diagnosed with prostate cancer and they also asked me whether I use to hear about prostate cancer then I said yes. They told me that prostate cancer is the disease which cannot be cured but it can be treated. However, they did not inform me how I should behave or what I should eat while I am having this type of disease. They only informed me that I might need to be operated so that it cannot spread throughout the whole body, therefore I need to decide whether I agree to go for an operation or not. I said there is nothing that I can do, so I have accepted the disease therefore I can be operated. When the operation day approached, I was operated. After an operation the nurses only came to my bed and asked me what type of an operation I undergone and I informed them but they never advised on how I should be especially when I go home.

Researcher: You said the nurses gave you the information because they informed you that you were diagnosed with prostate cancer and they also asked you whether you use to hear about prostate cancer and you said yes, however they did not tell you on how you should how you should behave or what you should eat. How do you describe the adequacy of the health information you received from the nurses?

Participant: They only asked what I have told you, but they did not tell that there is also this and that…, no. That was the only information I was given. The other thing that I was told was only about the machine whereby they told me that I will be sent to the machine that can burn the disease.

Researcher: What information did you receive from nurses regarding the benefits or the side effects of treatment for prostate cancer?

Participant: About the medicines they only informed on how to take them because they are written on top of the plastic bags. They also informed that when the medicines are finished I may just sent someone to come fetch other medicines, as it is not really necessary to come myself but rather someone else may just come.

Researcher: Have nurses not give you the information regarding the benefits or the side effects of treatment for prostate cancer?

Participant: No, they only tell me the benefits and even the doctor informed me that if I adhered to the treatment it may suppress the infection. That was the doctor who informed me about that.

Researcher: What information did you receive from nurses regarding the progression of prostate cancer?

Participant: No, they did not tell me that. They only informed me about the blood results for example at Engela they told me that the ranges were very high. Later, they further informed me that if I see my ranges around 8, 9, or ten that means the infection is subsiding. That gave me some courage because previously I was at 100, but now I am around 5. I therefore do not know how today's results will be because they also said they will my blood for another investigation.

Researcher: What supportive care or counselling did you receive from nurses in order to cope with the diagnosis of prostate cancer?

Participant: Aa….[shaking his head in disagreement] the nurses only asked me whether I use to hear about prostate cancer, but they never gave me counselling for example by saying this is what you should do or not to do as from now, no. About whether I know about prostate cancer I only use to hear about cancer where by a person may have his/her arm or leg be amputated but about prostate cancer I never use to hear about it.

Researcher: The diagnosis of prostate cancer may cause some psychological disturbance among some patients, and that could be the time the patient will require counselling. How psychologically were you supported by the nurses after being diagnosed with prostate cancer?

Participant: No, I was never given counselling in the hospital, however later heard about people talking about counselling in the radio because I like listening to the radio at home and that is where I heard that being diagnosed with prostate cancer does not necessarily mean the end of the world, but prostate cancer can be treated. That I did know about it because after being diagnosed, I only placed myself in God's hands because I did not know whether I will become better one of the day.

Researcher: How do you describe the physical supportive care from the nurses especially during the time you have been on the wheelchair and could not move on your and immediately after an operation?

Participant: It was the nurses who took me to theatre for an operation and it also them who returned me back and placed on my bed. However, after operation I never seen any nurse coming to me to dress my wound, until I find myself being told one day that I am going home and they will give me some solutions that I can clean the with while at home. I was never even given the solution that they told me earlier. So I was never dressed until I was discharged.

Researcher: Are you saying you never got dressed after operation until your discharge?

Participant: No, I was never. I stayed in the hospital for two days and I was discharged without being dressed. When I came back for follow up the nurses asked me whether I dressed the wound at home and I said no….[shaking his head] how can I dress myself if you promised to give me some solutions for dressing that I can use home but you never did that? They further asked why I did not use salted water to dress the wound but I said no.

Researcher: So, you were not happy with the supportive care you received from nurses after an operation?

Participant: Yes, how can I be happy if I was only dressed in theatre after an operation but no dressing was done in the ward until I got discharged? They did not even inform me that there are some stitches that get absorbed instead being removed, until I asked them when the stitches will be removed. Instead of the coming to me and tell me that the stitches will not be removed but rather absorbed into the body, they only informed me after I have asked them.

Researcher: What complications did you notice especially that you have been dressed in the ward until your discharge?

Participant: I have just noticed that the wound was taking too long to heal, but it was attended to at Engela hospital. The pain at the wound is so not that severe, is only that there is also some pain on my feet and hips.

Researcher: What type of spiritual care did you receive during admission?

Participant: You mean people who came to pray for me?

Researcher: Yes, being pastors or nurses.

Participant: I never seen one here in Oshakati hospital, however at Windhoek there are some people who use to come and pray for the patients by encouraging them to believe in God.

Researcher: What type of spiritual care did you receive during admission, here in Oshakati hospital?

Participant: Is only my relative who use pray for me in the morning during visiting time, before she go back because she use to sleep outside the hospital premises.

Researcher: You said you were not counselling during your entire admission period. If you could you get an opportunity for counselling, how could you describe the conduciveness of the ward environment in terms of counselling?

Participant: I use to see nurses just using some screens when doing dressing to my colleagues in the same room where other patients are. I never saw a separate room where a patient can be taken. We are all kept in the veranda and that is where the nurses use to come and give the medicines, that so and so patient take your medicines.

Researcher: So, you never seen another separate room, only the veranda that you have seen?

Participant: Is only in this veranda where the nurses use to come and see and talk to all the patients.

Researcher: You have alluded to a number of concerns on supportive care especially during your admission. What do you think should be done in order for the nurses to give supportive care for men diagnosed with prostate cancer?

Participant: The moment the patient is diagnosed with prostate cancer, at least nurses should start counselling patients by informing them that being having prostate cancer is not the end of the world therefore a patients should not be afraid because prostate cancer can be treated. They should inform the patients what they should and what they should not drink. Like us we got discharged without even being informed about the cause of prostate cancer whether it is from food or from other things, no. This type of information was once on the radio and that is where I heard about the cause of prostate cancer prostate cancer. Here in the hospital no nurse sit with me to explain the causes of prostate cancer or to explain to me the type of prostate cancer that I have whether it is number 1, number 2 or what … [shaking his head], no I never hear it. So, it is go one to be informed about these things, however they do not need to informed me about on when I will die… [laughing], no I do not need that. We just need to be informed that as far as we are keeping on taking our medicines as prescribed, the disease will just became better. Yes, is what we need to hear which is good also.

Researcher: What else would you like to comment on regarding the supportive care you received from nurses in oncology departments?

Participant: Aaa… [breathing deeply] at least I am very thankful to one nurse who encouraged me and explained to me issues regarding the operation that the operation is not that complicated therefore may not really take too much time. That is what encouraged me to make a decision of accepting the operation. I have accepted my disease. This disease was not there, therefore when other patients comes here or at other hospital, it is very important for both nurses and doctors to properly explain to the patients the cause of prostate cancer and that it can be treated, how to take the medicines, what to and what not to and so on. It also important whenever the patient come for follow up to be asked how he is coping with treatment, otherwise if they are not being asked it seem like as if patients are treating themselves. They should also explain the purpose an operation as opposed to taking medicines only without an operation.

Researcher: Thank you very much for allowing me to enter into conversation with you.

Participant: Thank you too.

ANNEXURE H: Individual interview guide for family members of men diagnosed with prostate cancer in the Intermediate Hospital Oshakati

Title: A model for nurses to facilitate supportive care for men diagnosed with prostate cancer and their families in the Intermediate Hospital Oshakati: A hospital based approach

Central question:

1. Tell me about your experiences of the support you received from nurses in the oncology departments after your husband/family member was diagnosed with prostate cancer?

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Possible probing questions

1.1 What do you understand by the term “supportive care”?

1.2 How helpful was the supportive care you receive from the nurses in the oncology departments after your husband/family member was diagnosed with prostate cancer?

1.3 How would you describe the health information you received from the nurses in the oncology departments regarding prostate cancer?

1.4 What information did you receive from nurses in oncology departments regarding the treatment side effects and the progression of prostate cancer?

1.5 What supportive care did you receive from nurses in the oncology departments in order to cope with the diagnosis of prostate cancer in your husband/family member?

1.6 What information did you receive from the nurses in the oncology departments regarding the long-term consequences of prostate cancer?

1.7 How were you psychologically supported by the nurses after your husband/family member was diagnosed with prostate cancer?

1.8 How frequently did you receive counselling from the nurses after your husband/family member was diagnosed with prostate cancer?

1.9 What do you think should be done in order for the nurses to give supportive care for family members of men diagnosed with prostate cancer?

1.10 How conducive is the environment in which you usually given counselling sessions?

1.11 What else would you like to comment on regarding the supportive care you received from nurses in oncology departments?

ANNEXURE I: Transcription of an individual interview with a family member of a man diagnosed with prostate cancer in the Intermediate Hospital Oshakati

Family Member no: 2
Date: 25.07.2019
Time:
Language of Interview: Oshiwambo (Translated to English)
Place: Intermediate Hospital Oshakati
Department: (Nuclear Medicine Department)
Region: Oshana
Gender: Male (grandson to the patient)
Age: 39

Researcher: Good morning Sir?

Participant: Good morning

Researcher: You brought your grandfather to the hospital?

Participant: Yes, he is my real grandfather and I brought him to the hospital.

Researcher: Ok, thank you very much. My name is Salomo Salomo. I am a postgraduate student at the University of Namibia, conducting a research with regard to prostate cancer. The title of the research is:" A model for nurses to facilitate supportive care for men diagnosed with prostate cancer and their family in the Intermediate Hospital Oshakati. One of the objectives of the study is to explore and describe the experiences of family on the supportive care received from nurses in oncology departments. This study has been approved by the Research Ethics Committees at University of Namibia and Ministry of Health and Social Services. Your participation in this study is entirely voluntary. You are free to decline to participate. You are also free to withdraw for the study at any time. There will be no need for your details or your name and the confidentiality will be assured as nobody will kink the information to the provider. On the other hand the information will not be shared with unauthorised people apart from the supervisors of the study.

With me I am having a tape recorder that will be used to record our conversation and it will be kept safe after the data collection and nobody will temper with it in terms of the answers. The interview will last for about 30 minutes to 1 hour. The findings of this study will be used to develop the model that will serve as a guiding tool to the Ministry of Health and Social Services which will ultimately lead to an improved supportive care forwards men diagnosed with prostate cancer and their family. Based on the objectives of the study that I have explained to you earlier on, do you agree to participate in the study?

Participant: Ok. Have we already started with interview?

Researcher: No, but we shall be starting soon. As for now, I was trying to tell you what the study is all about in order to get the consent from you.

Participant: Ok

Researcher: Our first question is: Tell me your experiences on the supportive care you receive from nurses in oncology departments after your husband/family member was diagnosed with prostate cancer?

Participant: Ok, thank you very for an opportunity to engage in the interview with you so that I can express to you what I know. This hospital especially at this Nuclear Medicine department where we are now, previously when we were here we went back home very happy because we were informed that my grandfather will be required to come back for follow up, however we shall not be given a specific date but the hospital will call him well in advance a day before the actual follow date. The nurse whom we found here previously treated us so well, she is a good nurse, therefore we went back home that day we felt so good. She was even the one who called me yesterday that we should bring my grandfather to the hospital as the medicines are now available, so he should come to the hospital. When we came today after the health passport was stamped, we then came to the Nuclear Medicine Department, and as we talk I cannot complain because everything is in order. My grandfather has appreciated the supportive care we are getting here and he still believes that his treatment will be in order.

Researcher: Thank you very much. Earlier on you stated that the type of supportive care that you get from this department seems to be good. Can you ……[could not continue as participant interjected]

Participant: I cannot even say the supportive care at this department seems to be good, but they are actually very, very good because until now as we are talking everything is just in order.

Researcher: What do you mean by saying that the supportive care at this department is very good? What is that the nurses did to your grandfather that made you to say so?

Participant: At the beginning we at this department, we came without knowing exactly at which area we should be but the nurse whom we found here directed so well by informing us where we should sit before we are called to go to the machine I highly appreciate the way things are organised in this department because we did not go in front other people that we found there and we did not also stay there for a long time before we were called in. We were really well directed early at the beginning. The other thing that I have also appreciated is that, before we came here my grandfather did not eat anything at home but when we came here he was given food as well as water by the nurses, so now we are just waiting to be called into the room where the machine is.

Researcher: Earlier on I have informed you that one of the objectives of the study is to explore and describe the experiences of family on the supportive care received from nurses in oncology departments. In your own understanding, what do you understand by the meaning of "supportive care"?

Participant: I may not be able to remember all the supportive care that I was given in this department, but for example when I came here I did not came here as a patient but when my grandfather was given food I was also given mine. That is one of the supportive care because I am now sitting here I will not even think of going somewhere else to look for food to eat, so that is one of the supportive care I was given here and I highly appreciate it, and if we could I could stay with you today in the hospital I am sure there is a lot of additional supportive care I could tell you.

Researcher: Is this the first time you bring your grandfather at the hospital or do you use to bring him previously?

Participant: No, I use to bring him not only today.

Researcher: Is there another department in the hospital that you use to take him for healthcare apart from this one?

Participant: In this department, nuclear medicine, it is for the second time I bring him. The first time I took him to Oncology Clinic, which referred us to the Nuclear Medicine Department, therefore this is for the third time I bring him to Oshakati Hospital, however I use to take him to Engela hospital which is our nearest hospital where he used to be treated and sometimes get admitted.

Researcher: The oncology clinic that referred to earlier, is it the one in this hospital?

Participant: Yes, it is the one in this hospital.

Researcher: You stated that you are happy with the supportive care that you get from the Nuclear Medicine Department. How do you describe your experiences on the supportive care you receive from nurses at oncology clinic?

Participant: I only took him to the Oncology clinic once, however their supportive care is just similar with the one in the Nuclear Medicine Department in which we are now. However, I once brought my grandfather there … [pointing to OPD] at room 5 but that day I was very disappointed because my grandfather was not assisted well by the nurse that we found because he did not even direct him on he should start or sit, instead he just answered my grandfather very badly until my grandfather realised that there was no good care at that department. I can also confirm it because I was also there. When he went into that room he was just pushed out without even telling them what his health problems was or why he came to the hospital. That day we just went home with our concerns, but lucky enough he did not became sick at home because usually if my grandfather is angry due to something bad happen he use to became sick but that day never get sick, so I just counsel him.

Researcher: As a family member, how did you feel after your grandfather was pushed out of the room without being assisted?

Participant: I felt very bad because I did not expect a nurse who was supposed to serve the public but instead he is using bad words towards patients. If I came in your room where you are as a nurse seeking for information and you just chased me away without listening to my concerns, I will feel very bad and I shall not tell anything because you simply cut me off. I do not think that is a good picture at all, I therefore urge public servants their attitudes so that if the person is seeking for an assistance may at the wrong place then he/she simply need to be corrected and guided as where he/she should go or start instead of just say go.

Normally, most of the senior citizens just use to come at the hospital but they do not know where to start because they might not came along with any relatives that day or the relatives may follow at a later stage, therefore such citizen is likely just to be in the hospital without knowing where to go until gets late.

Researcher: You said your grandfather was chased away at the oncology department … [could not continue participant interjected]

Participant: Not at oncology clinic but at room 5. There was a male nurse that day and I can be able to identify him I found him.

Researcher: Does nurses use to consider you as a family member when you to bring your grandfather to the hospital?

Participant: Every time when I use to bring him to the hospital I use to be present when he is being discussed with and when he is being treated, except the day the he was taken to the machine before an operation. I took him into the doctor’s room and the doctor informed me to go wait outside until he is done with him, but after he was done they called me get him.

Researcher: How can you describe the health information you received from the nurses in oncology departments regarding prostate cancer, as a family member?

Participant: First, I was given the information that my grandfather has been treated, and then they informed about the time he should take his medicines at home. I was informed on how to be with him as a prostate cancer patient, by not mistreat him or making him feel bad but to be with him as a patient. I have accepted what I was told by the nurses, even if you go ask my grandfather now he will tell you that he respects me and I respect him too.

Researcher: Is there anything else that you wanted to be told by the nurses but they could not tell you?

Participant: I did not noticed anything, unless may be after he is done with the machine now, but in case I would like to ask something from the nurses about my grandfather I am always free to do that because I do not want to leave the hospital without having proper information about his treatment.

Researcher: The diagnosis of prostate cancer may cause some psychological disturbance among family members. How psychologically were you supported by the nurses after your grandfather was diagnosed with prostate cancer?

Participant: Most people believe that the moment one is diagnosed with prostate cancer, he is almost approaching death, therefore I was counselled that it does not really mean that being diagnosed with prostate cancer does not necessarily mean the end of the world, but a person can be treated therefore I should not think the person’s death is close. That is what I will tell the family at home, as most of the time I use to tell family members especially the elders ones as well as those close to him about his condition, therefore it does not mean that it is the end of his world but may get much better as he kept being treated.

Researcher: Who gave you the counselling?

Participant: I was counselled by nurses.

Researcher: At what department?

Participant: At oncology clinic, and that is where I have accepted that yes, my grandfather is having cancer and that is what resulted in him being operated, and come for follow up today. Today, as of now, I might not really able to tell what is next for him in terms of treatment as whether he will be referred to another hospital but we are still for him to be treated.

Researcher: Are you saying you are feeling psychologically prepared regarding your grandfather’s illness?

Participant: Yes, I have been prepared and I am very thankful about it.

Researcher: As a family member is too close to your grandfather and who use to bring him for follow up in most cases, do you feel there is anything that you are not comfortable with in terms of treatment?

Participant: The corridors of the Oshakati hospital are too long because most of the time my grandfather use to walk very slowly, therefore we use to arrive here at oncology department is too late. It seems the wheelchairs are not enough or I just do not know. That is where my grandfather use to experience some difficulties because I was not able to lift him up, for example today we are just two and even if we arrive here earlier we mostly use to find ourselves leaving this department very late and it will take you 30 minutes to walk from here to the main hospital gate because he use to walk very slowly. The time he arrives home, he used to be very tired due to the fact that he has been sitting for too long. I think they need to add more wheel chairs in this Oshakati hospital, so that old people who cannot walk properly or fast can be assisted.

Researcher: I want to take you back a bit on the issue of counselling that you were given in the hospital by nurses. How conducive is the environment under which you were given counselling?

Participant: At least counselling was not done in the public, but it was just done as we are now even though there were about two to three nurses I thought maybe that is how it should be because it was only, my grandmother and the three nurses, so I appreciate it because if you are counselled by only one nurse that nurse may forget a thing or two but if you are with three nurses like the way it was done at least other nurses can add if one forgot something, at least they can remind each other.

Researcher: Is there anything else that you would like to comment on regarding the supportive care you received from nurses, as a family member?

Participant: I really do not have much to say further because so far I think the health services are in order. I just want to ask where to go further if I realise that my grandfather did not understood what was said during counselling sessions so that if he forgot what he was told at least I know where to go either in this hospital or at Engela which more closer to us. It is not only me that may need such assistance but other people may also need it, therefore it is important for the nurses to keep on reminding us on what was said during counselling sessions. The country is developing with new health information coming up but we are living at the villages, therefore they should help us by updating with the new developments at least through the radio, or they can put some leaflets with health information at the hospital gates for people to pick them up and read at home. That I think it will help us on how to take care our loved ones with cancer in order to improve their lives.

Researcher: Does the nurses give you attention as a family member when you bring your grandfather for follow ups, or you were engaged during the first consultation?

Participant: This is my second time here at nuclear medicine department, but I was just given the same care as that of the previous visit so I think that is how their arrangement is, because I can tell how they are also helping other people who found me here for example they were given food as well as health information and the direction regarding where one can locate the toilet or where to wash hands as well as where one should sit, so these are good care that being given. Nurses also follow you to see whether you are really sitting at the place that they told you should go and sit. Yes … [nodding his head].

Researcher: Is there a time your grandfather was admitted due to prostate cancer?

Participant: Yes, he was admitted last month, but I cannot remember the exact date, however if I check in his health passport I shall be able to find it out because I am having his health passport here.

Researcher: Did you pay him a visit during admission?

Participant: Yes, I visited him. I was also the one who brought him for admission, and when I went back and left one of the family members who was taking care of him while hospitalised. Later, I came back to visit him and upon discharge it was still me who came to fetch him and take him home.

Researcher: How do describe your experiences on the supportive care you receive from nurses at the ward where he was hospitalised?

Participant: That I cannot really say much on it because there was one of the relative who was taking care of him while hospitalised, but I did not hear her complaining. In fact she appreciated the Oshakati hospital because during her stay she was also being given food just like the patient. She also said that his grandfather was well taken care of in the hospital, therefore did not notice of anything to complain of. So, I was not with him fulltime during hospitalisation but my grandmother who was with him came home happy.

Researcher: What are your final words on supportive care for men diagnosed with prostate and their family?

Participant: I just want to tell you that what you are doing now may be is new plan, but please continue helping us and I really thankful even on behalf of people who are not here.

Researcher:	Thank you very much for the discussion. In our discussion I have picked up that you are among those who are close to your grandfather as you the one who most of the time bring him to his follow ups and visit him when hospitalised, please continue support him.
Participant:	Thank you very much too. My house is very close to that of my grandfather and we even in the same fence, so he gave me a portion of his land because I is having big piece of land. I have to help him as much as I can and even if I was to travel somewhere and he suddenly became ill I have to cancel the trip.
Researcher:	Thank you very much.
Participant:	Thank you too.

ANNEXURE J: Individual interview guide for registered nurses in the Oncology departments at the Intermediate Hospital Oshakati

Title: A model for nurses to facilitate supportive care for men diagnosed with prostate cancer and their families in the Intermediate Hospital Oshakati: A hospital based approach

Central question:

1. Tell me your experiences in facilitating supportive care for men diagnosed with prostate cancer and their families in the oncology departments?

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Possible probing questions

1.1 What do you understand by the term "supportive care"?

1.2 How helpful is the supportive care you provide for men diagnosed with prostate cancer and their families in the oncology department?

1.3 How would you describe the health information you provide for men diagnosed with prostate cancer and their families at oncology department?

1.4 How do you describe the availability of policies/guidelines on supportive care for men diagnosed with prostate cancer and their families in oncology department?

1.5 The diagnosis of prostate cancer may cause psychological disturbance, what supportive care do you provide for men diagnosed with prostate cancer and their families to cope with the diagnosis?

1.6 How frequently do you provide counselling for men diagnosed with prostate cancer and their families after the diagnosis of prostate cancer?

1.7 How conducive is your oncology department in terms of providing counselling for men diagnosed with prostate cancer and their families?

1.8 What information do you provide for men diagnosed with prostate cancer and their families regarding the long-term consequences of prostate cancer?

1.9 How do you describe the availability of IEC materials on supportive care for men diagnosed with prostate cancer and their families in oncology department?

1.10 How do you provide supportive care physically for men diagnosed with prostate cancer and their families at oncology department?

1.11 How do you provide supportive care psychologically for men diagnosed with prostate cancer and their families in the oncology department?

1.12 What training did you receive regarding the supportive care for men diagnosed with prostate cancer and their families in the oncology department?

1.13 For how long have you been working with men diagnosed with prostate cancer and their families in the oncology department?

1.14 What challenges have you experienced regarding facilitating the supportive care for men diagnosed with prostate cancer and their families in the oncology department?

1.15 How supportive is the management of the hospital of the oncology department?

1.16 What do you think should be done in order for the nurses to give adequate supportive care for men diagnosed with prostate cancer and their families in the oncology department?

1.17 What else would you like to comment on regarding facilitating the supportive care for men diagnosed with prostate cancer and their families in the oncology department?

ANNEXURE K: Transcription of an individual interview with a registered nurse at Oncology department of Intermediate Hospital Oshakati

Registered Nurse no: 11
Date: 30.08.2019
Time:
Language of Interview: English
Place: Intermediate Hospital Oshakati
Department: W-3B
Region: Oshana
Gender: Female
Age: 30

Researcher: Good Afternoon Sister?

Participant: Good afternoon Sir

Researcher: How are you?

Participant: I am fine, how are you?

Researcher: Ok, I am also fine sister.

Researcher: I am fine. Sister, my name is Salomo Salomo. I am here as a postgraduate student at the University of Namibia, conducting a research with regard to prostate cancer. The title of the research is:" A model for nurses to facilitate supportive care for men diagnosed with prostate cancer and their family in the Intermediate Hospital Oshakati: A hospital based approach. One of the objectives of the study is to explore and describe the experiences of nurses in facilitating the supportive care of men diagnosed with prostate cancer and their families in oncology departments. This study has been approved by the Research Ethics Committees at University of Namibia and Ministry of Health and Social Services. Your participation in this study is entirely voluntary. You are free to decline to participate. Similarly, you are also free to withdraw for the study at any time. There will be no need for your details or your name and the confidentiality will be assured as nobody will kink the information to the provider. On the other hand the information will not be shared with unauthorised people apart from the supervisors of the study.

With me I am having a tape recorder that will be used to record our conversation and it will be kept safe after the data collection and nobody will temper with it in terms of the answers. The interview will last for about 45 minutes to 1 hour. The findings of this study will be used to develop the model that will serve as a guiding tool to the Ministry of Health and Social Services which will ultimately lead to an improved supportive care forwards men diagnosed with prostate cancer and their family. I am therefore kindly requesting you to give your honest opinion as a Registered Nurse who usually facilitates supportive care for men diagnoses with prostate cancer in this oncology department. Based on the objectives of the study that I have explained to you earlier on, do you agree to participate in the study?

Participant: Yes, I am willing to participate.

Researcher: Being a registered who worked with men diagnosed with prostate cancer, tell me your experiences in facilitating the supportive care for men diagnosed with prostate cancer and their families in oncology departments?

Participant: Aa… [adjusting herself well on a chair] my experience on that topic, men with cancer, is that the ones that I met not really newly diagnosed but they have been diagnosed and they use to come in the hospital for follow up or admission. Usually a patient when he come he usually complaining of paid usually in the lower abdomen that patient usually if he does not have a catheter he complaining of difficult in passing urine. When the urine is in the bladder he is complaining that my bladder is full but I cannot pass urine, that is what we experienced and if that patient sometimes they usually complaining of this haematuria, there is always blood in the urine and sometimes that one affect the because the blood use to form in the bladder and become clot. Once the clots get in the way of the catheter the patient will pass urine with difficulty or not passing urine at all and if that case happen they usually come to the hospital and get admitted and usually the doctor use to put a three way catheter in order for us to do irrigation. There is a special water for irrigation and you put it up as if you put up the vacolitre and connect because there is a line specially for that and then the water goes into the bladder and come out in the urinary bad. Sometimes you can do that, but sometimes the water is just going in but is not coming out where by you have to use a syringe and then you irrigate by putting water and you pull it by force, usually that is the supportive care we use to give and the doctor use to prescribe analgesics, just to relieve pain. Yes.

Researcher: Thank you very much, sister for the supportive care that you use to give. Earlier on I stated that the study is about supportive, being a registered nurse who worked with men with prostate cancer, how do you understand by the meaning of “supportive care”?

Participant: Aa…[taking a deep breath] the way I understand supportive care, you are helping a person to deal with what he or she have. You are supporting in the way that aa … aa … [with eyes closed] you help the person to cope with that condition the person is having, either you can give let me say the patient usually thinking that why me to have this condition, so can give that support in the form of psychological way whereby you encourage the person that no.. this I is not only you but there are many people with this disease but with our help we are giving medication for you not to feel pain, so you just support that patient to cope with the disease or any condition that he is in. There are a lot of supports we can give, sometimes you find if the person is in that end stage there are times that the person is unable to help himself, by that we can also help whatever the patient need, yes.

Researcher: Thank you very much, sister. Any other supportive care that you would like to add on top of what you said already?

Participant: Jaa… [looking up while smiling] spiritual care we also use to give and emotional by the … aa … when I mention about spiritual it is not really us that we use to give it but there is pastor in the hospital whenever the patient is in the hospital or whenever the patient feel that …aa… you go the patient and say how about if we call a pastor just to talk to you. So, we use to do that for them. I mentioned psychological, spiritual, emotional, and what else … aa … aaa … aa … [looking down] ok, that is all I can remember for now.

Researcher: You said you give spiritual support whereby by you use to call the pastor to come and talk to the patient. How helpful do you think spiritual support that you give to them?

Participant: Jaa…[looking up] it really helps because sometimes the patient like in the beginning when the patient is diagnosed he was just told that you are having that condition and that is it, and now we are starting with medications and whatsoever but the patient sometimes use to ask themselves … oh …, why … is it a punishment from God but if you just call a pastor and talk to that patient, tomorrow you can find that this patient is in the different mood and you can just tell that it really helps. The patient can even say the pastor was here and we talked and … aa … it really helps.

Researcher: How do you provide spiritual support to patients from different denominations in the presence of one pastor in the hospital?

Participant: In that situation, we do not just say we have a pastor in that hospital because that patient may belong to that church so we usually ask; do you call any pastor that you would like us to call? The patient will tell you that no I am having this pastor in our village and so forth then we conduct the family that we talk to the patient and he say he would like to see the pastor, so can you go to him and see if the pastor can able to come to the hospital to see the patient? They use to come.

Researcher: Earlier you talk about talking to the patient in order to cope with the diagnosis. Can you please elaborate on that, how do you do that?

Participant: Uuhh … [taking a deep breath] by doing that, there are times you find a patient does not want to accept, so there are times you talk to the patient, you talk, you talk, and then the patient still does not want to accept, so, that way it is not only the nurse but we call in people to intervene like the doctor you call the doctor again and he will come and explain to the patient and the then the doctor also has the right to call a social worker to come and talk to the patient also to help the patient to cope with that condition because for the they are having the way. To us is just to explain what condition the patient is having, how we treat it and how we manage it, but a social worker has her own way how to tell the patient to cope with the condition.

Researcher: The diagnosis of prostate cancer may cause psychological disturbance, what supportive care do you provide for men diagnosed with prostate cancer and their family to cope with the diagnosis?

Participant: Now, is it a patient separate or family member, or all?

Researcher: Let us start with the patient.

Participant: Uhh …, that one if I talk to the patient I explain to him that this is the disease, this is what is happening, aa … aa … [scratching her head] usually you just talk to the patient, let me say I talk to the patient today and I tell him … I tell him….I tell him, and I leave that patient, I just tell him the reality of the condition and will give him health education what he need to do in order to know what to do to keep on being better because we know we are not trying to cure the disease but we are just trying to help the patient to be better. Then, I will come back again tomorrow to whether he accepts or he is still in denial. If he is still in denial, because patient are having different attitudes, sometimes I talk to him and he is fine and tomorrow when I come you see the patient is facing in the wall. He will show you may be he do not what to talk to you or in that way the next option is just to talk to the doctor whereby the doctor will also come in to talk to the patient and if the patient is still doing the same, it when we go to the social worker, yes.

Researcher: You said you might find the patient facing the wall. What do you think makes the patient to face the wall?

Participant: He is just may be … aa … the patient is stressed or may be is just the condition that makes him to do that, especially for men you find the doctor put in the catheter and some of them use to be told that I am putting on this so that it can be there even for six months, you just come to the hospital and the doctor check on it and you go back home as it is just for it to prevent that condition of you not passing urine. You find that sometimes this man is married, and he will be thinking that now what will my life be as I am having a wife, maybe he feel that the wife may go out of the house because he is no longer to perform the normal duty that he use to perform with the wife, so that can also contribute. Sometimes you will think maybe it is not really the condition that disturb the patient but that catheter he has to stay with.

Researcher: As a registered nurse who work with men diagnosed with men diagnosed with prostate cancer, how can you describe the health information you provide for men diagnosed with prostate cancer and their family at oncology department?

Participant: We usually give health education regarding uhh … [looking up with eyes closed] especially with those with catheters, we usually give health education on how to stay at home because they use to be discharged with their catheters. There will be a time when you teach the patient with a relative that when you change especially the urine bag, so you teach them how to change the urine bag and you advise the patient to drink a lot of water and also, and then you tell that if there is any change may be if the patient want to pass urine that you do not try to pull the urinary catheter it out but they must try to come to the hospital, and also on nutrition they need to eat … aa … usually they do not have a specific diet so well we tell them whatever they can eat as long as it is nutritious food.

Researcher: As a registered nurse who works with men diagnosed with men diagnosed with prostate cancer for the period that you work with, how do you describe the availability of policies and guidelines on supportive care for men diagnosed with prostate cancer and their family in oncology department?

Participant: I did not see … uhmm … what I see is just pamphlets, I did not see guidelines related to prostate cancer, and may be if there is I did not read it, yes.

Researcher: Did I hear you saying you did not come across policies and guidelines specific to supportive care for men diagnosed with prostate cancer and their family, and probably if they are there you did not come across them?

Participant: Yes. I did not read it if they are there. No…[shaking her head].

Researcher: In the absence of the policies and guidelines that should guide you on daily basis, how can you describe your experiences on facilitating supportive care for men diagnosed with prostate cancer and their family in the absence of the policies and guidelines?

Participant: Can you repeat the question may be?

Researcher: Almost every condition is having its own policies and guidelines such as that of Malaria or TB policy that guides you on how to manage that specific condition. If I heard you well earlier, you stated that you did not come across policies and guidelines specific to supportive care for men diagnosed with prostate cancer and their family. In the absence of the policies and guidelines that should guide you on daily basis, how can you describe your experiences on facilitating supportive care for men diagnosed with prostate cancer and their family in the absence of the policies and guidelines?

Participant: It was not difficult because the seniors in the wards we learn from them and when there is a case she will call you, that let us go to this patient, let us talk to this patient, so for us we have been just learning from them. When they are giving that care at least we are picking something and tomorrow when we are in the ward and you are alone, you will remember how she gave that supportive care and then you just do the same.

Researcher: In the absence of a senior sister who may be on leave, how do you describe such situation?

Participant: It is not that much difficult because adding to that experience of the seniors, we also use our knowledge that we learn at school that when we were taught you just relate that if I come across this condition this is what I am going to do. Prostate cancer was also part of general nursing science so we just relate from what we have been taught at school.

Researcher: As a registered nurse who works with men diagnosed with men diagnosed with prostate cancer and their family and expected to facilitate supportive care for them, but now you are confronted with a situation of unavailability of policies and guidelines, how does makes you feel? How do you describe that situation?

Participant: It is not … aa … [yawning] during that time I was just from school and maybe I was not that open about guidelines otherwise I could go and search for such guidelines. May be I was not open about the guidelines that is why I am saying if it was there, I did not read it. I did not feel that much bad about it, maybe it was just because may be I was not that open.

Researcher: Did you only have prostate cancer cases in the ward?

Participant: No.

Researcher: What other cases did you have?

Participant: We use to have aa… the time I worked in that ward, ward 3, it was having a lot of conditions. It was a surgery unit, it was a ENT unit, which is… it was also an oncology unit, there were a lot of cases, yes.

Researcher: Did you come across other policies apart from that of prostate cancer?

Participant: Yes, other policies are there.

Researcher: If other policies are, these policies you could also have come across them.

Participant: Yes, but I did come across it or may be … may be … I did not, because you find those Malaria guidelines, Tb guidelines, these ones even when you are in the ward it is the song that the nurses are telling you, but these ones aaye … [shaking her head] noo … I did not find it.

Researcher: If you are working in a ward where you facilitate supportive care for men diagnosed with prostate cancer, then one should expect you sing the same song just like people are singing for other conditions. How do you describe that situation of no song on prostate cancer?

Participant: I am even surprised that you are asking about these guidelines because I did not hear about it. I did not know, I just do not know whether there is a guideline for that.

Researcher: Do you feel being challenged working with men diagnosed with prostate cancer and their family in the absence of policies and guidelines?

Participant: Yes, it is a challenge because there are a times you go to the patient you talk to him but you feel that this patient is not even listening to me and also the knowledge that you are having that time so usually you just to call the senior that I am having this patient and I am talking to him but the patient does not … aa … I am even asking him questions but … for example you usually ask do you have anyone in the family diagnosed with this condition, and the patient will not even answer. In this case you just to ask for a senior and the senior will come and talk to the patient and tomorrow you will see the difference. That is why I am saying we learn from them.

Researcher: How does that making you feel as a registered nurse who works with patients on daily basis but in the absence of the policies and guidelines?

Participant: Uhh … [shaking her head while looking down] it is not good. Sometimes you feel that may be I do not know much about the condition and you yourself you feel that you do not know much about the condition or just how to handle the patient; you will also think how will the patient feel? Tomorrow you go there and the patient will tell you that can you please call a senior? It is of bit of not good, it will make you feel bad that this patient do not want to talk to me or he may feel that I do not know anything and something like that. It is not good … [shaking her head].

Researcher: Sister I would like to ask you a follow up question regarding coping with the diagnosis. The diagnosis of prostate cancer may cause psychological disturbance to men or to his family members. What supportive care do you give to the patient or family member whose psychological integrity is disturbed by the diagnosis of prostate cancer and who may not be willing accept the diagnosis?

Participant: Usually aa … [looking up] we got more involved if that patient is married because usually in most cases the wife will come and she has a lot of questions and by asking her questions you will know where the relatives stands and you will talk to them in a way that they will be able to cope also. Let me give an example that I am having a patient and the patient is sick so if I am feeling sorry for that patient that patient will also have that feeling that no, I am sick so they will be none to support the other so you talk to the them that this is the diagnose the patient is having so you have to be strong and be with the patient and whenever the patient is saying this and that, just give encouragements that no you will be better. The nurses and every one, whatever you will be want to do we will help you; we will be there for you.

Researcher: You talk about giving counselling to men diagnosed with prostate cancer and their family. How frequent do you give the counselling in your ward?

Participant: Counselling … [taking a deep breath] it depends on the condition of the patient. There are times … because this prostate cancer is usually occur in men, usually the one I met is from 50 upward, yes. So, you …, for them to accept the condition it does not take long, you talk to him today, tomorrow, on a third day this patient is already coping. Usually only few of them who take long to cope, so it depends. If you talk and see that the patient understand the condition and is trying to cope, then you can … you just do counselling let me say like today and give them after two days and then you repeat the same or maybe you just add, and you skip a day so it depends on how many patients you are having in the ward. It is not just once that once I give I go but we usually coming back to see whether the patient is coping.

Researcher: To the family members?

Participant: To the family members it is aa … it also depend like usually you talk to them on admission and it depend on the condition of the patient. If the patient is coping well on a discharge day we call them and talk to them again. On the condition whereby the patient does not want to cope we go to the social worker. The social worker also involves the relatives, yes.

Researcher: Talking about counselling, what training did you attend with regard to counselling men diagnosed with prostate cancer and their family?

Participant: I did not go … [laughing] to any counselling training.

Researcher: How do you cope doing counselling without being trained on that specific area?

Participant: Aaa …, uh … [Scratching her head] Uhmm … the only knowledge that I am using is just the knowledge from school when we were taught on that topic how to give health education with that condition. I just use the knowledge from the school and from my seniors.

Researcher: Sister for long has been practising nursing?

Participant: Uhmm … it is for 5 years now.

Researcher: For how long have you been working with men diagnosed with prostate cancer and their family?

Participant: I only work in ward 3 for six months.

Researcher: Five years of experience and having worked with men diagnosed with prostate cancer is quite a long period. How can you describe the sufficiency of the knowledge on counselling that you acquired from school?

Participant: Jaa… it is sufficient, yah, it is enough; because it is just the way you present it to the patient. Let me say call and talk to my patient and I see that may be the patient is still not coping, when you call your senior, you also have to come and you see how she is doing it. Usually what you talk to the patient, it is just the same she is also talk to the patient; the words that she use may be what I needed is only on how to present it to a patient, yes, it is almost the same.

Researcher: Looking at your environment in ward 3 as an oncology ward, how conducive is your oncology ward in terms of providing counselling to men diagnosed with prostate cancer and their family?

Participant: During that time it was not well conducive because sometimes you find yourself that you want to give counselling to the patient but that patient is unable to walk. For those who are unable to walk we usually have a certain room whereby you can put the patient on the wheelchair and take him to that room, but there are times you find that that patient is unable to walk and to put him on a wheelchair and give counselling it was difficult. It is just difficult to give counselling to the patient while others are there, it is just not easy.

Researcher: What makes it to be not easy?

Participant: Because you are talking about his condition while others are there. Sometimes if you ask him a question, he might not feel free to tell you something regarding to himself and confidentiality is it just not there. The patient will not be free. Let me say he is on this bed …[pointing nearer on her left side] and the neighbour is on the other bed … [pointing nearer on her right side] he might not even want to talk to you because the neighbour will know his condition and he will think that may be this one when he goes home he will talk about my condition at home. It is not easy.

Researcher: How do handle that situation?

Participant: There in some cases you find that, ok, you just have to find the way either you have to take a bed trolley and put the patient on the bed trolley and you move the patient to another room where there is a procedure room then you talk to the patient.

Researcher: You are a registered who usually giving counselling to men diagnosed with prostate cancer and their family, and you are now having this situation of patients put together, how does that make you feel?

Participant: Uh … it is … aa … it is … it is it is not really a bad thing because you just want to help this patient, may be it can be time consuming like what you said but for you as long as you are having what you want to do to the patient it not really a big deal, as long you want to help the patient.

Researcher: You worked with men diagnosed with prostate cancer and their family for six months. What health information do you provide to them regarding the long term consequences of prostate cancer as a disease?

Participant: Uhm … can you repeat the question?

Researcher: Cancer is having stages that might come with consequences, depends on the management. What health information do you provide to them regarding the long term consequences of prostate cancer as a disease, in case you do it?

Participant: Usually that part is done by the doctors, because the doctors are the one who do say now that you expect this and this. It is the doctor that gives health education on those stages.

Researcher: Earlier on I asked you about the availability of policies and guidelines on supportive care for men diagnosed with prostate cancer and their family, to which you said they are not available. I would like to ask you more or less similar question regarding the IEC materials. How do you describe the availability of IEC materials on supportive care for men diagnosed with prostate cancer and their family in your unit?

Participant: The pamphlets are there I have seen them. They are there and the posters.

Researcher: How do you describe their adequacy?

Participant: Uhmm … [looking up] they are there but not so much, they are few.

Researcher: How does that impact your facilitation of supportive care for men diagnosed with prostate cancer and their family in terms of health information provision?

Participant: Jaa … it impact in the way that sometimes when you are giving health education you would love to have those, to use posters to show the patients some posters by saying this is the disease, this is how …aa…[looking up smiling] this are the parts it affects, just to show what is happening, yes.

Researcher: Some patients may not be able to themselves in one way or the other, how physically do you provide supportive care men diagnosed with prostate cancer and their family in your unit?

Participant: We use to bath them, we do full wash and for some if the person is not able to move we do feeding and give medication and then we do their bed that is how we help them.

Researcher: I asked you about the availability of IEC materials that you said they not available in adequacy. How friendly are your IEC materials to men diagnosed with prostate cancer as senior citizens and their family?

Participant: They are very helpful.

Researcher: What makes you to say that?

Participant: Because sometimes you find sometimes that they are written in English and some are written in Oshiwambo, for example let me say a patient come with the relative and then may be that patient cannot read you read for them but at least the other pamphlet you give to the relative. You tell them that this is what is happening you keep on reading it whatever you do not understand you ask and then whatever you read in this patient you also read to the patient so that he can understand more about the condition.

Researcher: Earlier on I asked you about the trainings on counselling which you said you did not attend, but you were simply using the knowledge from your basic training and assistance from the senior nurses in the ward. What training did you receive regarding the supportive care for men diagnosed with prostate cancer and their family?

Participant: I did not receive any training on that.

Researcher: How do you cope with facilitating supportive care for men diagnosed with prostate cancer and their family without having been trained?

Participant: Oh… it is not a difficult thing, it is easy.

Researcher: What makes sister to say it is easy?

Participant: Uhmm … it is … [taking a deep breath] it is easy because you just have to talk to the patient and if the patient is not coping you call a senior and again if the patient is … you see that still is still not coping, you call a social worker. Usually our counselling is just based on the disease process and then that is it. Comes these things of being psychological disturbed and other stuffs, we just call the social worker to come and talk to them.

Researcher: What about any other training on cancer in general?

Participant: No, I did not attend any training on cancer.

Researcher: Do you think there is a need for you as a registered nurse who with work men diagnosed with prostate cancer and their family, to undergo training?

Participant: Yes definitely there is a need.

Researcher: Because the ward were I was allocated to we use to deal with these patients, but at least someone could have knowledge on how to deal with prostate cancer it would be easy if one could attend training on that.

Researcher: What makes important for you to attend training?

Participant: Just to give better education or counselling to the patient, because if you have that knowledge … let me say usually we know our self in the ward that this one is trained on this and some people are gifted we are not the same, and if you know you just say call this to talk to the patient if there was a need.

Researcher: Are you saying the supportive that you are giving to the patients including counselling are not proper?

Participant: Not to say proper … [shaking her head] the knowledge that I was having that time it was not sufficient because there are time you find yourself, let me give an example, I remember one day I was giving counselling to the patient with prostate cancer and then the patient started crying and just have to call a senior to come and continue with counselling because for me I feel, noo … noo … I could not do anything as there nothing much I could do as by that time I did not know how to handle a patient whereby you find lying and when you say this the patient is not even listening, yes.

Researcher: This is very interesting. How that does makes you feel having a patient in front of you for counselling and when the patient started crying as a registered nurse you do not know how to handle him but you have to call in the senior sister to come to your rescue. How does the scenario on that specific day made you to feel?

Participant: I felt that… I just felt bad that I could not do anything to help the patient but if I could be someone with knowledge or underwent specific training on that I could at least know what to do from there.

Researcher: Based on the background that you just gave now, how do you describe your competency in terms of facilitating supportive care for men diagnosed with prostate cancer and their family on which an element of counselling is also included?

Participant: Uhh … it’s not …, may be you can repeat the question.

Researcher: There was a time that you counselled a patient and the patient started crying and you could not continue, as somebody had to come to your rescue due to the fact that you lacked training. My question is, how do you describe your competency or the confident that you have in terms of facilitating supportive care for men diagnosed with prostate cancer and their family with that picture in mind? Do you think you are confident enough?

Participant: Uhmm … by that time or now?

Researcher: Both that time and now.

Participant: Ok, by that time I was not competent because when I call in a senior I also said no I have to be there also so that tomorrow when I face the same situation again I do not have to call the senior. I stayed there, I listened and I observe how she was giving the counselling. Now, I think I can do it.

Researcher: What makes you to think you can do it in the absence of training?

Participant: Because the experience that I learned from them because that time I even came to a point, one day, it was not a difficult patient but we managed to give counselling to the patient.

Researcher: Thank you very much, sister. We are almost nearing to the end of our interview. Prostate cancer as a condition on its own, in your opinion, how attentive is the Ministry of Health and Social Services to this condition?

Participant: Jaa… it need a lot of attention because sometimes you … aa … [looking up] the way I see it is not regarded as something to … how do I put it … it is not in the same category with other diseases but it is a bit far from others because if you just going in any certain ward and you ask for the guidelines example for Malaria, everyone knows about it or you ask any guideline for TB anyone will sing that song but for it needs to be lifted up a bit. Nowadays the cases are increasing, it need attention.

Researcher: What do you think should be done in that regard sister since you said it is kept far from malaria and tuberculosis?

Participant: People should do trainings on prostate cancers like workshops … even since I started, I never heard someone going for a workshop on prostate cancer. Give more training to the health workers so that they will be able to deal more with the condition.

Researcher: How frequent do you attend in-service trainings in the hospital specifically to supportive care for men diagnosed with prostate cancer and their families?

Participant: I did not attend even one. I did not attend any in-service training regarding prostate cancer.

Researcher: No refresher training regarding prostate cancer?

Participant: No … [shaking his head]

Researcher: We are close to the end. You said prostate cancer is not getting attention for the Ministry of health and social Services, how do you describe the knowledge of the community members to prostate cancer?

Participant: I do not think they have too much knowledge on that, may be if they only know that there is prostate cancer but the awareness for the condition need to be taken to the community so that they will know. Because may say no I only know this but if I am to have the patient with prostate cancer I do not know how to deal with the patient in terms of to be done and so forth.

Researcher: What about patients, do they knowledge on prostate cancer?

Participant: Some …, some of them.

Researcher: What makes you to say that?

Participant: Because I am just relating to what I have seen, sometimes you ask or sometimes a patient comes in the ward when admitted, obviously the doctor was supposed to explain everything to the patient before sending to the ward. Know you come to the patient and you ask, what did the doctor say or what do you know about this condition? The patient say I do not know anything, so you start again or you ask what did the doctor tell you? No he just told me I am having prostate cancer, that is it and then you just go in … go in … go in …, but if someone could have knowledge about that even if the patient was told by the doctor can tell you, but sometimes was told by the doctor but on the way to the ward the patient may forget what the doctor said but if someone could just know, the patient can at least tell you about the condition.

Researcher: What about family members?

Participant: The family members … aa … aa …, some of them, but even some they will even ask you questions that know our patient is like this and like this, what should be done and so forth. Some you ask what do you know about this, how are you going to be the patient at home, have you ever heard someone with this condition, or did you have someone in the family with this condition, some of them will tell you they do not know anything.

Researcher: Having worked with men diagnosed with prostate cancer for six months, what challenges do you experience regarding facilitating the supportive care for men diagnosed with prostate cancer and their families at oncology department?

Participant: Aa … challenges … challenges … challenges [with eyes closed while looking down] there are few challenges whereby you find, let me give an example a patient does not know anything about the condition, it is a challenge because you have to start from the beginning to the end to teach this patient the condition. Another one is denial, the patient does not want to believe and some of them even refuse going home with a catheter it is also a challenge, because you now have to convince this patient and you find yourself in a situation telling…ok now you go with one at home and then when you come back we will see how you are doing and remove just to give them that hope. Another challenge is caring the catheter, some people find at home they are with someone who is not even willing to help, you find the patient coming to the hospital … noo … I just came alone no one is willing to bring me, so, is also a challenge because even you want to give health education giving to the patient alone when the patient comes back you will just see there is no care at home.

Researcher: What do you recommend to be done in that regard?

Participant: It is just the … may be more trainings should be done just to help the health workers to give health information and counselling to the patients and also to be the health education to be done in the community so that people can understand so that if someone is diagnosed with prostate cancer, what care to give to them.

Researcher: Having worked with men diagnosed with prostate cancer for six months, how do you describe the adequacy or the availability of the resources that you were supposed to use during facilitating the supportive care for men diagnosed with prostate cancer and their families?

Participant: Uhh … during that time there were not a lot, they were few.

Researcher: What makes sister to say they were a lot?

Participant: Because I can even, aa … if they could have been there, like the case I have mentioned earlier that I called in the sister to come in to intervene, at least she could have referred to these resources that if you are having a situation like this go and read this and this so that tomorrow you can do this and this. I think they were few.

Researcher: Having worked with men diagnosed with prostate cancer for six months, how supportive is the management to your department?

Participant: Uhmm …, I do not have an answer to that … [shaking her head while looking down].

Researcher: You do not an answer to that?

Participant: No…[shaking her head]

Researcher: Thank you sister. Recently you stated a number of challenges and you also stated what should be done and one them you said should be training. Any other comment sister would like to make in terms of you think should done in order for the registered nurses to facilitate supportive care for men diagnosed with prostate cancer effectively?

Participant: Yes, just may be to undergo trainings and to attend to more in-service trainings regarding prostate cancer.

Researcher: Your final words regarding supportive care for men diagnosed with prostate cancer and their family?

Participant: Uhmm …, my final words … [smiling while looking up] uhmm … [shaking her head]

Researcher: Anything else you would like to say other than what you stated earlier on?

Participant: Nothing else … [shaking her head]

Researcher: Thank you very much, sister, I would like to take this opportunity to thank you very much. We spent a couple of minutes here, but I believe it was a time well spent. I really appreciate your presence and your willingness to participate in this interview, so, thank you very much.

Participant: Thank you too … [whispering with a smile]

ANNEXURE L: Participant information leaflet and consent form

TITLE OF THE RESEARCH PROJECT: A model for nurses to facilitate supportive care for men diagnosed with prostate cancer and their families in the Intermediate Hospital Oshakati: A hospital based approach.

REFERENCE NUMBER:

PRINCIPAL INVESTIGATOR: Salomo Salomo

ADDRESS: PO Box 26, Tsandi-Uukwaluudhi

CONTACT NUMBER: Cell: +264 812833833

Dear Participant,

You are being invited to take part in a research project. Please take some time to read the information presented here, which will explain the details of this project. Please ask the investigator of the study any questions about any part of this project that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research entails and how you could be involved. Also, your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

This study has been approved by the Research Ethics Committees at the University of Namibia and the Ministry of Health and Social Services, therefore the study will be conducted according to the ethical guidelines and principles of the International Declaration of Helsinki, and the Namibian National Research Ethics Guidelines.

a) **What is this research study all about?**

b) The study will be conducted at the Intermediate Hospital Oshakati, Oshana region, Namibia.

c) One of the objectives of this study is to explore and describe the experiences of nurses in facilitating the supportive care of men diagnosed with prostate cancer and their families in the oncology departments, in order to develop a model for nurses to facilitate supportive care for men diagnosed with prostate cancer and their families in the Intermediate Hospital Oshakati.

Explain all procedures:

a) With your permission, and as a registered nurse working at oncology department, you are expected to participate in the interview in which you will describe your experiences in facilitating supportive care for men diagnosed with prostate cancer and their families at the oncology department. The interview will be conducted in a private room so that no one can hear the conversation except the researcher .The interview will take about 45 minutes to an hour to complete.

b) A voice recorder will be used during the interview session to ensure the trustworthiness of the data. The voice recording will be deleted after the study is completed. The researcher will share the transcribed materials with his study supervisors. Your input in this research will be highly appreciated.

c) Anonymity and confidentiality will be maintained as no names or addresses will be required from you as a participant, so the information will not be linked to you. You have the right to withdraw from the study at any time or to discontinue your participation without any penalty. You are under no obligation to participate in this research. Participation is voluntarily and there will be no reimbursement.

d) The findings of this study will enable men diagnosed with prostate cancer to be given supportive care by nurses at health facilities. Similarly, a model will serve as a guiding tool for the Ministry of Health and Social Services, ultimately leading to improved supportive care for men. It will also serve as a tool to empower nurses to provide individual supportive care based on men’s needs.

Explain the use of any medication, if applicable.

No medication will be used.

2. Why have you been invited to participate?

a) Explain this question clearly.

You have been invited to participate in this study because you are a registered nurse working in the oncology department and we are optimistic that your contributions to this study will assist us in reaching the study goal. In addition, we believe that you meet the following selection criteria, namely:

- You are a registered nurse working in the oncology department.

3. What will your responsibilities be?

a) Explain this question clearly.

The principal investigator will facilitate the following:

- Ask you questions with regard to your experiences in facilitating supportive care for men diagnosed with prostate cancer and their families in the oncology department.
- Ask probing questions to facilitate discussions and elicit individual views and description of experiences.

b) *Explain the length of time that the participant is expected to participate in the study (i.e. 2 hours, 4 days, etc.)*

The interviews will take about 45 minutes to an hour.

4. Will you benefit from taking part in this research?

a) Explain all benefits objectively. If there are no personal benefits then indicate who is likely to benefit from this research e.g. future patients.

The findings of this study will enable men diagnosed with prostate cancer and their families to be given appropriate supportive care by nurses in oncology departments. Similarly, a model to be developed during the study will serve as a guiding tool for the Ministry of Health and Social Services, ultimately leading to improved supportive care for men diagnosed with prostate cancer and their families. It will also serve as a tool to empower nurses to provide individual supportive care based on men's needs.

5. Are there any risks involved in your taking part in this research?

a) Identify any risks objectively.

You will mostly be asked questions for about 45 minutes to an hour by the principal investigator. All interactions with you will be done by the trained and professional principal investigator, therefore no risks will be involved. No medical or other physical experiments will be conducted on participants during the study.

6. If you do not agree to take part, what alternatives do you have?

b) *Clearly indicate in broad terms what alternative treatment is available and where it can be accessed, if applicable.*

You may disagree to take part or withdraw from the study at any time without giving a reason. You may also refuse to answer questions you are not comfortable with. Participation in the study is completely voluntary and your withdrawal will not affect you in any way.

7. Who will have access to your medical records?

a) *Explain that the information collected will be treated as confidential and protected. If it is used in a publication or thesis, the identity of the participant will remain anonymous. Clearly, indicate who will have access to the information.*
All research participants will be given anonymised codes. Anonymity will be preserved by coding the data in a way that participants cannot be identified in any presentations of the findings. Information collected from the research will not be shared with unauthorised individuals except the study supervisors.

8. What will happen in the unlikely event of some form of injury occurring as a direct result of your taking part in this research study?

a) *Clarify issues related to insurance coverage if applicable. If any pharmaceutical agents are involved will compensation be according to ABPI guidelines? (Association of British Pharmaceutical Industry compensation guidelines for research related injury which is regarded as the international gold standard). If yes, please include the details here. If no, then explain what compensation will be available and under what conditions.*

No injuries are expected or envisaged because of the non-invasive and health risk free interviews to be employed in this study.

9. Will you be paid to take part in this study and are there any costs involved?

The study is voluntary; therefore participants will not be paid for take parting part. There are also no costs required from them.

10. Is there anything else that you should know or do?

As stated earlier, the study procedures will comprise a non-invasive and health risk free interview. Therefore, there is no need to inform your family practitioner and the medical insurance company that you are participating in a research study. However, if you have any concerns or complaints that have not been adequately addressed by the principal investigator, you may contact the following study supervisors; Dr H. Amukugo, hamukugo@unam.na Tel (061) 2064617, and Dr A. Shilunga, hashilunga@unam.na Tel (061) 2064617. You may also contact the Centre for Research and Publications at +264 061 2063061; *pclaassen@unam.na*. In addition, you will receive a copy of this information and consent form for your own records.

11. Declaration by participant

By signing below, I ……………………………….…………. agree to take part in a research study entitled *"A Model for nurses to facilitate supportive care for men diagnosed with prostate cancer and their families in the Intermediate Hospital Oshakati: A hospital based approach".*

12. I declare that:

a) I have read or had read to me this information and consent form and it is written in a language with which I am fluent and comfortable.

b) I have had a chance to ask questions and all my questions have been adequately answered.

c) I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.

d) I may choose to leave the study at any time and will not be penalised or prejudiced in any way.

e) I may be asked to leave the study before it has finished if the study researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (*place*) ....….......…………….. on (*date*) …………....……….. 2019.

....

Signature of Participant Signature of witness

13. Declaration by investigator

I (…………………………………………………….....) declare that:

- I explained the information in this document to …………………………………..
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above
- I did/did not use an interpreter. (*If an interpreter is used then the interpreter must sign the declaration below.*

Signed at (*place*) ....….......…………….. on (*date*) …………....……….. 2019.

....

Signature of investigator

ANNEXURE M: Letter – Proof of Editing

Alexa Barnby
Language Specialist
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5 November 2021

To whom it may concern

This is to certify that I, Alexa Kirsten Barnby, an English editor accredited by the South African Translators' Institute, have edited the doctoral thesis titled "A model for nurses to facilitate supportive care to men diagnosed with prostate cancer and their families in the Intermediate Hospital Oshakati: A hospital based approach" by Salomo Salomo.

The onus is on the author, however, to make the changes and address the comments made.