THE LIVED EXPERIENCES OF RURAL-BASED GRANDPARENTS RAISING HIV/AIDS-ORPHANED GRANDCHILDREN IN THE KINGDOM OF SWAZILAND: A PROPOSED SELF-CARE HEALTH EDUCATION PROGRAMME

BY

SIFISO I. SITHOLE

THE LIVED EXPERIENCES OF RURAL-BASED GRANDPARENTS RAISING HIV/AIDS-ORPHANED GRANDCHILDREN IN THE KINGDOM OF SWAZILAND: A PROPOSED SELF-CARE HEALTH EDUCATION PROGRAMME

SIFISO I. SITHOLE

A thesis submitted in fulfilment of the requirements for the degree

Doctor in Philosophy

in the

Faculty of Health Sciences

School of Nursing

at the

University of the Free State

November 2009

Study Promoter : Dr. Lily van Rhyn

STATEMENT BY THE RESEARCHER

"I certify that the dissertation hereby submitted by me for the PhD degree at the University of the Free State waive is my independent effort and had not previously been submitted for a degree at another university/faculty. I furthermore waive copyright of the dissertation in favour of the University of the Free State."

DEDICATION

I DEDICATE THIS PIECE OF WORK TO THE MEMORY OF MY LOVING PARENTS:

THE REVEREND NDABANINGI SITHOLE

&

MRS. ALICE CANAAN SITHOLE

AND ALSO
TO THE MEMORY OF
MY DEAR SIBLINGS:

DINGINDLELA SITHOLE

&
SIKHULULEKILE SITHOLE
&
MPILWENHLE SITHOLE

ACKNOWLEDGEMENTS

More people than I can possibly document in this space contributed immensely and wonderfully toward the development and completion of my doctoral dissertation. I wish to particularly and sincerely acknowledge the following:

The Participants: *Ngiyabonga kakhulu nine bekunene*.

Study Promoter: I am very thankful to Dr. Lily van Rhyn for the many roles she played in the development of this research, *DANKIE* Lily.

Special Faculty: Professor M. Makiwane, Professor Agnes van Dyk, Mr. Eric Sibanda, Dr. Michael T Masarirambi and Dr. Winnie N Nhlengethwa.

Faculty of Health Sciences: Mrs. Maureen S Motsa, Dr Eunice M Mabuza, Dr Murmly D Mathunjwa, Mrs. Oslinah B Tagutanazvo, Dr Isabella S Ziyane, Ms Siphiwe BP Thwala, Ms Sakhile KS Masuku, Mr. Alfred Murye, Mr. Jerry DZ Nxumalo and Mr. Lucky Dlamini.

Library staff at the Faculties of Health Sciences and Agriculture.

Family: Mr. Tom MD Mtine, Ms Madalitso I. Mtine, Reginald G. Jr. Barrow, Siphikelelo-Jentimane-Sithole, Alberto Jentimane, Dr. and Mrs. Mohammed A Kamal, *Inkhosikati* Make Joyce-Kruger, Mrs. Betsy Fulton, Thabsile Shongwe, Tony Kaiser and Berjee Barrow-Kaiser, Samantha Sithole, Jania Mkunga and Chris Okaro, and Simbai and Chipo Chizendgeni

THE LIVED EXPERIENCES OF RURAL-BASED GRANDPARENTS RAISING HIV/AIDS-ORPHANED GRANDCHILDREN IN THE KINGDOM OF SWAZILAND: A PROPOSED SELF-CARE HEALTH EDUCATION PROGRAMME

SUMMARY

Since the late 1990s, the Swazi adult population has been dying from HIV/AIDS related illnesses and leaving behind children who end up being looked after by older adults, in

particular grandparents in rural areas. Empirical evidence abounds with findings that indicate that older adulthood is predominantly characterized by declining health. Owing to the HIV/AIDS epidemic that has killed many Swazi adults, most grandparents, especially those in rural areas have become primary caregivers of HIV/AIDS-orphaned minors.

This research investigated 14 rural-based grandparents whose ages ranged from 60 through 88 years and looked after, on a full time basis, grandchildren orphaned through HIV/AIDS in the lowveld of the Kingdom of Swaziland. Primarily, the study sought to explore and describe the lived experiences of rural-based grandparents raising grandchildren orphaned through HIV/AID. Secondly and based on the findings, the ultimate purpose of the study was to formulate a strategy to address the findings thereof.

The study was guided by the four phases of the nursing process, namely assessment, planning, implementing and evaluation. While phase one focused on exploring and describing the day-to-day personal realities of these rural-based grandparents raising grandchildren orphaned through HIV/AIDS, phase two described the development of the conceptual framework that was used to guide the development of the health education programme. Phase three focused on the structure and process of the actual programme. Phase four evaluated the developed programme.

Phase one:

This phase was the phenomenological part of the study and had a design that was qualitative, exploratory, descriptive and contextual. As the study was naturalistic, the data were collected at the homesteads of the participants through audio taped face-to-face unstructured in-depth

interviews that were guided by the following two open-ended-questions, ***''Ngiccela ungichazele kabanti kutsi engabe kunjani kunakekela batukulu bako labashiywa batali babo?"*** ["What/How is it like to care for your grandchildren whose parents died through HIV/AIDS?"] and ***"Ukhona njani kumelana netidzingo tonkhe telabatukulu bako?"*** ["How do you manage to look after your grandchildren whose parents dies through HIV/AIDS?"] An exploratory interview preceded the main data collection for the purpose of ensuring that the two questions were clear enough for the participants to understand and describe their day-to-day encouters with such children.

Other sources of data were: field notes, health records and to a lesser extent, photographs that were taken of objects and relevant scenary but not the participants. The researcher adhered to the prescribed research standards.

Data analysis started soon after completion of each interview. The data were analyzed through the method of Tesch (1990:93). Six major categories were identified: NO SUPPORT, COMPROMISED HEALTH, RESOURCE AND BASIC NEEDS CONSTRAINTS, FEELING OVERWHELMED, CONCERNS ABOUT THE FUTURE OF THE GRANDCHILDREN and SACRIFICING. The majority of the afore-mentioned identified categories needed interventions that were collaborative between various stakeholders. However, the category COMPROMISED HEALTH was found to be an area that nursing could do something about. Consequently, a health education programme to empower with self-care rural-based grandparents raising GOTHA in the

lowveld was the strategy that was chosen. With the completion of data analysis phase one had been completed.

Phase two:

This phase marked the post research stage and focused on the development of the conceptual framework that guided the development of the proposed health education programme to empower with self-care rural-based grandparents raising grandchildren orphaned through HIV/AIDS in the lowveld. Its structure and process were described.

Phase three:

Phase three was divided into two interrelated parts, namely phases 3(a) and 3(b). While phase three(a) described the structure of the proposed health education programme, phase three(b) focused on describing the process apsect of its implementing. The implementers of the proposed health education programme were identified as community health nurses.

Phase four:

Phase four formed the final phase of the development of this research and sought to evaluate the programme. Selected stakeholders were requested for their input on the developed health education programme. Also discussed in this phase were the study contributions, limitations and implications, especially to government and community health nursing practice, education, management and research. Recommendations were suggested.

Key words:

lived experiences, rural-based, grandparents, orphan, HIV/AIDS, Grandchild, health education, programme, self-care and empowerment

TABLE OF CONTENTS

CHAPTER ONE

INTRODUCTION AND PROBLEM STATEMENT

1.1 Introduction 1
1.2 Study context 2
1.3 Background to the study problem 9
1.4 Statement of the problem 20
1.5 Purpose of the study 21
1.6 Significance of the study 22
1.7 Clarification of concepts 23
1.7.1 Adult child 24
1.7.2 HIV/AIDS 24
1.7.3 Empowerment 25
1.7.4 Grandchild 25
1.7.5 Grandparent 25
1.7.6 Grandparenting 25
1.7.7 Health education programme 25
1.7.8 Rural-based 26
1.7.9 Lived experiences 26
1.7.10 Orphan 26
1.7.11 Propose 27
1.7.12 Self-care 27
1.8 Overview of research design and methods 27
1.8.1 Research design 28
1.8.1.1 Qualitative 28
1.8.1.2 Exploratory 28
1.8.1.3 Descriptive 29
1.8.1.4 Contextual 29
1.8.2 Research methods........ 29

1.8.2.1 Phase One: Exploration of the lived experiences of rural-based grandparents raising grandchildren orphaned through HIV/AIDS 29
1.8.2.1(a) Population of the study 30
1.8.2.1(b) Sampling and sampling type 30
1.8.2.1(c) Unit of analysis 30

1.8.2.1(d)Inclusion criteria 31
1.8.2.1(e) Exploratory interview 31
1.8.2.1(f) Data collection 32
1.8.2.1(g) Data analysis 32
1.8.2.1(h) Literature control 32
1.8.3 Phase Two: A description of the development of the conceptual framework 33
1.8.4(a) Phase Three(a): A description of the programme structure 33
1.8.4(b) Phase Three(b): A description of the process for implementing the programme 33
1.8.5 Phase Four: A description of the evaluation of the proposed health education programme 34
1.9 Trustworthiness 34
1.10 Ethical considerations 34
1.11 Arrangement of chapters 35
1.12 Chapter summary 36

CHAPTER TWO

RESEACH DESIGN AND METHODOLOGY OF THE STUDY

2.1 Introduction 37
2.2 Research design 37
2.2.1 Qualitative 37

2.2.2 Exploratory 38
2.2.3 Descriptive 38
2.2.4 Contextual 39
2.3 Analytical strategies 41
2.3.1 Critical thinking 41
2.3.1.1 Analyzing 41
2.3.1.2 Interpreting 42
2.3.1.3 Self-regulation 42
2.3.1.4 Evaluating 42
2.3.1.5 Explaining 43
2.3.2 Synthesizing 43
2.3.3 Reflexivity 43
2.3.4 Phenomenological bracketing 44

2.3.4.1 Prior to data collection 44
2.3.4.2 During data collection 44
2.3.4.3 Post data collection 44
2.3.5 Intuiting 45
2.3.6 Inductive reasoning 45
2.3.7 Deductive reasoning 45
2.3.8 Coding 46
2.4 Research methods 47
2.4.1 Phase One : exploring and describing the lived experiences of rural-based grandparents raising grandchildren orphaned through HIV/AIDS 47
2.4.1.1 Population of the study 48
2.4.1.2 Sampling and sample type 48
2.4.1.3 Unit of analysis 48
2.4.1.4 Inclusion criteria 48
2.4.1.5 Exploratory interview 49
2.4.1.6 Data collection 50
2.4.1.6 (a) Accessing the research setting 51

2.4.1.6 (b) Road conditions 51
2.4.1.6 (c) Unexpected encounters 52
2.4.1.6 (d) Identifying and recruiting the participants 53
2.4.1.6(e) Approaching the homestead 54
2.4.1.6(f) Accessing the participants 54
2.4.1.6(g) Establishing rapport 55
2.4.1.6(h) Setting for the interview 56
2.4.1.6(i) Mini audio-taping lesson 56
2.4.1.6(j) Interview method 57
2.4.1.6(k) Actual interview 58
2.4.1.6(l) Role of the researcher 58
2.4.1.6(m) Therapeutic communication 58
2.4.1.6(n) The probing technique 60
2.4.1.6(o) Data redundancy 61
2.4.1.6(p) Termination of interview 61
2.4.1.7 Health cards 62

2.4.1.8 Field notes 62
2.4.1.8(a) Methodological notes 62
2.4.1.8(b) Descriptive notes 63
2.4.1.8(c) Theoretical notes 64
2.4.1.8(d) Personal notes 64
2.4.1.9 Photographs 64
2.4.1.10 Data handling 65
2.4.1.10(a) Immediate steps 65
2.4.1.10(b) Intermediate steps 65
2.4.1.10(c) Later steps 66
2.4.1.11 Data analysis 66
2.4.1.12 Ethical issues 69
2.4.1.12(a) Permission to conduct study 69
2.4.1.12(b) Permission to use the data ... 71
2.4.1.12(c) Permission to take photographs..... 71

2.4.1.12(d) Permission to audio-tape 71
2.4.1.12(e) Informed consent 71
2.4.1.12(f) Non-maleficence 72
2.4.1.12(g) Self-determination 73
2.4.1.12(h) Right to privacy 73
2.4.1.12(i) Respect 74
2.4.1.12(j)Confidentiality and anonymity 73
2.4.1.12(k) Research incentives........ 74
2.4.1.12(l) Scientific honesty 75
2.4.1.12(m) Voluntary participation........ 76
2.4.1.13 Trustworthiness 76
2.4.1.13(a) Credibility 77
2.4.1.13(b) Confirmability 77
2.4.1.13(c) Transferability 78
2.4.1.13(d) Dependability 79
2.5 Phase Two: A description of the conceptual framework 84
2.6 Phase Three(a): A description of the structure of the health education programme 84
of the proposed health education programme 84
2.7 Phase Three(b): A description of the process aspect of the health education programme 84

2.8 Phase Four: A description of the evaluation of the health education programme 85
2.9 Chapter summary 88

CHAPTER THREE

FINDINGS AND LITERATURE CONTROL

3.1 Introduction 89
3.2 Primary purpose of the study 89
3.3 Format for presenting findings 89
3.4 Demographic profile of R-BGs raising GOTHA 91
3.4.1 Unit of analysis and size 92

3.4.2 Gender dimension 93
3.4.3 Age dimension 94
3.4.4 Formal education 94
3.4.5 Marital status 95
3.4.6 Sources of income 96
3.4.7 Household composition 96
3.4.8 Health challenges of R-BGs 97
3.5 The demographic profile of grandchildren orphaned through HIV/AIDS 98
3.6 The lived experiences of rural-based grandparents raising grandchildren orphaned through HIV/AIDS 101
3.6.1 CATEGORY: NO SUPPORT 101
3.6.1.1 Sub-category: Children are dead 103
3.6.1.2 Sub-category: Raising GOTA alone 104
3.6.1.3 Sub-category: Absence of kinship 105
3.6.1.4 Sub-category: Being abandoned and/or disowned 106
3.6.1.5 Sub-category: Working even when not feeling well 107
3.6.2 CATEGORY: COMPROMISED HEALTH 108
3.6.2.1 Sub-category: Physical health problems 108
3.6.2.1(a) Loss of strength 108
3.6.2.1(b) Impaired mobility 109
3.6.2.1(c) Pain around the knee joints 110

3.6.2.1(d) Stress-related elevated blood Pressure 111
3.6.2.1(e)Insomnia 112
3.6.2.1(f)Sores in the stomach 112
3.6.2.1(g)Diabetes mellitus 113
3.6.2.1(h)Being HIV positive 113
3.6.2.1(i)Multiple physical health

complaints 114
3.6.2.1(j)Impaired vision 115
3.6.2.1(k)Impaired hearing................................ 116
3.6.2.2 Sub-category: Emotional pain 116
3.6.3 CATEGORY: RESOURCE AND BASIC NEEDS CONSTRAINTS.. 118
3.6.3.1 Sub-category: Financial constraints 118
3.6.3.2 Sub-category: Inadequate housing 119
3.6.3.3 Sub-category: Inadequate nutrition ... 123
3.6.3.4 Sub-category: Lack of clothing 125
3.6.3.5 Sub-category: Lack of adolescent parenting skill 126
3.6.4 CATEGORY: CONCERN RELATED TO THE FUTURE OF GOTHA 128
3.6.4.1 Sub-category: No adult supervision 128
3.6.4.2 Sub-category: Lack of educational opportunities for GOTHA 130
3.6.4.3 Sub-category: Inadequate clothing 131
3.6.5 CATEGORY: FEELING OVERWHELMED 132
3.6.5.1 Sub-category: Engaging in domestic activities everyday 133
3.6.5.2 Sub-category: Parenting small children 133
3.6.5.3 Sub-category: Role inadequacy 134
3.6.6 CATEGORY: SACRIFICING 135
3.6.6.1 Sub-category: Sacrificing money, food and personal effects 136
3.6.6.1(a) Financial sacrificing 137
3.6.6.1(b)Nutritional sacrificing .... 13.
3.6.6.1(c)Personal effect sacrificing ... 138

3.6.6.2 Sub-category: Borrowing of money 138
3.6.6.3 Sub-category: Begging for food 138

3.6.6.4 Sub-category: Income generating activities 139
3.6.6.5 Sub-category: Relying on food relief 140
3.6.6.6 Sub-category: Buying food on credit. 140
3.6.6.7 Sub-category: Doing piece meal jobs. 141
3.6.6.8 Sub-category: Divine intervention 141
3.7 Specimens of field notes 142
3.7.1 Descriptive notes 142
3.7.2 Theoretical notes 142
3.7.3 Personal notes 143
3.8 Summary of Identified categories 143
3.9 Brief overview of ways of addressing the findings 144
3.9.1 CATEGORY: CONCERNS RELATED TO THE FUTURE OF GOTHA 145
3.9.2 CATEGORY: NO SUPPORT 146
3.9.3 CATEGORY: RESOURCE AND BASIC NEEDS CONSTRAINTS 146
3.9.4 CATEGORY: SACRIFICING 147
3.9.5 CATEGORY: FEELING OVERWHELMED 148
3.9.6 Identification of category to address 148
3.10 Chapter Summary: 149

CHAPTER FOUR

DESCRIPTION OF THE CONCEPTUAL FRAMEWORK

4.1 Introduction 150
4.2 PHASE TWO: DESCRIPTION OF THE CONCEPTUAL FRAMEWORK 150
4.2.1 The six guiding principles of activity in a practice discipline 151
4.2.1.1 Agency 151
4.2.1.1(a) Practitioner........ 152

4.2.1.1(b) Educator 153

4.2.1.1(c) Researcher 155
4.2.1.1(d) Manager 155

4.2.1.1(e) Advocate 155
4.2.1.1(f) Consultant 156
4.2.2 Patiency 156
4.2.3 Terminus 157
4.2.4 Framework 159
4.2.5 Dynamics 161
4.2.6 Procedures 162
4.2.6.1 The self-care deficit theory 163
4.2.6.2 Self-care three-step nursing process 164
4.2.6.2(a) Step 1 164
4.2.6.2(b) Step 2 165
4.2.6.2(c) Step 3 165
4.2.6.3 The supportive-educative nursing system 166
4.2.6.4 Adult learning principles 167
4.2.6.5 Therapeutic partnership 167
4.2.6.5(a) Trust 168
4.2.6.5(b) Confidence 168
4.2.6.5(c) Openness 169
4.2.6.6 Directional arrow 169
4.2.7 The Process Aspect of the Conceptual Framework 170
4.2.7.1 The pre-educating stage 170
4.2.7.2 The educating stage 171
4.2.7.2(a) Step 1 171
4.2.7.2(b) Step 2 172
4.2.7.2(c) Step 3 172
4.4 The complete conceptual framework 173
4.5 CHAPTER SUMMARY 175

CHAPTER FIVE

THE STRUCTURE OF THE HEALTH EDUCATIONPROGRAMME

5.1 Introduction 177

xv.

5.2 Health education-related concepts 177

5.2.1 Health education 177

5.2.2 Empowerment 179

xv.

5.2.3 Self-care 180

5.3 Phase Two: The structure of the proposed health education programme to empower with self-care rural-based grandparents raising grandchildren orphaned through HIV/AIDS in the lowveld 180

5.3.1 Vision statement 181

5.3.2 Mission statement 181

5.3.3 Programme philosophy 181

5.3.4 Programme aims 182

5.3.5 Programme goals 182

5.3.6 Programme objectives 183

5.3.7 Content of the programme 183

5.3.7.1 Old adulthood 185

5.3.7.1(a) Conceptualizing aging 186

5.3.7.1(b) Myths about aging 186

5.3.7.1(c) Theories of aging 187

5.3.7.1(d) Human body systems 187

5.3.7.2 Identified physical health problems 188

5.3.7.2(a) Asthma 189

5.3.7.2(b) Diabetes mellitus 189

5.3.7.2(c) Elevated blood pressure 190

5.3.7.2(d) Chest tightness 190

5.3.7.2(e) Chest pain 191
5.3.7.2(f) Pain in the knees 191
5.3.7.2(g) Painful back 192
5.3.7.2(h) Skin rash 192
5.3.7.2(i) Sores in the stomach 93
5.3.7.2(j) HIV infection 193
5.3.7.2(k) Impaired hearing 194
5.3.7.2(l) Impaired vision 194
5.3.7.3 Other identified health related challenges 195
5.3.7.3(a) Inadequate intake and maintenance of food 196
5.3.7.3(b) Inadequate sleep 197

5.3.7.3(c) Overweight 197
5.3.7.3(d) Inadequate personal hygiene practice 197
5.3.7.3(e) Imbalance between activity and rest 198
5.3.7.3(f) Imbalance between solitude and social interaction 198
5.3.7.3(g) Lack of exercise 198
5.3.7.3(h) Lack of environmental sanitation 100
5.3.7.3(i) Ineffective ventilation 199
5.3.7.3(j) Lack of proper ways of disposing human waste 200
5.3.7.3(k) Miscellaneous 200
5.3.7.3(k.i) Elderly abuse 200
5.3.7.3(k.ii) Knowledge deficit about individual rights 201
5.3.7.3(k.iii)Older adulthood and human sexuality 201

5.4 Chapter Summary ……………………………………………………………………………………………

CHAPTER SIX

THE PROCESS FOR IMPLEMENTING THE HEALTH EDUCATION PROGRAMME

6.1 Introduction ………………………………………………………………………………… 203
6.2 Programme implementers ……………………………………………………………… 203
6.3 Target audience ……………………………………………………………………………… 204
6.4 Workshop ………………………………………………………………………………………… 204
6.5 Phase Three (b): Guidelines for implementing the proposed health education programme to empower self care rural-based grandparents raising grandchildren orphaned through HIV/AIDS in the lowveld …………………………………………………… 205
6.5.1 Culture-focused guidelines for implementing the proposed health education programme ………………………………………… 206
6.5.1.1 Manner of approach ………………………………………… 208

6.5.1.1(a) Respect and dignity ………………… 208
6.5.1 1(b) Language …………………………………………… 209
6.5.1.1(c) Dress code ………………………………………… 209
6.5.1.1(d) Gender sensitive topics ………… 211
6.5.1.1(e) Prayer ……………………………………………… 211
6.5.1.1(f) Communication ………………………………… 212
6.5.1.1(f.i) Verbal communication ………………… 212
6.5.1.1(f.ii) Non verbal communication ……………… 212
6.5.1.1(f.ii.a) Facial expressions ……………… 213
6.5.1.1(f.ii.b)Eye contact …………… 213
6.5.1.1(f.ii.c) Use of make-up and fancy hairstyle …………………… 213

6.5.2 Education-focused guidelines for implementing the proposed health education programme 214
6.5.2.1 Theories of learning 215
6.5.2.2 Learning styles 215
6.5.2.3 Perceptual learners 216
6.5.2.4 Gender sensitivity 217
6.5.2.5 Adult learning principles 218
6.5.2.5(a) Self-concept. 219
6.5.2.5(b)Experience 219
6.5.2.5(c) Readiness to learn 219
6.5.2.5(d) Orientation to learning 220
6.5.2.5(e) Motivation to learn 220
6.5.2.6 Setting and timing for health education........ 220
6.5.2.7 Teaching-learning environment 221
6.5.2.7(a) External environment 221
6.5.2.7(b) Internal environment 221
6.5.2.7(b.i) Psychological environment 222
6.5.2.7(b.ii) Emotional environment 222

6.5.2.8 Educational objectives 222
6.5.2.9 Teaching plan 223
6.5.2.10 Teaching strategies 224
6.5.2.10(a) Lecture 226
6.5.2.10(b) Lecture/discussion 226
6.5.2.10(c) The singing method 227
6.5.2.10(d) Drama 227
6.5.2.10(e) Group discussion 228
6.5.2.10(f) Demonstration and return demonstration 228
6.5.2.10(g) Role-playing 229

6.5.2.10(h) Learner-centered teaching 230
6.5.2.11 Teaching aids 231
6.5.2.11(a) Visual teaching aids........ 231
6.5.2.11(b) Audio instructional aids 231
6.5.2.11(c) Audio-visual aids 231
6.5.2.11(d) Models and artifacts 232
6.5.2.12 Implications of aging on older adult learning 232
6.5.2.13 Evaluation 233
6.5.2.13(a). Formative evaluation 234
6.5.2.13(b) Summative evaluation 234
6.6 Levels of teaching 235
6.6.1(a) One-to-one basis 235
6.6.1(b Small groups 235
6.7 Characteristics of an effective CHN educator 236
6.8 Chapter summary 237

CHAPTER SEVEN

EVALUATION OF THE SELF-CARE HEALTH EDUCATION PROGRAMME

7.1 Introduction 238
7.2 Synopsis of the study and programme development 238
7.3 Phase Four: evaluation of the proposed programme 241

7.3.1 The development of the evaluation instrument........ 241
7.3.2 Feedback on the programme content and structure........ 241
7.3.2.1 Category 1: R-BGs raising GOTHA 241
7.3.2.2 Category 2: Peri-urban elderly 244

7.3.2.3 Category 3: Nurse educators 245
7.3.2.4 Category4: Pro-elderly NGO advocate 245
7.4 Limitations of the study 246
7.5 Contributions of the study 246
7.6 Implications of the study findings 249
7.6.1 Central Government 249
7.6.2 Ministry of Health and Social Welfare 250
7.6.3 Ministry of Housing and Urban Development 251
7.6.4 Ministry of Finance and Economic Planning 252
7.6.5 Ministry of Agriculture and Co-operatives 253
7.6.6 Ministry of Education 253
7.7 Implications on community health nursing 254
7.7.1 Community health nursing practice 254
7.7.2 Community Health Nursing Education 254
7.7.3 Community Health Nursing Research 255
7.7.4 Community Health Nursing Management 256
7.8 Recommendations 257
7.9 Concluding summary 258
8 References 260
9 Appendices 281
9.1 Appendix A Approval by Ethics Committee (RSA) 282
9.2 Appendix B Request to conduct study in Swaziland 284
9.3 Appendix C Approval to conduct the study from Ministry of Health to conduct study 287
9.4 Appendix D Informed consent 289
9.5 Appendix E Unstructured data collection instrument 292

9.6 Appendix F Main study interview 294

9.7 Appendix G Workshop 307
9.7 Appendix H Specimen of teaching plan 307
9.8 Appendix h Teaching plan 312
9.8 Appendix I Evaluation instrument 316

LISTS OF TABLES

CHAPTER TWO

2.1 Selection of therapeutic communication techniques 59
2.2 Strategies utilized to enhance trustworthiness 78
2.3 Summary of all four phases the development of this research 86

CHAPTER THREE

3.1 Demographic data of the participants 92
3.2 Health challenges (according to body system)of the R-BGs raising GOTHA 97
3.3 Summary of all identified categories and sub-categories 102
3.4 Summary of CATEGORY: NO SUPPORT 103
3.5 Summary of CATEGORY: COMPROMISED HEALTH 108
3.6 Summary of CATEGORY: RESOURCE AND BASIC NEEDS CONSTRAINTS 118
3.7 Summary of CATEGORY: CONCERN RELATING TO THE FUTURE OF GOTHA 128
3.8 Summary of CATEGORY: FEELING OVERWHELMED 132
3.9 Summary of CATEGORY: SACRIFICING 136
3.10 Limited financial resources 142
3.11 Change in traditional values 142
3.12 Personal notes 143

CHAPTER FOUR

4.1 The six guiding principles for

nursing activity ... 151
4.2 List of principles and elements of the PHC strategy ... 154
4.3 Procedures included in the self-care health education programme ... 162

CHAPTER FIVE

5.1 Summary of programme structure and content ... 184
5. 2 Selected identified health problems of R-BGs raising GOTHA ... 188
5.3 Summary of other health related challenges to R-BGs raising GOTHA ... 195

CHAPTER SIX

6.1 Summary of guidelines to facilitate the the implementation of the health education programme ... 295
6.2 Summary of selected culture-focused guidelines ... 207
6.3 Summary of selected education-focused guidelines type and instructional4 strategies and aids ... 216
6.4 Learner type and instructional strategies and aids ... 216
6.5 Learning preferences for women and men ... 217
6.6 Information retention rate through the various senses ... 225

LISTS OF FIGURES

No. Title of figure Page.

CHAPTER ONE

1.1 Map of the Kingdom of Swaziland
in Southern Africa 2
1.4 *Umhlanga* ritual (Reed Dance) 5
1.6 The four regions of Swaziland 7

CHAPTER TWO

2.1 Soil erosion 40
2.2 Road condition 52
2.3 A reptile 53
2.4(a) When approaching a homestead: front view 54
2.4(b) When approaching a homestead: side view 40

CHAPTER THREE

3.1 A traditionally built structure/room 121

CHAPTER FOUR

4.1 Agency in the proposed self-care health

education programme 152
4.2 The various roles of the community
health nurse 153
4.3 Patiency in the proposed self-care
health education programme 156
4.4 Terminus of the proposed self-care health education
programme 158
4.5 Framework of the proposed self-care
health education programme 160
4.6 Dynamics of the proposed self-care
health education programme 161
4.7 Orem's nursing process – Step 1 164
4.8 Orem's nursing process - Step 2 165
4.9 Orem's nursing process – Step 3 165
4.10 Therapeutic partnership 167
4.11 Partnership quality: trust 168
4.12 Partnership quality: confidence 168

4.13 Partnership quality: Openness 169
4.14 Directional arrow 169
4.15 The therapeutic partnership triad 170
4.16 Educating phase 173
4.17 The complete conceptual framework 174

CHAPTER SIX

6.1 *A woman putting on umgcula* 211

CHAPTER SEVEN

7.1 The steps for evaluating
instrument development 242

LIST OF ABBREVIATIONS

AIDS	Acquired immune deficiency syndrome
CHN	Community health nurse
CHNs	Community health nurses
E	Emalangeni. Swazi currency. E1 - 00 is equivalent to R1 - 00
GOTHA	Grandchildren orphaned through HIV/AIDS

HIV	Human immunodeficiency virus
NGO	Non governmental organization
NGOS	Non governmental organizations
R-BG	Rural-based grandmother
SDHS	Swaziland Demographic and Health Survey
ULARN	Umchumanisi Link Action Research Network
UNAIDS	Joint United Nations Program on HIV/AIDS

SISWATI WORDS	**ENGLISH TRANSLATIONS**
iNgwenyama	Official title of the Head of State in Swaziland
iNdlovukati	Official title of The Queen Regent in Swaziland

tinkhundla	Many constituencies/political areas
inkhundla	One constituency/political area
tigodzi	An area within the community
imiphakatsi	Many chiefs' residences areas
umphakatsi	The official residence of a chief
kuhlonipha	Respect
ubuntu	A quality that includes the essential human virtues: compassion and humanity. Origins are from Xhosa and Zulu.
Umhlanga	Reed. Known in conjunction with the famous annual ritual of The Reed Dance.
siSwati	denoting the Swazi language or in the Swazi tradition and/or custom.
imbasha yalabadzala	A small of food provision given to one to use for minor requirements/needs.
emahiya	traditional attire for men
emahlanzeni	in the lowveld
tinsandzane	a child who has lost one parent
tingedzama	a child who has lost both parents
boGogo	Grandmothers
boMkhulu	Grandfathers
batukulu labatintsandzane	grandchildren who are orphans
umnumzane	head of homestead/family/home
enkhundleni	at/in the constituency
umugcula	a piece of cotton cloth worn by women It serves multiple purposes.

CHAPTER ONE
INTRODUCTION AND PROBLEM STATEMENT

'A journey of a thousand miles must begin with a single step.' (Lao-tsu 'Tao Te Ching)'

1.1 INTRODUCTION

Chapter one marks the beginning of phase one of this study. It also forms the base upon which the subsequent health education programme was developed. The chapter starts by describing the country in which the study was implemented. Thereafter, the following topics are discussed: background information to the study problem, statement of the problem, purpose of the study significance of the study findings and clarification of selected relevant concepts. In addition to, an overview of the design and methodology of the study is briefly outlined in this chapter while greater details thereof shall be discussed in chapter two. The way the chapters are arranged is explained and the chapter ends with a summary.

Human immunodeficiency virus (HIV) infection has become one of the most destructive plagues in history (van Dyk, 2005:3). According to Kawewe (2006:online) approximately 95% of the estimated 34 – 46 million of the global population with HIV infection live in the global South with sub-Saharan Africa claiming 25 million (60%) of them. As a result of the progression of HIV infection, many adults have died from acquired immune deficiency syndrome (AIDS), leaving behind children under the care of the extended family whose gatekeepers are the elderly, namely, and grandparents. This pattern of second time parenting by grandparents (Haglund, 2000:120), particularly in sub-Saharan Africa as a consequence of the social effects HIV/AIDS epidemic, has been observed by a number of

authors (Corey and Adamson, 2004:online; Joint United Nation Programme on HIV/AIDS, 2004:61-64). The Kingdom of Swaziland is not exempt from this social phenomenon (Hall, 2005:online).

The Kingdom of Swaziland, a member state in sub-Saharan Africa, has been severely affected by the HIV/AIDS epidemic (Swaziland and National Emergency Response Committee for HIV and AIDS (United Nation Programme on HIV/AIDS-Swaziland, and 2008:2). Many Swazi adults have died from HIV/AIDS epidemic and left behind children who, to a greater extent, are being cared for mostly by their grandparents (Hall, 2005:online) since the extended family system has weakened and no longer as effective as before (Eagle, 2007:onlne ; Kavuma, 2001:online). Therefore, the majority of the Swazi elderly bear the brunt of the HIV/AIDS orphan crisis.

The elderly are highly commended for the role they play in the HIV/AIDS orphan crisis. However, it is noted that the unexpected family/social obligation of having to look after such children (M2 Presswire, 2004: online) is, indeed, a cause for concern, particularly, in light of their advanced age. According to Clark (2003:440) the developmental stage of older adulthood is, to a greater extent, manifested by declining physical health.

1.2 STUDY CONTEXT

This research was implemented in the Kingdom of Swaziland, which shall from now on be referred to in this study text simply as 'Swaziland'. Swaziland is a small land locked country that is situated in the eastern part of Southern Africa. She shares her borders with the Kwa Zulu-Natal and Mpumalanga provinces to the south, west and north, in the

Republic of South Africa and Maputo province to the east in the Republic of Mozambique (refer to figure 1.1). The country occupies a land area measuring 17,363 square kilometers (Ministry of Health and Social Welfare, 2006:19) most of which is suitable for arable farming (Dlamini, 2003:96).

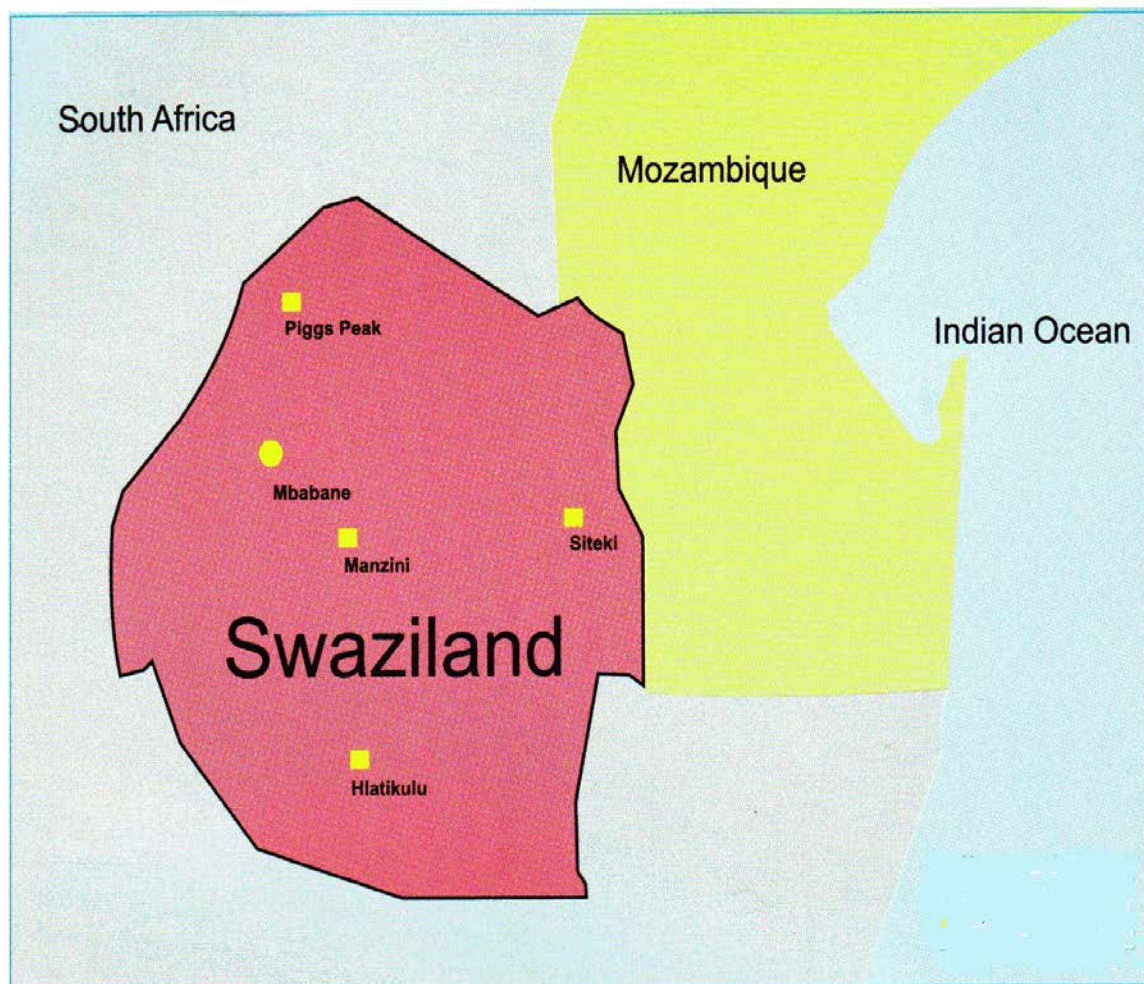


Figure 1.1 Map of the Kingdom of Swaziland. The country is located in Southern Africa and shares her borders with the Republics of South Africa and Mozambique. Source: UNICEF-Swaziland (2006:5).

Formerly a protectorate of Britain during the colonial period, Swaziland attained her independence in 1968 (Ginindza and Masuku, 2007:1). The country is a monarchy and the Head of State holds the title *Ingwenyama* [The Lion], a position bestowed upon him through traditional

rites (Swaziland Government Gazette Extraordinary, 2005: S16). The current Head of State is His Majesty King Mswati III who rules the country in collaboration with his mother whose official title is *Indlovukati* [The Queen Regent], but generally referred to by the Swazis as 'Queen Mother'.

While the *Ingwenyama* (The Lion) is the Head of State, the Prime Minister is the Head of Government and appointed into that position by the former. The Prime Minister is appointed every five years at dissolution of Parliament or as deemed by the political situation. The *Ingwenyama* (The Lion) may also re-appoint a Prime Minister if his previous performance was good. The day-to-day administration of the country as a whole is the responsibility of the Prime Minister together with an appointed team of cabinet ministers.

The legislative body of the country is closely tailored to that of Westminster and has a bi-cameral House of Parliament, namely, lower and upper houses. While the lower house (House of Assembly) seats elected Members of Parliament, the upper house (Senate) comprises those individuals who are appointed by the *Ingwenyama* in his capacity as the Head of State.

The legal framework of Swaziland is based on a dual system combining the Roman-Dutch law and Swazi traditional law and custom (Ginindza and Masuku, 2007:1). For the first time in 30 years, which was in the year 2005 the first written constitution of the country was ratified by the *Ingwenyama* (Swaziland Government Gazette Extraordinary, 2005:S15) and

became effective in February 2006 (Ginindza and Masuku, 2007:1).

Members of Parliament are elected from the current 55 *tinkhundla* (constituencies) in the four regions (refer to figure 1.3) of the country. One of their many functions is to represent their communities, namely the people who elected them. The *tinkhundla* (constituencies) in turn, are made up of *imiphakatsi* (chiefdoms), of which there currently are 360 in the entire country (Ministry of Health and Social Welfare, 2007:2) and administered by chiefs who are appointed into these traditional positions by the *Ingwenyama* [The King]. In turn, the *imiphakatsi* (chiefdoms) are made up of *tigodzi* (areas). These *tigodzi* areas) are made up of families.

With regards to the composition of the population, unlike most African countries where there are more that one tribe, the population of Swaziland is relatively homogenous (Ministry of Health and Social Welfare, 2002:10) with majority of the population being ethnic Swazi, mixed with a small number of Zulus and non-Africans (Ginindza and Masuku, 2007:1).

Known as a peace-loving and warm-hearted nation, the Swazi people are also proud and protective of their rich culture (Swaziland Business Year Book, 2005:7). Among the most well celebrated Swazi rituals is *Umhlanga*, which is popularly known in English as the Reed Dance (refer to figure 1.2) (Swaziland Year Book, 2005:8).

Figure 1.2 *Umhlanga* ritual (Reed Dance). Source: Phototaken by the researcher in August 2006.

This traditional ceremony takes place at the *Ludzidzini* Royal Kraal, where thousands of maidens from the four regions of the country converge to pay homage to His Majesty the King and the Queen Regent.. During this ceremony, thousands of colourfully dressed maidens sing and dance as they entertain the Royal Family and general public including tourists from all over the world.

Kuhlonipha (respect) is one of the central values in the Swazi way of life. It is part of the Bantu heritage whose philosophy of *ubuntu* is well integrated in the day-to-day life activities of the Swazi people. *Kuhlonipha* (respect) may manifest itself in a number of ways some of which include the following: deportment, manner of speaking, dress code and interacting with others, especially those older than oneself. The people speak siSwati, their local

language. English is the second official language in Swaziland and used among others as the language medium for instruction in education and the commercial industry.

Administratively, Swaziland is divided into four distinct areas referred to as regions (refer to figure 1.3). The four regions are named: Hhohho (north-west), Manzini (west-central), Lubombo or lowveld (north-east) and Shiselweni (south-west).

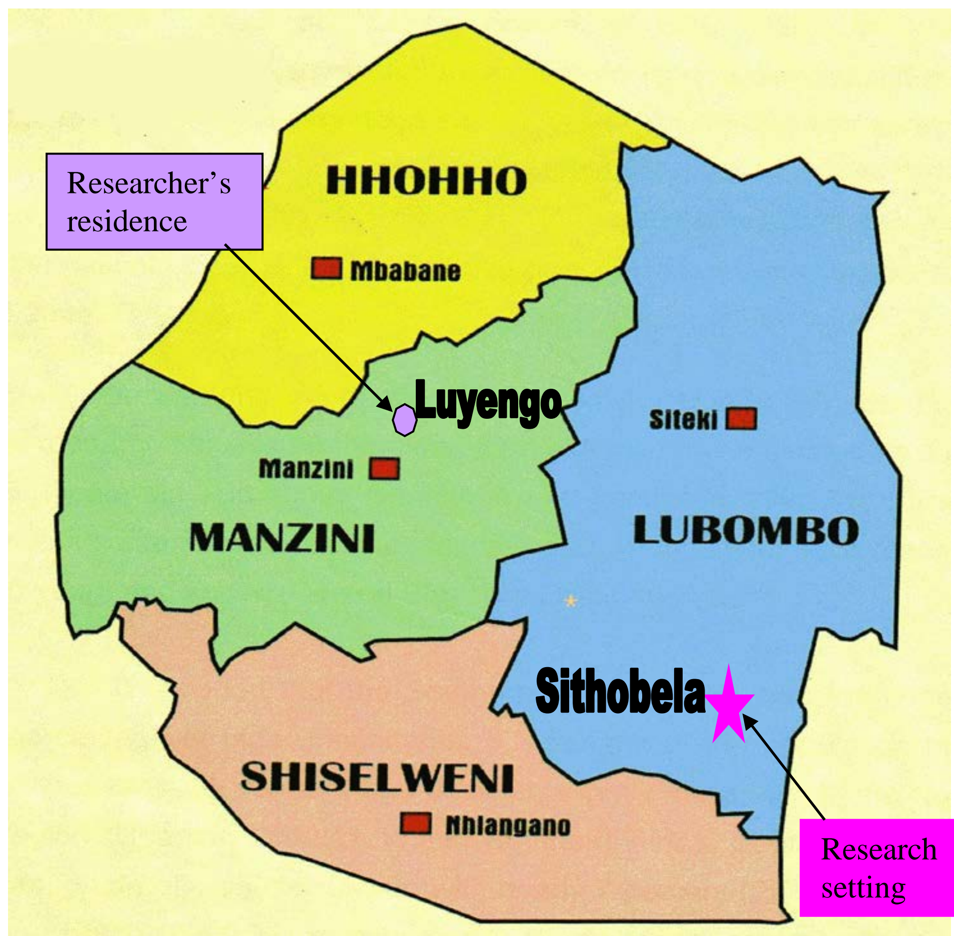


Figure 1.3 The four regions of Swaziland. Map of the Kingdom of Swaziland showing the four regions, research setting and researcher's area of residence. Source of map: Mabuza (2008:2).

According to the Ministry of Health and Social Welfare (2002:24) the HIV prevalence rate has been indicating an upward tendency in all the four regions with the Manzini region at the top with 41.2%, followed by Lubombo that 38.5%, then Shiselweni with 37.9% and lastly, Hhohho region with 36.6%.

The present study was implemented in the Lubombo region, which is also referred to as the just lowveld. In particular, the data were collected from rural-based grandparents (R-BGs) who resided in one area of one chiefdom in the *Sithobela Inkhundla* (constituency) (refer to figure 1.3). These R-BGs were bringing up grandchildren orphaned through HIV/AIDS (GOTHA).
The economy of the country is diverse. To a greater extent, it is agriculture-driven (Ginindza and Masuku, 2007:1) with large fields of sugar cane and cotton that are cultivated in the Lubombo region for export purposes. The manufacturing and processing industries are still developing and quite diverse. These are predominantly a private sector enterprise and range from small factories to large concerns employing several thousands of people. The categories of goods produced by the various Swazi manufacturing industries include: food and beverages, clothing and textiles, timber, pulp and paper, metal products, and plastics and chemicals (Swaziland Business Year Book, 2005:53).

From the Population and Housing Census Brochure (2007), the following information was extracted. The *de jure* population of the country stood at 1,018,449 people and reflects an increase in the Swazi population as compared to the 1997 population size of 929718 people (The Nation, 2007:4).

Selected statistics on the children, gender and the elderly are briefly outlined in the next three paragraphs.

Swaziland continues to have a youthful population (The Government of Swaziland and UNICEF Corporation, 2000-2005:22) with 39.6% of the total population being of the age of 15 years and below or 52% of the total population being of the age 20 years and below (Population and Housing Census Brochure, 2007). Such a youthful population suggests a high child:adult dependency ratio. Such a high child:adult ratio, particularly in the wake of HIV/AIDS, has implications on the burden of caring by older adults, particularly, grandparents who seem to be bearing much of the brunt of the AIDS-orphan crisis.

While in 1997, the elderly aged 60 years and above constituted up 4.6% of the entire Swazi population (Musi, 2006:online), it is noted that the size of this population group has increased to 5.4% (Population and Housing Census Brochure, 2007). Such increase in the population of the elderly is in line with the phenomenon of population aging, like in the rest of the world, including in sub-Saharan Africa (Velkoff and Kowal, 2007:1 ; Corey and Adamson, 2004:409). Owing to improved health services over the years, more people live longer.

Out of the total population that represents the elderly only, 41% of that elderly population are male while the remaining 59% are female (Population and Housing Census Brochure (2007). The reason for having fewer males was assumed to be associated with a shorter life expectancy of 58 years among Swazi men while that for women is 65 years (Ministry of Health and Social Welfare, 2002:10). The afore-mentioned life expectancy statistics are applicable

only to the current older generation who are perceived as being at 'low risk' of contracting HIV infection (Knodel and van Lantingham, 2002:online). Life expectancy for the current younger Swazi generation plummeted to about 31.3 years because of the HIV and AIDS epidemic (The Nation, 2007:5). It has been observed that most grandparents absorb into their households children whose parents have died.

Thus far in this discussion, the country context and selected relevant statistics from the Population and Housing Census Brochure (2007) have been presented. The chapter now focuses on the core of the research problem, rural-based grandparents (R-BGs) raising GOTHA in the lowveld. Selected relevant background information to the research is presented next.

1.3 BACKGROUND TO THE STUDY PROBLEM

Swaziland is one of the sub-Sahara African countries that have been severely affected by the HIV and AIDS epidemic (United Nations Development Programme Swaziland, 2008:8). Ever since the first person was diagnosed as living with HIV infection and AIDS in Swaziland in 1986 (United Nation Programme on HIV/AIDS-Swaziland, 2008:2), HIV infection prevalence rate has shown an upward trend. According to Ministry of Health and Social Welfare (2006:20) from an HIV infection prevalence rate of 3.9% in 1992 when the HIV sero-sentinel surveillance exercises commenced, the rate increased to 42.6% in 2004. A slight decrease to 39.6% was reported in 2006 (United Nation Programme on HIV/AIDS Swaziland, 2008:13). Generally, the HIIV/AIDS epidemic continues to take hold of the Swazi people, especially, the age group 15 – 49 years who are gainfully employed and also sexually active (Ministry of Health and Social Welfare, 2006: 21). As these adults continue to die from the deadly

infection many children have become orphaned and left to fend for themselves.

While some of the HIV/AIDS-orphaned children have no other choice but to remain in their parental homes and become child-headed households (Simelane, 2004:1; Thwala, 2004:1), others opt to join or find themselves joining the ever increasing population of street kids (Zimmerman, 2005:online; Ndlovu, 1999:32). However, it is noted that the majority of the AIDS-orphaned children seek refuge within the context of the extended family. Currently, it would seem that grandparents are the only noticeable members of this social unit (Mhlongo, 2008:10, Mabuza, 2005:7).

Even though the majority of the Swazi older adults are at the forefront of the HIV/AIDS epidemic because of looking after GOTHA, such valuable contribution to their families and communities at large has remained unrecognized, especially by government. These older adults who are caring for GOTHA are not given the support they deserve (Dlamini, 2009b:10) which to some extent, is disrespectful. According to the late and former Deputy Prime Minister of Swaziland, Mr. Albert Shabangu, as quoted from an interview by Hall (2005:online):

> ***"Elders in our societies are revered in our culture. We must see to their needs because our older citizens are facing a situation they never expected. At this time in their lives, they had believed they could relax after a life of hard work. Instead, many grandparents have to raise young children all over again. This is after their own children have died of AIDS."***

Concerning the treatment of the elderly, Buckley (1996:online) pointed out that historically, African societies have conferred great prestige on the aged because

of experience and wisdom that they accumulated over the years. The author also highlighted that the blessings and curses of the elderly were thought to hold enormous force. The elderly also helped with rearing grandchildren and young people sought their advice.

It is noted that the way the elderly are treated by contemporary society leaves a lot to be desired. Such treatment of the elderly in their societies has generated serious concern even at the level of the United Nations with resultant special sessions being hosted with member states at different conferences to remind governments of their obligation toward the welfare of their elderly (M2 Presswire, 1999:online). The august Assembly felt that society in general had lost all respect for the elderly and not treating them with the dignity they deserve especially because they are valuable members of their societies. Such an observation was also made about the way the elderly are treated in Swaziland (Dlamini, 2009b: 10).

Generally, in the African tradition, children who lost parents were looked after within the cultural context of the extended family net (Matshalaga, 2004:9). Members of the extended family unit comprised, among others, grandparents, uncles, aunts and cousins, and they all contributed toward the wellbeing and welfare of the needy children. Adults were primarily the ones who were responsible for the effective functioning of the extended family as they provided with material and financial support to the family unit (Makiwane, Schneider and Gopane, 2004:9; Knodel and van Lantingham: 2002:online). However, and sadly too, it is noted that those traditional structures and modes of caring for orphaned children are no longer

effective because of resource depletion as a result of the HIV and AIDS epidemic (Zwane, 2007:263).

According to Mabuza (2008:5) traditionally in Swaziland, the needs of the elderly were taken care of together with those of the rest of the extended/traditional family. Among the needs and as part of the many functions of the family (McEwen, 2002:344), the elderly were provided with food, security and also cared for when they became sick. Matshalaga (2004:9) and Fajemilehin (2000:23) reported similar patterns of caring of the elderly by the extended family in Zimbabwe and Nigeria, respectively.

Raising grandchildren by grandparents is not a new social phenomenon (Whitley, Kelly and Sipe, 2001:online). Time and again, grandparents have looked after grandchildren as deemed by family situations and/or crises. Some of the challenging situations that have called for grandparents to assist with looking after grandchildren were: adolescent and single parenthood, and divorce (Roe and Minkler, 1998/99:online), the birth of a child with mental retardation (Sithole, 1998:46), parental incarceration as a consequence of cocaine abuse (Haglund, 2000:120) and parents with mental health challenges (Weber, 2001:online). It is noted that within the Swazi context, grandparenting has always been the rule rather than an exception since the three generations, namely, grandparents, adult children and grandchildren, have always shared the same roof (Swaziland Review, 2006:86).

However, though grandparenting is not a new social phenomenon, what is unique about it currently, is that the grandparents have become involved in minding these children on a full time basis, with no support from neither family

nor the state and yet elderly-related literature abounds with information to the effect the development stage of old adulthood has many physical health challenge implications (*Umchumanisi* Link Action Research Network (ULARN), 2003:online).

Despite the fact that Swaziland attained her independence four decades ago, there is no compulsory old age pension (Women and Law Southern Africa, 1998:31). Unlike the elderly in other countries in sub-Saharan Africa such as the Republic of South Africa (Makiwane, et al, 2004:67), Botswana, Namibia and Lesotho (Deveureux, 2006:online) whose elderly receive a monthly pension, Swazi elderly continue to depend, to a greater extent on their gainfully employed children. It is noted and with sadness particularly in this era of the HIV and AIDS epidemic, that with the demise of their adult children all financial and emotional support ceases for most elderly (Knodel and van Lantingham, 2002:online). They then have to see how best they can fend for themselves and also their inherited GOTHA.

Approximately 79% of the Swazi people live in rural areas (Population and Housing Census Brochure, 2007) and out of these, the majority are older adults, especially elderly women (Musi, 2006:online). A major feature of rural areas in Swaziland is that they remain underdeveloped and are rife with poverty (Dlamini, 2003:97). Emlet and Poindexter (2004:online) highlighted that most rural areas are underserved with essential services including health services, too. Though the elderly in Dlamini’s (2001:24) study were able to get to clinics, the majority of them could not afford health care since health services were not free for the elderly and they had financial constraints.

Though Swaziland is classified as a middle-income country because of a gross domestic product per capita of $1,229 (ULARN, 2003:online), the majority of Swazi older adults are poor and survive on subsistence farming (Musi, 2006:online). It is noted that 69% of the Swazi population lives below the poverty datum line (The Nation, 2007:5) of which the elderly are one affected group. According to Ndlovu (2008:1) two thirds of the Swazi population survives on less than seventy-seven United States cents dollar per day!

Poverty, which is rife in Swaziland particularly in the rural areas, is a concept that is difficult to define. While according to the World Bank (2000:291), poverty is: a state of not having enough to satisfy the basic needs such as food, shelter, clothing and medication, Ngwisha (2003:9 – 10) described it as a low standard of living that lasts long enough to undermine the health, morale and self-respect of an individual or group of individuals. In his description of poverty, Ngotiama (2003:73) alluded to the fact that poverty was a manifestation of the following: low employment patterns, lower income levels, widespread malnutrition, high mortality rates, under-urbanized nature of housing and poor health and education facilities. All the afore-mentioned definitions of poverty are applicable to the situation of the elderly who reside in rural areas.

Since about 2003, the majority of Swazi elderly receive a social grant for the elderly known in *siSwati* as *imbasha yalabadza*. This money is not old age pension but some small allowance/gift from the King/government (Mavuso, 2008:11). It is distributed to those elderly who are 60 years old and above, and registered with their *tinkhundla*

(constituencies). However, what is peculiar about this social allowance is that it is not always available for elderly for a number of reasons. At times the money is available but somehow suddenly disappears with no trace from wherever it is kept (Simelane, 2008a:3) and other times the money is available but is diverted into other projects (Vilakati, 2009:9). Owing to not having any other source of economic livelihood, the majority of the Swazi elderly tend to rely on this social grant allowance to meet their various personal needs. Lukhele (2009:22) investigated the perceptions of the Swazi elderly about the adequacy of the social grant they received and the findings suggested that while some of the elderly were grateful to be receiving it, it was generally felt that the size of the grant could be increased.

The Swazi elderly are, may be regarded as a vulnerable group as the majority of them are included in the 69% of the population that lives below the poverty datum line (The Nation, 2007:5). They are a neglected part of the Swazi society (Dlamini, 2009a:10) and marginalized (ULARN, 2003:online). According to Musi (2006:7) poverty levels in Swaziland tend to be higher for many reasons some of which were documented as residing in rural places since these areas lack development and are rife with poverty, households that are headed by older heads because most elderly do not have financial means of livelihood, residence on Swazi Nation land whose land area is very little and does not allow for commercial farming but only for subsistence agriculture and female-headed household because most such households have resource constraints. .

The elderly are adults and as such are also entitled to participate in the political affairs of the country. Most

Swazi elderly are registered voters and take part in electing their new governments once every five years. However, a number of studies (Lukhele, 2009:21 and ULARN, 2003:online) have indicated that the elderly generally felt 'used' by aspiring Members of Parliament who gave the elderly false promises of having the interests of the elderly at heart. Once in Parliament, the Members of Parliament were mum about the situation of the elderly. This finding was also reported from a Uganda-based study (Najjumba-Mulindwa, 2003:online) and also documented by Ndlangamandla (2009a:9) in one of the local Swazi print media.

The plight of the elderly in Swaziland prompted the launching of two elderly-focused non-governmental organizations (NGOs) in 1988 and 2000, namely *Umtfunti weMaSwati* and *Philani MaSwati*, respectively. While the latter is more concerned with providing basic needs in life such as food and clothes, the former perceives its major role in the welfare of the elderly as that of protecting the elderly from any form of human violence especially elderly abuse (Vilakati, 2008:5). Though both NGOs are concerned with promoting the general welfare of the Swazi elderly, they both have severe resource constraints (Mamba, 2002:31). In order to provide the little they do to the elderly, the two NGOs depend, to a greater extent, on donations from the general local public as well as businesses, and philanthropists from outside the borders of Swaziland.

With reference to the impact of HIV and AIDS epidemic on the health care system in Swaziland, it was highlighted that approximately 50% (Nation, 2007:5) of bed occupancy in hospitals is by persons suffering from terminal illnesses

among which AIDS-related illnesses were included. As a result, of the wards being overcrowded by clients with chronic illnesses in hospital wards, many patients are referred to the home-based HIV/AIDS care programme (Uys and Cameron, 2003:5). However, it is noted that while this programme is said to be running in Swaziland, it has been reported as experiencing many operational challenges as evidenced the numbers of unsupported elderly persons who are involved as informal caregivers of adult children in their homes (Maziya, 2005:37).

In a Botswana-based study Motsa (1999:69) found among others that some of the elderly informal caregivers of adult children living with AIDS did not know the diagnoses of the adult children they were nursing and were also not using standard precautions. Lack of caregiver knowledge about standard precautions was also reported among Swazi elderly women who had contracted HIV infection while nursing chronically sick children (Mavuso, 2008:11).

An area of concern about elderly caregivers of minors is that in many instances, the HIV serum status of the orphaned children is not known and the elderly run the risk of contracting HIV infection from them because of lack of knowledge about the disease, its modes of transmission and other dynamics. The orphaned children are therefore potential, silent and innocent sources of HIV infection transmission to their grandparents. This assumption is supported by Nkambule (2007:186), who pointed out that rural elderly aged 50 years old and above, were likely to have lower comprehensive knowledge of HIV prevention and transmission.

It is worthwhile noting that up until now in the fight against the spread of HIV infection in Swaziland, programmers and activities have been mounted to empower the general public at large with HIV/AIDS-related knowledge, attitudes and skills but the elderly have been left out. Knodel and van Lantingham (2002:online) assumed that the elderly might have been left out from HIV/AIDS-related programmes because of the general perception that they a relatively 'low risk' population group unlike those in the childbearing age group who are still sexually active. It is documented that HIV infection is transmitted in many ways other than heterosexually (van Dyk, 2005:23-37). The elderly are also stakeholders in this deadly pandemic through their involvement of nursing adult children with chronic illnesses at home (Maziya, 2005:47) as well as bringing up AIDS-orphaned grandchildren (Matshalaga, 2004:10-40). They are at risk of contracting the deadly infection and therefore, in need of health-related information to empower them for their own protection and that of other household members.

According to McKenzie, Pinger and Kotecki, 1999:277), chronic conditions are systemic problems that persist longer than three months such as asthma, diabetes mellitus and joint pains. McEwen (2002:301) pointed out that as people age, they gradually develop more chronic health challenges. It would seem that regardless of the knowledge about the global phenomenon of population aging, including in sub-Saharan Africa (Velkoff and Kowal, 2007:1), few Swazi-based elderly-focused studies have been conducted to investigate the health-related needs of the elderly in Swaziland. Mabuza (2008) investigated the basic needs in general, of the elderly in the HHohho region of Swaziland while Dlamini (2001) explored the experiences of the

elderly who lived with their adult children in the peri-urban areas of Mbabane. Even though in both studies, the health aspect of the Swazi elderly was not the direct focus, the findings thereof indicated that the elderly had health challenges.

Studies that have investigated the elderly as a special population group internationally (Linsk and Mason, 2004:online ; Joslin and Harrison, 2002:621 ; Minkler, 2000:online) and in Swaziland (Mabuza, 2008:58 ; Maya, 2003:17 ; ULARN, 2003:online ; Mamba, 2002:18 ; Dlamini, 2001: 21-22) have revealed, based on their demographic data, that most of the elderly participants in their studies had chronic physical health challenges, such as: hypertension, arthritis, heart disease, diabetes mellitus and emphysema.

Through the Ministry of Health and Social Welfare, the Government of Swaziland is a co-signatory to the Declaration at the Alma Ata conference that was held in 1978 in Russia (Hattingh, Dreyer and Roos, 2006:60). The mission of this august Body was to guide member states in redressing the health inequalities among the various nations so that all citizens may access health services by 2000 (Ministry of Health Policy, 1983:7). The primary health care (PHC) strategy was to be used by member states to ensure that all citizens accessed health service, including even those in the remotest of remote areas. The World Health Organization (1988:15) defined PHC thus:

> Primary health care is an essential care based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community and through their full participation and at a cost that that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It

> forms an integral part both of the country's health system of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and the community with the national health system, bringing health care as close to the people as possible to wherever people live and work, and constitutes the first element of a continuing health care service

It is, however, noted and with sadness that despite adopting the PHC strategy by Swaziland, health services, especially for the elderly and those in rural areas, remain inaccessible, unavailable and unaffordable (ULARN, 2003:online). According to ULARN (2003:online) the elderly were made to pay for health services even though a new health policy to the effect that they should be treated free of charge had been announced. Though not out of personal choice, some of the elderly in the study by Dlamini (2001:21-22) resorted to consulting traditional healers since health services were more readily available, accessible and unaffordable to them. The services of the traditional healers were more readily available in the sense that the traditional healers lived in the very same localities as the elderly did and therefore there were no transport costs incurred. The services were accessible because of the traditional healers were receptive and attended to their needs. Lastly, the services were affordable because the elderly could pay the fees either in cash and upfront or in kind if they had no money. For instance the eldrly could bring a chicken as payment for consultation and when she/he got better bring yet another chicken or something else. Payment whether in cash or in kind could be done later. Therefore, by living within the community the traditional healers availed themselves and also made their service available by not being too cash

upfront oriented. Their services differed from those of the modern health care system.
Though the elderly have health challenges, Gachuhi and Kiemo (2005:36) made an observation that issues about aging and the elderly seem to be given a low priority in Africa. Mabuza (2008:8) also made a similar observation through her study that investigated the basic needs of the elderly in the Hhohho region of Swaziland.

1.4 STATEMENT OF THE PROBLEM

Ever since the HIV and AIDS epidemic started taking its toll on the Swazi people, especially the adult population, in the late 1990s, the elderly in most families have been at the forefront of looking after AIDS-orphaned children. The developmental stage of old adulthood, among others, is characterized by declining health such as cardiac diseases, arthritis, hypertension, impaired vision, hearing and mobility (Hatting, Dreyer and Roos, 2006:235).

The Government of Swaziland through Ministry of Health and Social Welfare adopted the PHC strategy in order ensure health for all citizens across the life span, including those who live in the remotest of remote areas (Ministry of Health Policy 1983:7). The majority of the elderly are domiciled in rural areas where the typical traditional Swazi home exists. However, not all citizens have access to health services. Health for all remains mostly a slogan at the same time as it is a big challenge for the Ministry of Health and Social Welfare in Swaziland owing to the fact that health services remain, to a greater extent, unavailable, inaccessible and unaffordable (ULARN, 2003:online), particularly to the poor and elderly of which the rural–based elderly are one such affected population group. Inability to access health services by all members

of the society, including the elderly, negates the very essence and philosophy of PHC and the objective of the Ministry of Health and Social Welfare (Ministry of Health Policy, 1983:1).

Through working with undergraduate nursing students in rural Swaziland, in particular the constituency of *Sithobela*, the researcher, who is a family health nurse clinician, became aware of and concerned about the unsatisfactory health status of the elderly. From observing the rural families that were being affected by the HIV/AIDS epidemic which continues to kill the adult population, the situation of the elderly has been deteriorating because they have to take on the burden of raising their HIV/AIDS orphaned grandchildren and also because they were loosing their means of financial and emotional support through the deaths of their adult children. The researcher, therefore, felt that if she studied this situation she might be able to find a way to improve, the general health aspect of the elderly, in particular, those rural-based grandparents who were looking after GOTHA.

Nursing, especially, community health nursing is a practice discipline that exists to provide nursing care to population groups or families and individuals outside the hospital environment (Dreyer, King and Swanepoel, 1999:5). The dearth of information, with regards to the phenomenon under study, namely R-BGs raising GOTHA, with special consideration to the plight of the Swazi elderly and rural areas generally being underserved with health facilities and services, represented an important gap in the knowledge and practice base of community health nursing in Swaziland, hence the need to embark on study of this nature.

1.5 PURPOSE OF THE STUDY

According to Brink (2003:67) the purpose of a study is a concise clear statement of the specific goal or aim in studying the problem. The goal may be to identify, describe, and explain or to predict something related to the solution of the problem.

Therefore, the purpose of this study, primarily, was to

- explore and describe the lived experiences of R-BGs raising GOTHA in the Chiefdom of *Nkonjwa* within the Sithobela *inkhundla* (constituency) in the lowveld.

Based on the findings from the analyzed data, a second purpose of this study was to

- formulate a strategy to address the central finding. The findings from the data revealed that the R-BGs raising GOTHA had health challenges and also lacked self-care. Therefore, in view of this central finding, the strategy that was identified as most appropriate nursing intervention was to develop a health education programme that shall be used by community health nurses to empower R-BGs raising GOTHA in the lowveld.

1.6 SIGNIFICANCE OF THE STUDY

Health-related needs for the elderly in Swaziland remain obscure and a cause for concern particularly in light of the HIV and AIDS epidemic and the AIDS orphan crisis that has forced them into new social role as full time primary caregivers of minors. Literature abounds with data to the effect that with aging, there are many health-related

changes that take place in the human body. While the elderly generally suffer the consequences of declining physical health, very little has been done to either address or redress that situation.

Health is an asset and needs to be promoted across the life span; however, it has been observed that Ministry of Health and Social Welfare focuses more on the younger population groups to the exclusion of the elderly. For instance, there are health promotion programmes for the under five year olds, school going population, adolescents, youth and expectant women but none are in place for the elderly. This is in spite of Kaseke's (1998:43) findings about the situation of the elderly in Swaziland and the recommendation that the Ministry of Health and Social Welfare needed to formulate a strategy to address the situation, including the health needs, of the elderly.

The researcher was interested in the rural area primarily because the Swazi population is predominantly rural-based as evidenced by 79% of the total population (Population and Housing Brochure, 2007) that is resident on Swazi nation land. The majority of the rural-based population is comprises elderly persons (Musi, 2006:online) it is where the traditional family home is located (Women and the Law Southern Africa, 1998:27). While the PHC strategy that the Ministry of Health and Social Welfare long adopted (Ministry of Health Policy 1983:1) advocates health for all and all for health, it is noted that rural areas continue to be underserved with health services and this is in direct contrast to the PHC strategy whose mission is to:

> … bring health services as close to the people as possible to wherever people live and work, and constitutes the first element of a continuing health care service.

Therefore, through this study that is qualitative, exploratory, descriptive and contextual, and the thick descriptions (Leedy and Ormrod, 2005:154) the study is very significance. Primarily, the phenomenon, namely rural-based grandparents raising GOTHA shall be understood in light of the HIV and AIDS epidemic and its effects on the health of the elderly. The findings shall lend support to policy-makers as they formulate among others pro-active policies for the elderly and families. The study findings shall have implications among others on the four faculties of nursing namely, nursing practice, education, management and research.

1.7 CLARIFICATION OF CONCEPTS

In this sub-section, the following selected relevant concepts to the study are clarified.

1.7.1 Adult child

Most parents in the African culture tend to refer to their grown up/mature sons and daughters, regardless of age and gender, still as their children (*bantfwana*). The adult child in question could be a 70 year old with own grandchildren but still being referred to by my child (umntfwanami) by her/his 90 year-old mother. Therefore an adult child is a mature adult and biological offspring of the elderly person. It is NOT an adult with child-like mentality.

1.7.2 HIV/AIDS

While the two abbreviations stand for human immunodeficiency virus (HIV) and acquired immune deficiency virus syndrome (AIDS), the former the virus that when contracted and the infected person does not take proper

care of her/him self, the infection progresses until the infected individual develops AIDS-related illnesses and becomes known as having full blown AIDS and thereafter she/he dies (van Dyk, 2005:3).

According to United Nations Population Development Programme Swaziland (2008:37) the HIV infection prevalence rate in Swaziland is still unacceptably high, namely 39.2%. The age group that is mostly infected by HIV is the 15 – through 49 years age group (Ministry of Health and Social Welfare, 2006:21). As a result of the increase in the acquisition of HIV infection and deaths from AIDS-related illnesses of the Swazi adult population, many children have become orphaned and left under the care of the extended family. However, it is noted that the extended are no longer as effective as in the past since the people who make up these social units are the very ones who mostly are dying through AIDS leaving the elderly on their own. Many grandparents who are looking after GOTHA have severe resource constraints.

1.7.3 Empowerment

According Delaune and Ladner (2006:3) empower refers to a process of enabling others to do for themselves. Health education (Delaune and Ladner, 2006:194) is a major tool used by all nurses for empowering clients. The proposed health education programme shall be used by programme implementers to empower with self-care R-BGs raising GOTHA so that they may enjoy optimum levels of health and functioning.

1.7.4 Grandchild

The Longman Dictionary of Contemporary English (1995:621) defined a grandchild as a son's or daughter's child. In addition to the definition, this child must not have celebrated her or his 18th birthday. At 18, it is taken that a human being is capable of self-sustaining.

1.7.5 Grandparent

In this study, a grandparent refers to either a male or female aged 60 years and above. This is the age of retirement from public service in Swaziland and usually denotes one has disengaged from being economically productive. The grandparent must be the biological parent to the parent(s) of the orphaned grandchild/grandchildren being cared for.

1.7.6 Grandparenting

Parenting was defined by the Longman Dictionary of Contemporary English (1995:1028) as the skill or activity of looking after children by a parent. In this study, grandparenting shall refer to an older adult who is a grandparent and aged from 60 years and above and bringing up grandchildren whose parents have died through HIV/AIDS.

1.7.7 Health education programme

According to Dennill, King and Swanepoel (1999:150), a health education programmes is a planned opportunity for people to learn about health and thereafter undertake voluntarily to change in their behaviours with regard to their health. Magagula, (2002:18) pointed out that appropriate health education increases knowledge and self understanding about the aging process, helps the elderly to discover and develop their capacities and thus enhance value of their potential contributions to society.

1.7.8 Rural-based

To be rural-based refers to being located or domiciled in a non-urban setting such as the countryside. According to Clark (2008:717) rural areas are more sparsely populated than urban areas. In Swaziland, rural areas are generally referred to Swazi Nation Land that is administered by chiefs on behalf of the *Ingwenyama* [The Lion] His Majesty The King. That is where the majority of the Swazi people live, including the elderly (Musi, 2006:online). According to Thomas (2007:16) rural areas are not the same as urban ones and therefore life experiences also different.

1.7.9 Lived experiences

The Longman Dictionary of Contemporary English (1995:474) defined experiences are events or occurrences that leave an impression on someone. According to Burns and Grove (2005:56) phenomena occur only when there is a person who experiences the phenomenon that she/he describes and not studied by the researcher. Therefore, in the present study lived experiences are those experiences that are described by R-BGs raising GOTHA in the lowveld.

The lived experiences may be positive, neutral and/or negative such as joy, indifference and/or sadness. In the present study, the lived experiences and strategies of coping of the R-BGs raising GOTHA shall include anything and everything they describe as their day-to-day encounters of caring for their orphaned grandchildren.

1.7.10 Orphan

The Longman Dictionary of Contemporary English (1995:1001) defined an orphan as a minor aged from birth through 17 years and has lost both parents. In the present study, orphan was taken to refer to a minor who had lost either

one or both parents. This is because in Swaziland, most of the time, Swazi women bring up children single-handedly. When these women die, as is currently happening due to HIV and AIDS-related illnesses, that child will have lost the only biological parent she/he ever had and knew. The father of the orphan may be genuinely dead, or not be known of his whereabouts or be irresponsible and have denied paternity, as often does happen.

1.7.11 Propose

To propose is to plan or intend to do something (Random House Webster Dictionary, 1993:530). The self-care health education programme is being proposed to the M Ministry of Health and Social Welfare by the researcher based on the study findings. The proposed health education programme seeks to empower with self-care R-BGs raising GOTHA in the lowveld of Swaziland.

1.7.12 Self-care

Self-care is a construct that was defined as the performance or practice of activities that individuals initiates and perform on their own behalf to maintain life, health and wellbeing (Foster and Bennett, 2002:127). The proposed health education programme is intended to empower with self-care R-BGs raising GOTHA through imparting knowledge, attitudes and skills to them. Having self-care shall help to promote optimum health and level of functioning among the R-BGs raising GOTHA.

1.8 OVERVIEW OF RESEARCH DESIGN AND METHODS

Research design refers to the structured framework of how the researcher wishes to carry out the research process in order to solve the research problem (Babbie and Mouton, 2005:647). While this section only presents an overview of

the research design and methods that were utilized in this research, more details about this section are given in chapter two.

1.8.1 Research design

The design of this study was qualitative, exploratory, descriptive and contextual in order to understand the phenomenon of R-BGs raising GOTHA in the Chiefdom of *Nkonjwa* at Sithobela *Inkhundla* (constituency) in the lowveld. According to Burns and Grove (2005:734), design refers to the blueprint for conducting a study that maximizes control over factors that integer with the validity of the findings. However, this study was qualitative as it sought to understand the phenomenon under investigation from an emic perspective (Babbie and Mouton, 2005:53). Qualitative studies are generally, descriptive, exploratory, descriptive and contextual in nature.

1.8.1.1 Qualitative

According to Creswell (1998:15) qualitative research is an inquiry process for understanding based on distinct methodological traditions of inquiry that explore a social or human problem. The researcher built a complex, holistic picture, analyzed words, had thick descriptions (Babbie and Mouton, 2005:277) of the R-BGs of raising GOTHA and conducted the study in a natural setting, namely the homesteads of the R-BGs.

1.8.1.2 Exploratory

According to Silverman (2001:9) an exploratory study is carried out when one knows relatively little about the subject under investigation. There was no research that had been carried out to investigate this phenomenon before this study. Typical exploratory investigations have small

samples as they seek insight and understanding of the phenomenon of interest to the researcher (Polit and Beck, 2004:718). By using the exploratory design in this study, the researcher wished to have *versternung* (Babbie and Mouton, 2005:30-32) about R-GBs raising GOTHA in the lowveld.

1.8.1.3 Descriptive

The objective of descriptive research is to accurately portray persons or situations as they present themselves (Polit and Beck, 2004:716). Therefore utilizing the desriptive design enabled the researcher to capture the various situations of the R-BGs raising GOTHA and describe them so as to bring out the contexts.

1.8.1.4 Contextual

This research was contextual was in that the researcher sought to understand R-BGs raising GOTHA within the concrete natural milieu or context within which they occurred. (Babbie and Mouton, 2005:272). Therefore, this study was carried out in a rural-based area in the lowveld so as to enable the researcher to understand the lived experiences of R-BGs raising GOTHA.

1.8.2 Research methods

Research methods, were described by Silverman (2001:89), as techniques that take on a specific meaning according to the methodology in which they are utilized. For this study, the following techniques of data collection were utilized: unstructured individual interviewing (Brink, 2006:151 - 153), field notes (Polit and Beck, 2004:382 - 383), health records of the R-BGs and photographs.

1.8.2.1 Phase One: Exploration of the lived experiences of rural-based grandparents raising grandchildren orphaned through HIV/AIDS

According to Burns and Grove (2005:55), phenomenological studies seek to describe experiences or phenomenon as they are lived which in phenomenological terms is generally referred to as the 'lived experiences' of study participants. Therefore, THE FOCUS OF PHASE ONE WAS TO COLLECT THE data primarily through face-to-face in-depth interviews with R-BGs raising GOTHA in the lowveld in their homesteads. Some of the analytical strategies the researcher used during this phase were: phenomenological bracketing, critical thinking (analysis, interpretation, synthesis and inferring, reflecting and intuiting).

1.8.2.1(a) Population of the study

The population of a study refers to a complete set of persons or object that possess some common characteristic that is of interest to the researcher (Brink, 2003:213). However, the researcher does not investigate the entire population but selects a fraction from it. The population of the present study comprised R-BGs raising GOTHA in the lowveld.

1.8.2.1(b) Sampling and sample type

Brink (2003:133) defined sampling as the process of selecting a fraction of a population in order to obtain data regarding the phenomenon of interest, in a way that represents the population of interest. This study used non probability sampling. According to Burns and Grove (2005:744) when using this type of sampling, not every element of the population has the opportunity for selection in the sample. The purpose of the study was not to generalize the findings but to gain insight and

understanding. Hence using non probability sampling approach.

The type of sample was purposive. Purposive sampling, also known as judgmental or theoretical sampling (Creswell, 1998:62) was used as it allowed the researcher to select those R-BGs who possessed the experiences of raising GOTHA and also met the criteria for inclusion (Polit and Beck, 2004:74 – 75) into the study.

1.8.2.1(c) Unit of analysis

According to Babbie and Mouton (2005:648) a unit of analysis refers to the 'what' or 'who' is being studied and in social sciences, individuals are the ones most commonly studied. The R-BGs who met the researcher developed criteria for inclusion into the study were recruited.

1.8.2.1(d) Inclusion criteria

In order to be eligible for inclusion into the study, the R-BGs needed to fulfill the set inclusion criteria (Burns and Grove, 2005:343). Some of the criteria were that the R-BGs raising GOTHA had to be :

- aged 60 years and above.
- live with those children on a full time basis.
- be biological parents of the parents of those children.

1.8.2.1(e) Exploratory interview

Prior to collecting the data for the main study, an exploratory interview (Kumar (2005:10) was conducted. The purpose of this interview was to ascertain whether the researcher designed research questions were clear and also could be easily understood. This interview was carried out in the same research setting as the main study was later carried out.

1.8.2.1(f) Data collection

Leedy and Ormrod (2005:143) highlighted that the qualitative researcher uses multiple forms of data in a single study. In this study, face-to-face individual in-depth interviews were used to evoke the day-to-day subjective realities of the R-BGs raising GOTHA in the lowveld. Also, field notes (Polit and Beck, 2004:382) were utilized. The researcher also made use of the health records that she found with the R-BGs. Owing to the naturalistic nature of the study, the researcher also took photographs of scenery that was interesting and/or relevant to the study.

Data collection was guided by the following two questions:

1. "***Ngicela ungichazele kabanti kutsi engabe kunjani [kunakekela batukulu bako labashiywa batali babo*"** ['Kindly describe for me what/how it is like caring for your AIDS-orphaned grandchildren?"] and

2. **"*Ukhona njani kumelana netidzingo tonkhe telabatukulu bako?*"** ["How do you manage to look after your AIDS-orphaned grandchildren?")

A more detailed description of the process of data collection is given in chapter two.

The researcher let the R-BGs speak as much as they could on the subject and for as long as they could. Utilizing therapeutic communication techniques such as nodding in acknowledgement of what the R-BGs were saying, use of silence to allow each R-BG to process her/his information prior to speaking and also seeking clarification of their descriptions. In order to increase the details of the explorations, the probing technique was used (Brink, 2006:152). The researcher terminated data collection when she experienced that no new information was coming forth

and the R-BG was repeating what she/he had said in the beginning.

1.8.2.1(g) Data analysis

Data analysis in qualitative research is not a separate entity but starts already with the completion of the first interview (Silverman, 2000:121) and is an ongoing phenomenon. The data were analyzed manually as the researcher desired to immerse herself in them.

Prior to analyzing the data, they were transcribed verbatim in the siSwati language and then translated into English. The translations were checked by a linguist. Open coding was used to analyze the data. The method of Tesch (1990:93) which has eight steps for data analysis was utilized to analyze the collected data whence the categories emanated.

1.8.2.1(h) Literature control

The researcher collected the data first and then analyzed before conducting a literature control (Burns and Grove, 2005:95) as is expected of qualitative research as is expected of qualitative data analysis. . Literature control helped to compare with other studies that had been carried out before.

As has already been alluded to, chapter two shall give greater details of the research design and methodology.

1.8.3 Phase Two: A description of the development of the conceptual framework

Based on the findings in phase one, phase two sought to describe the conceptual framework that guided the development of the health education programme to empower with self-care R-BGs raising GOTHA. The conceptual

framework emanated through inductive reasoning from the findings in phase one.

1.8.4(a) Phase Three(a): A description of the health education programme structure

Phase three was divided into two parts. Primarily and guided by boh the category of COMPROMISED HEALTH and the developed conceptual framework, phase three (a), focused on describing the structure and components of the proposed health education programme to empower with self-care R-BGs raising GOTHA. The structure of something refers to how its parts are connected together or organized (Oxford Advanced Learner's Dictionary, 2000:1189). Therefore, this sub-phase focused on how the proposed health education programme was organized.

1.8.4(b) Phase Three(b): A description of the process for implementing the health education programme

Phase three (b) was concerned with describing the two sets of guidelines, namely, culture and teaching-learning process related-guidelines that were formulated to help facilitate the implementation of the programme by the community health nurses as they are the designated programme implementers. Guidelines are rules or standards that one can use in order to execute particularly something challenging (Oxford Advanced Learner's Dictionary, 2000:528). Macionis (2008:60) defined culture was defined as ways of thinking, ways of acting and the material objects. According to Banks (2000:online), teaching-learning process is a planned interaction that promotes behavioural change that is not a result of maturation or coincidence.

Both the afore-mentioned factors have implications on the developed health education programme.

1.8.5 Phase Four: A description of the evaluation of the health education programme

Phase four marked the final phase and was concerned with programme evaluation by selected stakeholders. Evaluation was still part of programme development. An evaluation instrument was developed by the researcher and assessed for its adequacy by programme evaluators from one local monitoring and evaluating unit.

1.9 Trustworthiness

Trustworthiness is a concept that denotes good qualitative research as far as its objectivity in concerned. (Babbie and Mouton, 2005:276-278). The four strategies of: confirmability, credibility, dependability and transferability were applied to the present study to ensure scientific rigour. While credibility deals with truthfulness of the data, confirmabilty is similar to objectivity, dependability refers to consistency and stability of the data and transferability is concerned with the extent to which the findings may be transferred to other settings (Polit and Beck, 2004:36).

1.10 Ethical considerations

All research has ethical implications (Brink, 2006:30). Few examples of ethical issues in this study were: permission to be obtained from relevant ethical authorities (Brink, 2003:46), self-determination (Polit and Beck, 2004:732), informed consent (Burns and Grove, 2005:739) and non-maleficence (Pera and van Tonder, 2004:23)

Kvale (1996:116) pointed out that conducting research requires honesty on the part of the researcher. She/he should acknowledge her/his limitations and strengths. In this study, the researcher avoid at all costs dishonesty, by among others, not manipulating any data and acknowledging references from their authors.

1.11 ARRANGEMENT OF CHAPTERS

The study had altogether seven chapters. While the first three chapters formed phase one, the remaining four chapters formed phases two (chapter two), phase three (a) (chapter five) and phase three (b) (chapter six) and phase four (chapter seven).

Phase One

Chapter One	Introduction and problem statement.
Chapter Two	Description of the research design and methodology.
Chapter Three	Presentation and discussion of the findings and literature control. This chapter marked the end of phase one.

Phase Two

Chapter Four	Description of the development of the conceptual framework that guided the development of the proposed health education programme.

Phase Three(a)

Chapter Five	Description of the structure of the proposed health education programme to empower with self-care R-BGs raising GOTHA in the lowveld.

Phase Three(b)

Chapter Six	Description of the process of the

	proposed health education programme.

Phase Four

Chapter Seven	A description of the process of evaluating the proposed and feedback from stakeholders who evaluated the programme.Phase ofur marked the final phase of the research project as well as the development of the proposed health education programme.

1.12 CHAPTER SUMMARY

This chapter marked the beginning of phase one of the entire development of this study and the subsequent proposed health education programme. After a brief introduction, the chapter presented a description of the research setting as the study was implemented outside the Republic of South Africa, The background information to the study was discussed and problem statement documented. The purpose of the study was given after which the significance of the findings thereof was outlined. Selected relevant concepts were defined and clarified. An overview of the study design and chosen methods were described and their full details are presented in the next chapter, namely, chapter two. The chapter ended with a summary.

The next chapter is continuation of phase one and focuses on the design and methodology of the study.

CHAPTER TWO

DESCRIPTION OF THE DESIGN AND METHODOLOGY OF THE STUDY

Sitz im Leben - Enter the life world. (Stumpf, 1993:498)

2.1 INTRODUCTION

As this study sought, primarily, to describe the day-to-day personal realities of R-BGs raising GOTHA in the lowveld, chapter two now seeks to describe its design and methodology. According to Babbie and Mouton (2005:75) and Leedy and Ormrod (2005:12), the methodology of any research generally refers to the process or approach, kind of tools and procedures that are utilized to investigate the phenomenon of interest to the researcher. The study design is presented next.

2.2 RESEARCH DESIGN

According to Burns and Grove (2005:211) the design of a study is the end result of a series of decisions made by the researcher concerning how the study will be implemented. Babbie and Mouton (2005:74) pointed out that the design of a research reflects the plan or blueprint for

carrying out scientific inquiry. Therefore, in the present study, a research design that was qualitative, exploratory, descriptive and contextual was chosen to investigate the day-to-day subjective realities of R-BGs raising GOTHA in the Chiefdom of *Nkonjwa* at Sithobela *inkhundla* (constituency).

2.2.1 Qualitative

Though broad methodological approaches and commonly used in social research (Babbie and Mouton, 2005:270) the qualitative approach is relatively new in nursing research (Uys and Basson, 2000:51). Qualitatively designed research was chosen for this study because it was very important to gain insight and understand the day-to-day personal realities of the R-BGs raising GOTHA using flexible research methods (Polit and Beck, 2004:729) among which unstructured in-depth interviewing was one of them.

In particular for this qualitative study, the descriptive phenomenological tradition (Creswell, 1998:27-39) was chosen to investigate the R-BGs raising GOTHA in the lowveld because subjectivity (the day-to-day hassles of looking after such children) could be studied objectively by means of phenomenological bracketing (Creswell, 1998:52)by the researcher. Therefore, utilizing the descriptive phenomenological tradition enabled the researcher to *sitz im Leben* (enter the life world or/field of perception) of R-BGs raising GOTHA (Stumpf, 1993:498 ; Fouche and Delport, 2002:273) in the lowveld and perceive how they experienced caring for such children on a daily basis, and also make what sense these R-BGs made out of the encountered interactions with their GOTHA, and lastly, how these experiences were displayed by the R-BGs themselves (Creswell, 1998:51).

2.2.2 Exploratory

The Longman Dictionary of Contemporary English (1995:477) defined to explore as travelling through or examining an area in order to discover it. Exploratory studies help to break new ground and thereby discover new facts that assist in yielding novel insights about the phenonmenon under study (Babbie and Mouton, 2005:80). Even though the HIV/AIDS epidemic started taking its toll on the Swazi adult population in the late 1990s and the elderly absorbing GOTHA, very little was known scientifically prior to this study about the day-to-day encounters of, especially the grandparents who were raising GOTHA. Therefore, an exploratory research design was considered an appropriate study design to use.

2.2.3 Descriptive

According to Brink (2003:11), the purpose of descriptive research is to obtain complete and accurate information about a phenomenon under study through observing, describing and classifying it and thus provides novel information about that phenomenon. In the present study, the researcher made observational notes about the R-BGs and the research environment. The researcher first observed and finally documented these as soon as possible after observing (Polit and Beck, 2004:192).

2.2.4 Contextual

Qualitative studies are contextual in that what is being investigated needs to be explained and understood within a certain concrete environment (Babbie and Mouton, 2005:272 ; Creswell, 1998:61). The context of a phenomenon takes into account those circumstances that form its setting and in

terms of which it can be understood and assessed (The Websters Illusrative Encyclopedic Dictionary, 1990:379).

Unlike quantitative studies that investigate variables and relationships thereof in isolation from the context or setting, the present qualitative inquiry took into account various contexts that included among others: the geographical area, social welfare of the families, culture, economic standing of the families, physical appearance of the R-BGs raising GOTHA and physical settings of the homesteads, body language and voice tones of the R-BGs raising GOTHA (Richards, 2006:51).

According to Kamal (2008:18) the population of the entire Sithobela is approximately 50,000 people. This constituency is made up of three chiefdoms called Nkonjwa, *Mamisa* and *Luhlanyeni*. Out of the three, *Nkonjwa* was the smallest in terms of area and population.

The lowveld had been subjected to drought for a number of years. Prior to the state of chronic drought in the lowveld, the majority of the families in Sithobela including the rest of the lowveld, were relatively self sufficient nutritionally and survived, to a greater extent, through subsistence farming and also rearing cattle (Zwane, 2003:166).

Figure 2.1 Soil erosion. Part of the landscape in the drought-stricken Chiefdom of *Nkonjw*a in the lowveld. Photo taken by the researcher.

In addition, some of the families cultivated cotton on a small scale for commercial purposes. However, with diminished rainfall, harvests became poorer and extremely scarce the point food insecurity is prevalent up to this day. Many families are unable to sustain themselves nutritionally. Therefore, they rely on on food relief from non-governemntal organisations, such as the Disaster Task Force World Food Programme and World Vision International.

Economically, the lowveld lacks development and has not been able to offer employment opportunities to its adult popualtion and consequently the majority of the this population group survive, to a greater extent, on internal and/or external migrant working. While some of these adult population migrate to either local industrial towns such as Simunye and urban settings such as towns and the capital City of Mbabane, others cross the borders to go and work in

the mines in the Republic of South Africa (Whiteside, Ngcobo, Tomlinson and Hickey, 2003:21).

The majority of migrant workers usually leave behind their wives, children, and parents but support them through remittances. The migrant workers visit their families as and when they can. While on the one hand, migrant working has has been praised for its positive inputs into the lives of affected indigenous families, on the other hand, it has been blamed for the spread of HIV/AIDS (Whiteside et al. 2003:21). The long separation of spouses is thought to have contributed toward separated spouses finding other partners with whom to sicialize and have intimate relationships.

2.3 ANALYTICAL STRATEGIES

These are the various critical and intellectual ways of interacting with the data. The predominant strategies that were utilized by the researcher to interact with the data in all the four phases of the project development, namely, the study and proposed health education programme are outlined below and also displayed in a summary form in table 2.1.

2.3.1 Critical thinking

Research requires critical thinking. According to Schafersman (1991:online) critical thinking refers to the ability to think for one's self and reliably and responsibly make those decisions that affect one's life. In the present study and utilizing the core of critical thinking, namely, analyzing, interpretation, self-regulation, evaluating, explaining and inferring (Facione, 2009:online), the researcher was able to interact with all the data, from the beginning, namely, data collection through evaluation of the proposed health education programme to empower with self-care R-BGs raising GOTHA.

2.3.1.1 Analyzing

It is the process of breaking down concepts into simple parts so that its logical structure can be displayed (Blackburn, 2005:13). In the present study, analysis was primarily used in phase one which was the phenomenological part of this project in order to study the various pieces of data that had been collected by the researcher from the many data sources. The process of breaking down the data into their smallest components, helped to identify, first, the themes and then categories from the data. Breaking down the data into their smallest units also helped to make sense about the feedback from the various stakeholders about the developed health education programme.

2.3.1.2 Interpreting

To interpret refers to understanding something in a particular way (Random House Webster Dictionary (1993:348). After analyzing the collected data, the researcher was able to interpret the lived experiences of the R-BGs in the way she thought she had understood them. Validating these interpretations was done with the R-BGs themselves.

2.3.1.3 Self-regulation

This concept refers to fulfilling what is laid down by oneself without interference from external bodies (Oxford Learner's Dictionary, 2000:987). In the context of this study, the researcher exerted self-regulation by maintaining the position of neutrality as required of the research method of phenomenological bracketing and also by adhering to the prescribed ethical standards in research. Self-regulation helped to enhance trustworthiness of the study.

2.3.1.4 Evaluating

Though Suvedi (2005:online) pointed out that there was no widely agreed upon definition of evaluation, it is a process of determining the value of something (Oxford Learner's Dictionary,2000:396). Within the context of the nursing process, evaluating was described by (Reeves and Paul in George 2004:34-35) as the most challenging aspect of the nursing process because it requires a lot of measurements that will assist in making clinical judgement. The researcher used the strategy of evaluating among others when she developed the conceptual framework and programme and evaluating instrument.

2.3.1.5 Explaining

Is the process of telling someone why you did something in the manner you did what you did (Longman Dictionary of Contemporary English, 1995:477). The researcher explained the components of the conceptual framework and the structure and content of the proposed health education programme.

2.3.1.6 Inferring

According to the Oxford Advanced Learner's Dictionary (2000:613), to infer is to reach an opinion that something is true based on the evidence that is available. For instance, based on the findings from the data, the researcher made a decision to develop the health education programme to empower with self-care the R-BGs raising GOTHA, in order to address their health challenges and self-care deficit.

2.3.2 Synthesizing

Refers to the process of combining things or ideas after analyzing them in order to come up with a new coherent

whole (Longman Dictionary of Contemporary English, 1995:1462). The researcher first collected the data and analysed them. Thereafter, the findings from the data were synthesized. Synthesizing the findings culminated, among others, in the development of categories (Strauss and Corbin 1990:65-67), conceptual framework (Brink, 2003:206) as well as the content of the proposed health education programme for empowering with self-care R-BGs in the lowveld.

2.3.3 Reflexivity

According to Polit and Beck (2004:730), reflexivity refers to critical self-reflection about one's own biases, preferences and pre-conceptions. Since the qualitative researcher is considered as an extension of the data collection mechanism owing to the role she/he plays during data collection, reflexivity assisted the researcher to remain aware of herself throughout Phase 1 of the study (Polit and Beck, 2004;335). Self-reflection was achieved primarily through going back to the personal notes she documented after interviewing R-BGs raising GOTHA. The researcher also went through the pre-phenomenological bracketing notes that contained her feelings, opinions and attitudes about R-BGs raising GOTHA prior to interviewing them. This exercise helped to enhance trustworthiness.

2.3.4 Phenomenological bracketing

Also known as phenomenological epoche (Stump, 1993:495), it was defined as consciously blocking one's mind from any pre-conceptions (Blackburn, 2005:46). The researcher implemented it in order to enable herself to perceive the day-to-day realities of R-BGs raising GOTHA from their perspective (Leedy and Ormorod, 2005 pg 139).

In this study, phenomenological bracketing was applied before, during and after (refer to sub-sections 2.3.4.1, 2.3.4.2 and 2.3.4.3, below) interviewing the R-BGs raising GOTHA. Its application helped the researcher to be as objective as possible while collecting the subjective data from the participants. Remaining as objective as possible helped to enhance the credibility aspect of the data and thus also trustworthiness (Babbie and Mouton, 2005:274-275).

2.3.4.1 Prior to data collection

The researcher first documented all her personal feelings, perceptions and attitudes with regards to R-BGs raising GOTHA in the lowveld prior to going to interview them (Brink, 2006:113). The researcher’s feelings, opinions and attitudes could be negative, positive or a mixture of both. This was done so that the researcher would be able to differentiate between her own perceptions from those of the R-BGs raising GOTHA and thus remain neutral and true to the data.

2.3.4.2 During data collection

During the interviews, the researcher continued to block her own feelings, perceptions and attitudes about R-BGs raising GOTHA on order to remain in the R-BGs' frames of mind and be able to conceptualize their day-to-day encounters of looking after GOTHA.

2.3.4.3 Post data collection

Even after data collection, the researcher continued to block her mind whenever she read their transcripts and/or listened to their recorded interviews as part of ongoing data analysis. This was done in order to really perceive the lived experiences from the R-BGs' perspective (Tesch,

1990:93) rather than the researcher's perspective.

2.3.5 Intuiting

To intuit is the act of acquiring knowledge through insight devoid of conscious or logical reasoning (Burns and Grove, 2005:740). Some of the categories were generated through intuiting because of the researcher immersing herself in the data (Brink, 2003:120) until she understood what was happening in those data.

2.3.6 Inductive reasoning

This type of reasoning was defined as logical thinking that emanates from generalizing specific observations that have been made (Polit and Beck, 2004:12). From observing the specific situations of the various R-BGs raising GOTHA in the study, the researcher made a decision to do something about their compromised health states. The development of the proposed health education programme to empower with self-care R-BGs raising GOTHA in the lowveld, evolved through inductive reasoning.

2.3.7 Deductive reasoning

Brink (2003:208) defined deductive reasoning as a process of thinking whose direction is from general to specific. The proposed health education programme was, to a certain extent, also developed through deductive reasoning through realising the goal of the Ministry of Health in Swaziland, namely, health for all across the life span (Ministry of Health Policy, 1983:1) The goal takes into account that the elderly should enjoy good health and therefore a specific programme for the elderly was developed.

Deductive reasoning was also applied through integrating adult learning principles in the teaching/learning process

of the R-BGs raising GOTHA. According to Cornett (2004: online) older adults are considered as adults. Therefore, the principles of adult learning were also applicable to the health education programme.

2.3.8 Coding

According to Burns and Grove (2005:548) coding refers to categorizing data. A code is a symbol or abbreviation use to classify words or phrases in the data. Initial categories that are identified through coding are usually broad (Burns and Grove, 2005:548) and should not overlap.

In the present study and in line with qualitative data analysis principles, the coding of the data started as soon as possible after completion of each individual every interview with R-BGs raising GOTHA. Coding carried on until the final categories were developed. When utilizing descriptive phenomenology the researcher is encouraged researchers to use the very words that the participants use to describe their daily personal realities. Therefore, in this study, the researcher named some of the categories using the exact words that were said by the R-BGs raising GOTHA.

2.4 RESEARCH METHODS

According to Brink (2006:53) research methods are techniques that take on specific meaning according to the methodology in which they are used. Silverman (2000:88) pointed out that the researcher's choice of methods should reflect the overall research strategy since the methodology shapes which methods to use and how each method is used.

The methods or techniques that were predominantly involved in the present study were interviewing and field note

taking. To a lesser extent, photographs were also taken. Since the study was qualitatively designed, the researcher was also considered part of the data collection instrument and process (Tesch, 1990:70) owing to the required subjective process of reflecting, exploring, sifting and elucidating nature of everyday life experiences of the R-BGs (Kvale, 1996:147). Research methods that were utilized in this study are discussed below as part of phase one of the research development.

2.4.1 PHASE ONE: EXPLORING and DESCRIBING THE LIVED EXPERIENCES OF RURALBASED GRANDPARENTS RAISING GRANDCHILDREN ORPHANED THROUGH HIV/AIDS

Phase one which is also known as the phenomenological part of the study sought to gather as much data as possible from the R-BGs raising GOTHA in the Chiefdom of *Nkonjwa*. The data were gathered primarily through unstructured individual face-to-face interviews, field notes and to a lesser extent photographs that were randomly taken of interesting objects and scenery of the lowveld but not the R-BGs raising GOTHA.

During this phase and with the completion of each interview, the researcher started to analyze the data and compared the findings with one another (Strauss and Corbi, 21990:61). The researcher emerged herself in the data until she knew what was going on in those data. Categories (Strauss and Corbin, 1990:69) were developed. When all the data had been analyzed using the method of Tesch (1990:93) and categories had been developed and validated primarily with the R-BGs and then with the co-coders, literature control(Brink, 2003:197) was carried out in order to compare the findings with those of other related studies.

2.4.1.1 Population of the study

The population of any research refers to a complete set of persons or objects that possess some common characteristics of interest to the researcher (Brink, 2003:213). In the present study, the population comprised R-BGs who lived in the Chiefdom of *Nkonjwa* and looked after *tintsandzane* (children who have lost only one parent through AIDS) and/or *tingedzama* (children who have lost both parents, also through AIDS).

2.4.1.2 Sampling and sample type

Polit and Beck (2004:731) described sampling as a process of selecting a portion of the population to represent the entire population. However, the purpose of this study was not to generalize the findings but to gain insight and understanding about R-BGs raising GOTHA.

According to Silverman (2001:250) purposive sampling allows us to choose a case because it illustrates some features or process in which we are interested. The researcher was interested in exploring the lived experiences of the R-BGs raising GOTHA. Polit and Beck (2004:725) referred to a purposive sample as a handpicked sample or subset of the population of the study.

2.4.1.3 Unit of analysis

A unit of analysis (Babbie and Mouton, 2005:84) refers to a fraction of the population of a study. Unit of analysis is interchangeable with sample (Polit and Beck, 2004:308) of a study. The unit of analysis for the present study was facilitated through purposive sampling (Brink (2006:133). Purposive sampling refers to that only those R-BGs who had the experience of caring for GOTHA were exclusively chosen to be participants in the study. However, in order to be

selected into the study, the R-BGs had to meet the reseacher developed criteria that are listed in 2.4.1.3, below.

2.4.1.4 Inclusion criteria

Inclusion criteria were defined by Burns and Grove (2005:343) as those characteristics that a subject or element must possess to be part of the target population. In order to be eligible for inclusion in the present study, the R-BGs raising GOTHA in the Chiefdom of *Nkonjwa* had to:

- have celebrated their 60th birthday or be older.
- be the biological parent(s) of deceased adult child(ren) who died of HIV/AIDS.
- Be looking after one or several GOTHA who lived with them on a full time basis..
- be willing to particpate in the study.
- be able to articulate about their day-to-day personal realities of looking after their GOTHA.

2.4.1.5 Exploratory interview

An exploratory interview was undertaken prior to conducting the main study. It is usually carried out to help determining the feasibility of the study (Kumar, 2005:10). In the present study, an exploratory interview was carried out in order to refine the two open-ended research questions that were going to guide data collection from the R-BGs raising GOTHA. In particular, the exploratory interview sought to establish whether or not the two open-ended questions:

- were clear in terms of language, and
- could be understood by the R-BGs.

The exploratory interview was carried out in the Chiefdom

of *Nkonjwa* using a purposive sample of one R-BG (Grandmother Pilot) who was 60 years old, married and the predominant caregiver of five GOTHA from two deceased sons. The same way that were going to be used to identify and recruit the R-BGs in the main study was used to identify and recruit Grandmother P. All ethical considerations, as applied in the main study, were also taken into account for the exploratory interview exercise.
The purpose of the exploratory interview was achieved since both questions were clear and understood as evidenced by Grandmother P being able to respond to the questions at once without having to ask the researcher to repeat the questions. Therefore, with no further modification required, the two questions were ready for use to collect the data for the main study.

However, a latent function of the exploratory interview was observed to the effect that Grandmother P became emotionally affected at some point during the interview. Her voice tone altered and sounded as if she was choking, her eyes became pink and moist, and there was marked prolonged silence as she related her encounters of bringing up her GOTHA. Grandmother P had lost the second son, aged 35 years, through AIDS-related illnesses five months prior to the implementing of the exploratory interview. The son was a migrant worker and the sole breadwinner in the family. In a Swaziland based study, that was conducted Whiteside et al (2003:20 – 21) the one of the many findings was that the HIV/AIDS epidemic was responsible for the deaths of many Swazi migrant workers.
Upon completion of the exploratory interview, the researcher debriefed Grandmother P (Kwale, 1996:127). The rural health motivator was duly contacted and requested to keep watch over Grandmother P over a few days and refer her

to the Sithobela community mental health nursing team as deemed.

One day six months later while passing in that neighbourhood, the researcher made a brief social visit to the homestead of Grandmother P to check on how she was feeling post interview. She was found looking well and coping better with the losses of her two sons, though she continued to struggle with looking after her GOTHA. .

2.4.1.6 Data collection

According to Burns and Grove (2005:733) data collection involves the precise systematic gathering of information relevant to the research purpose, specific objectives or questions or hypotheses of a study. The data collection process for the present study is now discussed.

Richards (2006:42) pointed out that the data are generated collaboratively by both the researcher and the researched. Unlike quantitative research whereby data are collected at one point in time (Leedy and Ormrod, 2005:145) interviewing the R-BGs raising GOTHA was unique and flexible (Polit and Beck, 2004:332) since the researcher was in full time employment as well as pursuing the doctoral degree study programme. The only other time that was available to the researcher was during weekends and she chose to utilized Saturdays since most people use Sundays for spiritual purposes. Therefore, the researcher interviewed two R-BGs once every fortnight on a Saturday. While the first interview was scheduled for 9AM, the second one followed at 2PM.

2.4.1.6(a) Accessing the research setting

According to de Vos, Strydom, Fouche and Delport (2002:279) it is important to gain permission to enter the field that has been decided on. Therefore, the researcher approached *Umphakatsi* (Official residence of the Chief) at *Nkonjwa*in order to:

- inform this traditional office about the study.
- show them the letter from the Ministry of Health and Social Welfare giving permission to the researcher to conduct the study.
- ask for permission from this office to access the R-BGs raising GOTHA and collect the data from them.

Permission was granted and blessings given.

2.4.1.6(b) Road conditions

As most Swazi rural homesteads in the Chiefdom of *Nkonjwa*a were generally not built close together and also the challenging conditions of the gravel road networks, the researcher used a four wheel drive motor vehicle to access all the homesteads of the R-BGs in the study. Though not often, at times there just were no roads leading into the homesteads and other times the roads did not go the full way but ended in troughs as shown in figure 2.2. In such instances, the researcher and rural health motivator parked and locked the vehicle and continued on foot to those homesteads.

Figure 2.2 Road condition. An example of severe soil erosion that affected the road condition in the *Nkonjw* Chiefdom. Photo was taken by researcher.

2.4.1.6(c) Unexpected encounters

One afternoon after passing a particular spot in the path they were using the researcher and rural health motivator saw a snake (refer to figure 2.3) crossing where they had just walked past. The reptile was a young cobra. Owing to the hot weather, reptiles are common in the lowveld.

Figure 2.3 A reptile. A young cobra crossing a footpath. Photo taken by the researcher.

2.4.1.6(d) Identifying and recruiting the participants

Owing to the sensitive nature of HIV/AIDS and implicated ethics (D.Cruz, 2003: online), the researcher did not readily approach the R-BGs directly herself but requested the assistance of rural health motivators. According to Swaziland Rural Health Initiative (SRHI, 2000:4), rural health motivators are lay mature women who are appointed by their communities to help in community development through family health motivation and therefore an essential component of the Swaziland health care system. As they have been appointed, each rural health motivators undergoes a 12-week long training course in health-related matters. Upon successful completion of the course, each rural health motivator is assigned between 30 – 40 homesteads to look after. Owing to their vast knowledge about their communities in general, these lay caregivers were instrumental in identifying and recruiting for this study, the R-BGs raising GOTHA.

2.4.1.6(e) Approaching the homestead

As the researcher and rural health motivator approached the homestead of the R-BG raising GOTHA, they both shouted ***'Nibakhulu ekhaya'*** (a prescribed form of announcing one's presence when going to other people's homes) as per demonstration in figures 2.4 (a) and (b) below. The R-BG or other homestead occupants responded **''*Yebo*''** [Yes/I hear you] and the researcher and rural health motivator proceeded into the yard of the homestead.

(b) Front view

(b) Side view

Figure 2.4 When approaching a homestead. Side and front views showing the correct position when asking to be received in a visited homestead.

2.4.1.6(f) Accessing the participants

Effective recruitment of the participants is crucial to the success of the study (Burns and Grove, 2005:361). Six rural health motivators were requested to help with identifying those R-BGs who were raising GOTHA in the Chiefdom of *Nkonjwa* and met the criteria for inclusion into the study sample. It was brought to the attention of the researcher that there were two categories of orphans, namely those who had lost one parent (*tintsandzane)* and those who had lost both parents (*tingedzama*). Based on this information, the researcher asked each rural health motivator identify at

least two to three *boGogo* (grandmothers) and *boMkhulu* (grandfathers) who looked after any of these two categories of orphans.

Rural health motivators were requested by the researcher to first introduce the idea of this research to R-BGs who were looking after GOTHA. Once the R-BG felt comfortable with the idea and showed interest and willingness to be a participant, the researcher was then introduced to the R-BG raising during a planned initial home visit (Brink, 2006: 39). This initial visit also served the purpose of beginning to establish rapport with the R-BGs. Firstly, it served to help verify the inclusion sampling criteria. Secondly, it enabled the researcher to inform the prospective about the nature of the study and all relevant facts they needed to know. And understand. Thirdly, based on that information, the researcher expected to obtain the initial written informed consent from the R-BGs raising GOTHA. Burns and Grove (2005:361) emphasized that it is very important to give a detailed explanation about the study to the prospective participants so that they make an informed decision.

2.4.1.6(g) Establishment of rapport

According to the Oxford Advanced Learner's Dictionary (2000:965) rapport refers to a friendly relationship in which people understand each other well. Clark (2008:584) pointed out that clients need time to develop trust with the nurse before intimate issues can be discussed. Therefore, the first visit marked the initial attempts to establish rapport with the R-BGs raising GOTHA.

After the rural health motivators had introduced the researcher to the R-BG raising GOTHA and as part of getting

to be known, the researcher provided the R-BG with more information about herself. Such information included: researcher's place of birth, where she went to school, marital status, occupation, motivation behind carrying out a study of this nature and the choice of Nkonjwa chiefdom as the research setting. All this served to enlighten the R-BGs about the person of the researcher and also assist her/him in the decision-making process concerning whether or not to participate in the study.

No interviews were conducted on that first day of meeting, On average; each initial visit lasted approximately 30 – 50 minutes depending on how talkative the R-BGs were. In addition to the initial introductions, some time was also spent in social chatting as part of rapport building. Prior to departure from each homestead, a date for the first face-to-face interview was decided upon by mutual agreement (Brink, 2006:153) between the researcher and
R-BG raising GOTHA.

2.4.1.6(h) Setting for the Interviews

According to Brink (2006:153) and Leedy and Ormrod (2005:147) interviews may occur anywhere people can sit and talk in private. Except for two interviews that were conducted indoors, inside the sleeping huts of the R-BGs raising GOTHA on account of bad weather (some light drizzle and winds), the rest took place out doors. Only the researcher and R-BG raising GOTHA were present at the interview sessio. The interview was carried out with both of them sitting on a reed mat. The actual spots for holding the interviews were either at the edge of the homestead yard or under a tree in an adjacent field.

2.4.1.6(i) Mini audio-taping lessons

Once permission to use the audio-tape was granted by the R-BG raising GOTHA raising GOTHA, a quick demonstration of how to speak effectively into the microphone was given by the researcher to each R-BG that was interviewed. After the demonstration, the R-BG raising GOTHA returned the demonstration. The R-BGs raising GOTHA were quick to grasp the mini lessons and did well. They appeared as if they enjoyed talking into the microphone as evidenced by their facial expressions when the researcher played back the trial recordings to check on the recording quality. In an earlier study by Sithole (1998) the participants therein requested to keep the original recorded tapes so that every now and again they could listen to their own voices!

2.4.1.6{j) Interview method

Interviewing is a process of obtaining data in which the one seeking information (interviewer) asks questions and the one being asked (interviewee) answers those questions either in a face-to-face interaction or through the telephone (Brink, 2003:210). In this study audio-taped, individual face-to-face unstructured in-depth interviews were utilized to obtain the data from the R-BGs raising GOTHA in the lowveld.

Utitlizing the face-to-face interview method had a number of advantages among which some were that: it facilitated observations of any non-verbal behaviour of the R-BGs raising GOTHA by the researcher, there was a high response rate, it also took into account that the R-BGs raising could neither read nor write (Brink, 2003:153) and it afforded the R-BGs raising GOTHA privacy (Kvale, 1996:114) in light of the currrent HIV/AIDS epidemic and stigmatization (Kamal, 2008:37) in Swaziland.

Unlike using structured questions, utilizing the unstructured interview method did not give allowance for any preconceived ideations (Brink, 2006:149) and therefore helped to evoke as much of the subjective realities of R-BGs looking after GOTHA as possible (Brink, 2006:11) by allowing them to respond according to how they felt like as opposed to using structured questions (Polit and Beck, 2004:318).

According to Kvale (1996:147(it is important for the researcher to have competence in interviewing in order to obtain good and relevant data. The researcher conducted all the interviews in person based on the strength of having previously conducted research either as part of a research team (Sukati, Vilakati and Sithole, 2002) or independently (Sithole, 2000 ; Sithole, 1998 ; Sithole, 1993).

2.4.1.6(k) Actual interviewing

The interviews were conducted in *siSwati*, the R-BGs' natural language (De Vos, et al., 2002:81) which language Thwala (2009:21) also used to interview the participants in her study that followed the ethnographic tradition. The researcher started the interview with the following general open-ended request/question: ***''Ngicela ungichazele kabanti kutsi engabe kunjani kunakekela batukulu bako labashiywa batali babo"***['Kindly describe for me what/how it is like caring for your grandchildren who were left behind by their parents. "]

2.4.1.6(l) Role of the researcher

Phenomenological interviews are usually unstructured and very much like an informal conversations. While in an ordinary conversation people take turns to talk. in phenomenological research the researcher is expected to say

as little as possible in order to give the interviewee more opportunity so that she/he can be able to narrate her/her stories or desribes the sought after lived ecperiences that are under investigation (Leedy and Ormro, 2005:139).

2.4.1.6(m) Therapeutic communication

In order to maximize data collection, the researcher made use of a variety of therapeutic communication techniques, some of which were described in Potter and Perry (2005:459 – 462). Examples of some of the therapeutic communication skills/techniques that were implemented in the present study are depicted in table 2.1.

Table 2.1 Selection of therapeutic communication techniques.

Technique	**Application by the researcher**	**Justification**
Smiling	As and when deemed and with corners of her mouth and front teeth showing, the researcher addressed the R-BGs raising GOTHA	• To encourage rural-based grand-parents to be open and describe as much as possible about their personal realities of raising GOTHA.
Nodding	Time and again, the researcher lowered and raised her head gently while saying nothing or '*Ngiyabona Gogo*' [I see grandmother]	• To acknowledge the grandparents' narrations and thus encourage them to say more.
Use of silence	After asking each question, the researcher paused for long periods.	• To give the R-BGs raising GOTHA adequate time to organize their thoughts and speech before replying or continuing to talk. Older adults are generally slower in tempo and take their time in acting.

Making clarifica-tions	Time and again the researcher repeated some of the participants' statements, such as *"Grandmother is saying that she often skips her meals because there will not be any food in the house …"*	• To verify that the researcher had understood what has been said by R-BGs raising GOTHA.
Paraphrasing	The researcher also repeated what the grandparents had said but using her own words.	• To ensure that the researcher had heard and understood what the R-BGs raising GOTHA had said.
Summarizing	Upon completing each interview, the researcher outlined the main points of the descriptions of the R-BGs about their personal realities of looking after their GOTHA.	• To ensure that the researcher had heard and understood the R-BGs correctly about their day-to-day personal realities of bringing up GOTHA.

2.4.1.6(n) The probing technique

The probing technique (Rubin and Rubin, 2005:164) was utilized as deemed, such as when the R-BGs' responses were shallow, or the researcher did not quite understand what they were describing, for instance: ***"Ngicela ungichazisele kabanti kutsi kushokutsini ……*** ("May you kindly elaborate on what you mean by ….."); or the need for clarifying unclear sentences or phrases "***Kushokutsini Gogo/Mkhulu uma utsi …"*** ["What does it mean Grandmother/Grandfather when you say .."] and also to keep the conversation on topic ***''Ngiyabona Gogo/Mhukulu qubeka …''*** ["I see Grandmother/Grandfather, continue …). Other relatively neutral utterings are such as a simple ***''Hmm …"*** or **"Uhm"** **''Ohoo…"** were also said by the researcher.

Once the R-BGs raising GOTHA had exhausted their responses to the first question, the second one was asked, namely,

"Ukhona njani kumelana netidzingo tonkhe telabatukulu bakho*?"* ["How do you manage to look after your grandchildren?"]. The R-BGs raising GOTHA were left to respond to this question until there was no new information coming forth.

Polit and Beck (2004:335) highlighted that only one interview per day was adequate so that the researcher can have time to relax and refresh through for instance sport or exercise. However, for this study, the researcher interviewed two R-BGs raising GOTHA on a Saturday every fortnight because of distance and financial challenges experienced by the researcher. The researcher lived 140 km (one way) away from the research setting.

Kvale (1996:146) pointed out the following that there was no ideal interview, some people are harder to interview than others and therefore, it is up to the interviewer to motivate and facilitate the participants' accounts. While some of the R-BGs raising GHOTA were very talkative, others were more on the quiet side. The more senior ones were noted to be slightly more forgetful and therefore the researcher repeated the questions. When they digressed the researcher gently brought them back on track. According to Murray and Zentner (2001:795) being forgetful is part and parcel of aging.

2.4.1.6(o) Data redundancy

While the 12th R-BG raising GOTHA was being interviewed, the researcher began to sense a feeling of repetition of information fthat had been said by other previously interviewed R-BGs. By the time the 14th R-BG raising GOTHA was being interviewed the researcher decided that there was considerable data redundancy and this was indicative of

data saturation (Polit and Beck, 2004:308). This signified that the already collected data were adequate to give a picture (Burns and Grove, 2005:358) to answer the main resarch question about the nature of the day-to-day personal realities of R-BGs raising GOTHA in the Chiefdom of *Nkonjwa*.

2.4.1.6(p) Termination of interview

Toward the end of each interview, the researcher first summarized the main points (Kvale, 1996:128) raised in the interview by the R-BGs raising GOTHA. Prior to switching off the audio-tape, the reseacher thanked each R-BG raising GOTHA for taking the time to be interviewed and the information shared. The researcher also seized the opportunity to praised each R-BG for the their commitment and dedication in caring of their GOTHA. The audio-tape was then switched off.

As highlighted by Kwale (1996:128) each R-BG was given a debriefing session at the completion of the interview. Debriefing helped the R-BGs raising GOTHA to express the effects of the interview on them. As already mentioned, HIV/AIDS is a rather sensitive area to talk about in Swaziland. Debriefing is imperative in qualitative studies since their data collecting methods, such as in-depth interviews can be quite intrusive.

2.4.1.7 Health records

One data source that was added on while in the field were the health records of R-BGs raising GOTHA. These documents were presented to the researcher by the R-BGs raising GOTHA as evidence of the various conditions from which they suffered. Therefore, these health records became another source of data that would help substantiate the health of

the R-BGS raising GOTHA. The various conditions from which hey suffered are presented in the next chapter as part of the demographic data description and also as part of their verbatim quotations to support, in particular, the category COMPROMISED HEALTH.

2.4.1.8 Field notes

Field notes (Richards, 2006:58) are imperative in qualitatively designed research since according to Gray (2004:326) such notes remain the mainstay of qualitative data collection methods. Therefore, in addition to the unstructured face-to-face interviews, the researcher also made all four types of field notes, namely, descriptive, methodological, theoretical, and personal notes (Polit and Beck, 2004:382) while in the research setting or field (Burns and Grove, 2005:359).

2.4.1.8(a) Methodological notes

These notes focus on strategies and methods/techniques that are used to collect the data for the entire study (Polit and Beck, 2004:723). Despite careful planning, at times some research methods end up not working well and the researcher needs to take note of that and document why that particular strategy was not effective, and how that was corrected (Polit and Beck, 2004:383). For this study, the planned data collection methods gave no problems and therefore, no methodological challenges were encountered by the researcher.

2.4.1.8(b) Descriptive notes

These are also known as observational because they are what the researcher captures through perception or by, for example, camera, what she/he actually observes with her/his five senses, namely, sight (what she/he sees), hearing

(what she/he hears), nose (what she/he smells), tactile (what she/he feels) and taste (what she/he tastes) during data collection and interprets (Leedy and Ormrod, 2005:179). Owing to the objective nature of descriptive notes (Polite and Beck, 2004: 382), they are included in the data analysis.

2.4.1.8(c) Theoretical notes

Theoretical notes are detailed notes whence interpretations about the analyzed data can be made (Polit and Beck, 2004:734). Such types of notes, made good starting points for the researcher to start data analysis (Polit and Beck, 2004:383). In order to keep in focus when analyzing the data, the researcher kept asking herself loudly questions such as: *''What is this that I am hearing or seeing Grandmother G saying, here? ''Is there a hidden meaning behind what has been expressed in this statement?''* For instance, three R-BGs said statements to the effect that their '**daughters were sitting out there in other people's homestead and not properly married**'. Such statements had certain implications, such as; (i) primarily, it meant that because the daughters were not properly married the R-BGs raising GOTHA had foregone the joy of receiving *umsulanyembeti* (the cow that has never borne any calf that the mother-in-law is given by the son-in-law to console her for taking away her daughter and (ii) it negatively affected their self-esteem since it was not in line with traditional values cohabiting (Mkhonta, 2008:89). .

Other questions that the researcher kept asking herself as she read the transcripts or listened to the recorded tapes were: *''To whom is Grandmother A or Grandfather Q addressing this?''* Owing to the chronic drought and food insecurity all the R-BGs raising GOTHA received food

rations from those non governmental organizations. Some of the statements to this effect were: ***''Were it not for these good-hearted people we would be dead '' or*** *''What might have prompted the Grandparent B to say this?''* At the end of the very first interview, Grandmother A asked directly for money and said ''Are you really going to leave without even giving me as little as E5 - 00 (R5 - 00)?'' By then, Grandmother A did not know that she was still going to receive a hamper of food. Hunger might have prompted her to ask for the money and yet under normal circumstances she would not have done so.

2.4.1.8(d) Personal notes

The researcher also made personal notes. These kinds of notes helped the researcher to reflect (Polit and Beck, 2004:383) especially her own personal feelings (emotions and ethical stances) about the situation and observations made while in the research setting collecting the data. Personal notes helped to enhance the data quality (Brink, 2006:163) as the researcher remained neutral through phenomenological bracketing (Creswell, 1998:52) and all this had positive influenced on the trustworthiness of the study (Babbie and Mouton, 2005:276).

2.4.1.9 Photographs

A photograph is a picture made using a camera, in which an image is focused onto film or other light-sensitive material and then made visible and permanent by chemical treatment (Oxford Learner's Dictionary, 2000:873). According to Gillies, Highler, Roberts and Martinson (1989:xxi) the camera in nursing can serve as a notebook for recording visual content to facilitate more objective recollection by the researcher/observer.

2.4.1.10 Data handling

Immediately after the interving, the data were treated according to following three activities in preparation for the open coding process.

2.4.1.10(a) Immediate steps

Immediate steps were taken during the first 24 hours of obtaining the data and involved:

- duplicating the original recorded tapes as soon as possible using high speed dubbing before leaving the homestead. This was done in order to prevent from accidental loss of data (Creswell,1998:111).
- writing down her observations before leaving the homestead to go to the next one in order to avoid losing (Polit and Beck, 2004;384 ; de Vos etal., 2002:304) the finer details and also mixing up with observations from the next interviewee.

During the process of that evening, the two recorded tapes were listened to, one at a time in order to get a sense of the whole (Creswell, 1998:111). As documented by Tesch (1990:92) data analysis in qualitative research is an ongoing process that starts already as soon as the first interview has been completed. As the researcher listened to the two tapes she also compared them (Strauss and Corbin, 1990:61).

2.4.1.10(b) Intermediate steps

This period included from the 2nd through 7th day post data collection during which time the researcher:

- first transcribed the recorded tapes verbatim in *siSwati,* one complete interview at a time. Translating them verbatim translation was done in order to prevent

from losing any valuable information that had been obtained from the R-BGs (Creswell,1998:111).

- played back each completed recorded tape twice at low speed while listening very attentively to the audio-tape and reading the transcript simultaneously in order to ensure that all data were captured and correctly.
- thereafter, translated the transcripts from siSwati into English.

2.4.1.10(c) Later steps

The period from the 8th through 12th day post data collection was spent on the following activitie:

- the researcher engaged the services of a linguist to check the translated transcripts for accuracy and correctness of language. The linguist was a graduate and full time lecturer within the Department of African Languages at the University of Swaziland. In a meeting to get feedback, it was noted that though the linguist and researcher used slighlty different words to translate the from siSwati into English, their meanings were similar and compatible. Thereafter, the checked translations were placed together with the original taped narrations in *siSwati* and later submitted to the Study Promoter for verification as well and guidance.

2.4.1.11 Data analysis

According to Leedy and Ormrod (2005:150), there is no single right way to analyze the data in qualitatively designed studies. The researcher generally commences analysis with a large volume of data that through analysis sorting, and categorizing, those data are finally reduced to small sets of abstract underlying themes (Brink, 2006:6).

Data analysis in qualitative research is not a separate entity but commences already with the completion of the first interview (Silverman, 2000:121). The main concern of the researcher with regards to the analysis of the data was with preserving the uniqueness of the R-BGs raising GOTHA by each R-BG in order to understand the meanings and subjective realities of this phenomenon within the context it was happening (Speziale and Carpenter, 2003:89). Observational notes were included in the main data analysis. Generally there three steps that preceded main data analysis and these are described next:

Since, according to de Vos et al. 2002:305 it is a poor practice to 'stack' interviews and then try and analyze and synthesize all the tapes at once, immediately after the interviewng each R-BG raising GOTHA, the data were subjected to the following three steps.

Tesch's method of data analysis

Since the descriptions about raising GOTHA by R-BGs did not readily speak for themselves and the central aim of phenomenological data analysis, is to identify common themes in the participants' descriptions of their day-to-day subjective realities of the phenomenon under study (Leedy and Ormrod, 2005:150), the 8 steps of data analysis by Tesch (1990:93) were used to analyze the day-to-day encounters of raising GOTHA by the R-BGs in the lowveld. The steps are outlined next.

Step 1 **Read once all the transcripts** containing the descriptions of the experiences of the participants one by one. The researcher read all the transcripts in which the R-BGs described their subjective realities of raising GOTHA in order to get a sense of the whole (Tesch, 1990:93). In actual fact, the initial reading of the transcripts was

commenced as soon as possible with the completion of each interview (see data handling in 2.2.5.10 (t).

Step 2 **Read through again all transcripts** one by one. The researcher read all over the transcripts but the purpose this time was to highlight important information and its underlying meaning to the R-BGs with regards to raising GOTHA. Phenomenological bracketing/epoche (Brink, 2006:113) was maintained while interacting with data in the transcripts. The researcher also intuited. Reading and re-reading carried on until the meanings of the lived experiences of the R-BGs were known. The transcripts were read several times in order for the researcher to become really immersed in the data and thereby be in a position to understand their lived experiences.

Step 3 **Isolate and write down meaningful units. F**rom the highlighted information such as words, phrases and expressions that are related to the phenomenon under study, the researcher wrote out in the deliberately created wide margins (Leedy and Ormrod, 2005:150) on the transcripts the meaningful units from the data from the descriptions of what/how it was like caring for GOTHA by R-BG. The researcher compared the meaningful units from previously read transcript to the one just read.

Step 4 **Identify and cluster together descriptions of the lived experiences** of the participants. Using a paper with two columns, the lived experiences of raising GOTHA that were similar were grouped together in one first column, and those that were unique were also maintained and grouped together in the other column. The researcher then drew up the final **categories and sub-categories** from the clusters.

Step 5 **Reduction of the data**. This process entailed continued phenomenological bracketing and intuiting by the researcher in order to refine the categories until the meaning of the day-to-day personal realities of R-BGs raising GOTHA were known and the fundamental structure of their lived experiences from their descriptions were identified.

Step 6 **Validate with the participants** whether the **categories** and **sub-categories** reflected their lived experiences. Having grouped the categories and sub-categories and formulated a tentative underlying structure of the R-BGs lived experiences, the researcher returned once more to the research setting for validation purposes by the R-BGs themselves. The R-BGs all agreed that the identified categories and sub-categories indeed, reflected their lived experiences of raising GOTHA.

Step 7 An **independent co-coder** is required to analyze the same raw data separately from the researcher to ensure that there is corroboration in the identified themes between her/him and the researcher. The services of two independent co-coders were sought and obtained. The two independent co-coders both had PhD in nursing and were qualitative research experts. While one was local and Swazi, the other one was a professor at the University of Namibia.

The two co-coders were each provided with copies of all 14 transcripts containing the interviews (raw data) on the descriptions of the R-BGs about raising GOTHA and the method of analysis by Tesch (1990:93). Their role was to identify categories and sub-categories from the raw data, after which a face-to-face discussion between the researcher and one independent co-coder at a time was held.

Those categories that were different were discussed until a consensus was reached and there was corroboration.

Step 8 **Conduct literature control.** Once the categories had been identified and validated the researcher carried out literature control(Strauss and Corbin, 1990:50) to verify the R-BGs' lived experiences of raising GOTHA with other empirical evidence as well as other relevant sources of pertinent literature locally, regionally and internationally.

2.4.1.12 Ethical issues

The undertaking of scientism inquiry always has ethical implications (Brink, 2006:30). The following were some of the ethical issues of concern in the present study: permission to conduct the study, permission to use the data, informed consent, self-determination, non-maleficence, respect, confidentiality and anonymity, privacy and research incentives.

2.4.1.12(a) Permission to conduct the study

According to Creswell (1998:115) in order that the rights of the human participants, remain safeguarded, the researcher needs to have permission to conduct the study. Leedy and Ormrod (2005:102) highlighted that it is very important for studies to be reviewed through an internal review board and be approved at the stage of proposal before a single datum is collected.

Cognisant of the afore-gone, the proposal of this study was duly presented and reviewed in two stages. As the researcher was studying with the University of the Free State in the Republic of South Africa, the proposal

underwent academic and ethical scrutiny by three committees:

- the Expert Committee, a sub-community within the school of nursing and
- the Evaluation Committee, also a sub-committee witching the school pf nursing.

Comments that were made by the first two committees were very constructive and taken into account. The proposal was modified in accordance with the comments made. The proposal was then submitted to the final committee, namely:

- the Ethics Committee at Faculty of Health Sciences within University of the Free State in the Republic of South Africa.

With the approval of the Ethics Committee at Faculty of Health Sciences, University of the Free State in the Republic of South Africa, the researcher was ready for data collection. However, as the study was to be implemented in Swaziland, as the researcher was a Swazi citizen, the researcher also sought permission to conduct the study there. A copy of the proposal that had been submitted to the Ethics Committee at the Faculty of Health Sciences, University of the Free State in the Republic of South Africa, was submitted to the Research Unit of the Ministry of Health and Social Welfare. Permission to conduct the study was eventually granted.

2.4.1.12(b) Permission to use the data

Verbatim quotations are usually presented as part of the findings in qualitatively designed research. Since the findings of the study were going to be used, among others, to compile up this thesis, present papers at nursing conferences and publish articles in nursing journals, the

researcher asked for permission to use their data for those purposes and promised not to reveal their identities. The R-BGs raising GOTHA did not have any objections.

2.4.1.12(c) Permission to take photographs

The researcher sought and obtained permission to take photos of any objects within the homestead as deemed and relevant to the study. Some of the objects that were photographed were the traditionally built houses (refer to figure 3.1) of the R-BGs raising GOTHA and traditional dress code such as depicted in chapter six, figure 6.1. In the present study, the researcher took photos of the scenery/nature as deemed. When individuals were photographed, permission was first sought and obtained, and their faces were avoided refer to chapter two figure 2,4. No photos were taken of the R-BGs raising GOTHA.

2.4.1.12(d) Permission to audio-tape

Since individual in-depth interviews yield a lot of information because of their detailed nature (Tesch, 1990:56) and the fact that human beings have limited memory (Silverman, 2000:149 ; Leedy and Ormrod, 2005:146), an audio-tape was used to capture all the interview data. The researcher sought and obtained permission .(Kwalr, 1996:162-163) from the participants to use the device.

2.4.1.12(e) Informed consent

All research that has to do with human participants has implications for informed consent (Creswell, 1998:122). Therefore, the R-BGs:

- were briefed about the nature, purpose, risks-benefit ratio inherent in the present study (Brink, 2003:210).
- participated on a voluntary basis (Brink, 2006:37).

- were informed of their right to withdraw from the study anytime without disclosing any reason and with impunity (Polit and Beck, 2004:151).

Unlike quantitative research whereby data collection follows a structured plan and informed consent is required only once, in this study, it was re-negotiated as and when deemed such as when the researcher returned to the R-BGs to either seek more information or to validate information (Polit and Beck, 2004:159). A specimen of the consent form is included in appendix D.

Each R-BG raising GOTHA who met the inclusion sampling criteria was asked whether or not she/he wished to take part in the study. In this study there were 13 grandmothers and one grandfather. All the 14 R-BGs raising GOTHA responded positively to this question. The researcher thanked each R-BG raising GOTHA and then proceeded to explaining to her/him in great detail the nature and purpose of the study (Burns and Grove, 2005:361). Thereafter, each R-BG raising GOTHA was allowed to ask any questions about the study and answers were provided promptly (Kvale, 1996:127).

As the majority of the R-BGs raising GOTHA could neither read nor write, they were assisted by the researcher to endorse their signatures on the consent forms. The researcher assisted them with drawing an 'X' on the consent form document. Some of the rural health motivators who were witnesses, also could neither read nor write and therefore were also assisted in a similar manner to endorse their signatures which were in the forms of drawing an 'X' in the space provided for the witness. The researcher observed

that both the R-BGs and rural health motivators appeared embarrassed about not being able to either read or write.

2.4.1.12(f) Non-maleficence

In adhering to the principle of non maleficence which espouses that no harm shall be inflicted upon another or others (Pera and van Tonder, 2004:23), the researcher avoided asking any questions or displaying behaviour that negated this principle. Cognisant of the emotionality displayed by Grandmother Pilot in the exploratory interview, the researcher arranged for counselling services to be extended to affected R-BGs raising GOTHA from the community health nursing team at the Sithobela Rural Health Centre, if such a need arose.

2.4.1.12(g) Self-determination

The R-BGs raising GOTHA were taken as being in full control of themselves (Polit and Beck, 2004:147) since they were adults and independent entities capable of making their own sound decisions about whether or not to participate in the present study (Brink, 2006:32).

2.4.1.12(h) Right to privacy

The right to privacy (Brink, 2006:33) was ensured to the R-BGs raising GOTHA through:

- assuring them primarily, that their private thoughts and ideas were not going to be made public to other people.
- asking for permission to audio-tape the interviews and promise to destroy the tapes as soon as possible after achieving the study objective. .
- by interviewing them in the absence of any third party.

2.4.1.12(i) Respect

According to Brink (2006:31) and (Polit and Beck, 2004:147), human participants are to be accorded all respect primarily by virtue of being human beings. The researcher applied this principle in a number of ways that already have been included and are also included in the cultural guidelines in chapter six.

2.4.1.12(j) Confidentiality and anonymity

While confidentiality refers to the management of private data in research so that subjects identities are niot linked with their response (Burns and Grove, 2005:721), anonymity was defined by Brink (2006:34) as being nameless or anonymous.

Therefore, with regards to anonymity and confidentiality in this study, the R-BGs were given a statement describing the extent to which confidentiality of their records would be be maintained. Thus, they were that their interview data and transcripts would be kept confidential. They also were assured that their identities would remain anonymous in presentations, reports and publications of the study.

False identity such as fictitious names, alphabet, and numbers may be used to hide the identities of the participants. For instance, the R-BGs raising GOTHA were identified by using the alphabet. The first R-BG raising GOTHA to be interviewed was given the indemnity Grandmother A and so forth.

Even when the transcripts were sent for checking by the linguist, the identities of the transcripts of the R-BGs raising GOTHA remained concealed. All the data that were gathered within the scope of this research, namely,

recorded audio-tapes and transcripts in both languages of *siSwati* and English were kept under lock and key (Brink, 2006:35 ; Creswell, 1998:111) in the researcher's filing cabinet. Only when the purpose of the study has been achieved shall all the data be destroyed.

2.4.1.21(k) Research incentives

Though initially, the researcher had planned on merely thanking the R-BGs raising GOTHA after interviewing them, she ended up donating to each R-BG raising GOTHA a medium size food hamper at the completion of the interview as a token of appreciation for the time spent and information shared with the researcher (Polit and Beck, 2004:304). Each food hamper contained: samp, jugo beans, rice, salt, cooking oil, onions, bread, candles, matches, tea, powdered milk, bar of green soap for clothes, cakes of body soap, The R-BGs raising GOTHA were very grateful to receive the food items since there was food insecurity owing to the chronic drought.

The food hampers were only released after completion of each interview. Neither the Rural health motivator nor the interviewed R-BGs raising GOTHA had prior knowledge about the food hampers. It is noted that Thwala (2009:28) also gave out food donations after interviewing some rural-based women in her Hhohho region-based study at the completion of the interviews.

2.4.1.12(l) Scientific honesty

According to Kvale(1996:116), ''Moral research behaviour is more than ethical knowledge and cogitative choices, it requires the person of the researcher … the person of the researcher is critical for the quality of the scientific knowledge and soundness of ethical decision-making in any

research project.''

The researcher has a duty to be honest, primarily to her/him self and the participants. It is imperative to show respect to the scientific community by avoiding all dishonest unscientific ways. The researcher must at all times adhere to the prescribed ethical research standards. Therefore, in the present study, scientific honesty was upheld by the researcher through AVOIDING, among others, the following as summarised by Brink (2006:40-41):

- fabricating, falsifying and forging of any information.
- manipulating the research design and methods.
- selective detainment or manipulating the data.
- academic plagiarism by not acknowledging other author's academic efforts.

The researcher desisted from all behaviour that did not espouse ethical research.

2.4.1.12(m) Voluntary participation

Maziya (2005:33) pointed out that the rural-based participants in his study, also in the Lubombo region demanded some kind of stimulus to motivate them to participate in that study. They were offered food parcels and thereafter the researcher was able to proceed with data collation.

On the contrary, the participants in the present study, namely, the R-BGs raising GOTHA, did not make any demands to the effect of being motivated first in order to participate in the study. Their participation was done on a voluntary basis. The researcher observed that they all looked forward to taking part in the research to the point that some were even ready to be interviewed on that first

day. The researcher assumed that such eagerness to participate in the study might have been caused that it was their first time to be approached by a research since the area was very remote and also they were lonely and wishing to talk to someone about life in general. Mabuza (2008:96) who conducted a study in the Hhohho region found that most elderly were, to a greater extent, lonely.

2.4.1.13 Trustworthiness

One major challenge of qualitatively designed studies, is the issue of scientific rigour (Babbie and Mouton, 2005:274). Though qualitative and quantitative research are both ways of generating facts, they espouse different philosophical underpinnings and therefore use different criteria to evaluate scientific rigour (Polit and Beck, 2004:36).

Scientific rigour in the present study was ensured through the concept of trustworthiness (Babbie and Mouton, 2005:276) which included the following interrelated four strategies: credibility, confirmability, dependability and transferability. The four strategies are now described individually.

2.4.1.13(a) Credibility

Originating from Latin *credibilis*, credibilty denotes internal validity of a qualitative study. Credibility attempts to establish to what extent the researcher was faithful and adhered to the study design and methodology. It refers to the data being believable or truthful and answering to such questions as ''Do these findings ring true?'' ; ''Are the findings worth believing in?'' (Babbie and Mouton, 2005:277). Table 2.2 presents a summary of the application of credibility in this study.

n this study, Credibility was demonstrated through among others, prolonged engagement in the field with the participants. The interviews were audio taped. Each R-BG raising GOTHA was given ample time to describe her/his subjectives encounters with GOTHA. The researcher also returned to the field for the purpose of collecting more data or to validate thems and caregories.

2.4.1.13(b) Confirmability

To confirm is to establish the truth about something (Longman Dictionary of Contemporary English, 1995:286). Confirmability refers to the objectivity or neutrality of this study or the degree with which the findings in this study were the product of the focus of that inquiry and not the biases of the researcher (Babbie and Mouton, 2005: 278). The principle of truthfulness supports confirmability.

According to Polit and Beck (2004:435) the following six standards help to establish truthfulness in an inquiry: audit trail, data reduction and analysis products, process notes, materials relating to the researchers intentions and dispositions, instrument development and data reconstruction.

In the present study, confirmability answered to questions such as: ''How free from researcher bias were the lived experiences of the R-BGs?'' ; ''What was the degree of neutrality in this inquiry?'' ; ''Was there truth in the inquiry?'' (Babbie and Mouton, 2005:278). In the present study objectivity/neutrality was ensured as displayed in Table 2.2.

2.4.1.13(c) Transferability

Generally, to transfer, was defined in the Longman Dictionary of Contemporary English (1995:1537) as the process of moving from one point to another. Babbie and Mouton (2005:276). referred to transferability in qualitative research as the equivalent of external validity in quantitative research. Lincoln and Guba (1985) as cited in Polit and Beck (2004:435) referred to transferability as essentially the generalizability of the findings of a study to other settings or groups.

However, Babbie and Mouton (2005: 276) also emphasized that unlike in quantitatively designed research whereby the researcher is obliged to ensure that the findings can be generalized, in this study, the obligation for demonstrating transferability rests entirely on the individual researcher who wishes to apply it to the receiving context. The duty of the researcher was to provide the reader with detailed and thorough descriptions of the study setting or context, and the transactions and processes observed during the inquiry (Polit and Beck, 2004:435).

In the present study, an individual researcher who wishes to prove the transferability of the study findings using the same research, may be presented with the descriptions and verbatim quotations from the narrations of R-BGs. Some of the data that may assist the consumer of this study to transfer its findings to another setting or group are depicted in Table 2.2.

2.4.1.13(d) Dependability

Dependability refers to a process that is unchanging in

achievement or effect over a period of time. In qualitative research, dependability refers to the stability or reliability of the data over time and over conditions when similar conclusions can be made where two or more researchers use the perspective of the original researcher (Polit and Beck, 2004:716). In this study, dependability may/can be demonstrated through: internal auditing, external audit, thick descriptions of research methods, peer examination and co-coding process (refer to table 2.2).

Table 2.2 Strategies utilized to enhance trustworthiness

STRATEGY	STANDARD	APPLICATION
Credibility	1. Prolonged engagement	The researcher: • conducted interviews personally. • spoke with R-BGs raising GOTHA until there was no new information came forth. • stayed in with the R-BGs raising GOTHA in the field until the state of data saturation was achieved. • sought clarifications of the data from the R-BGs raising GOTHA raising GOTHA. • returned to R-BGs raising GOTHA for validation of interpretations of initially analyzed data.
	2. Reflexivity	The reseacher:

		• documented personal notes. • documented theoretical notes. • recorded individual in-depth face to face interviews with R-BGs raising GOTHA.
	3. Referential adequacy	The reseacher: • made descriptive notes • conducted literature control after analyzing all the collected and analyzed data. • Audio taped the interviews
	4. Peer debriefing	The reseacher: • briefed peers about the study and sought their inputs. • submitted the transcripts to a colleague for checking. • submitted transcripts with the raw data to the linguist for checking, • sought & obtained the services of an internal independent co-coder to analyze the raw data. • later met with internal co-coder over to discuss and compare the separately developed categories for the purpose of corroboration.
	5. Member checking	The reseacher: • returned to R-BGs raising GOTHA at *Nkonjwa* for validation of initially collected data and

		interpretations made thereof. • validation of developed categories by colleagues.
	6. Interview technique	The reseacher: • conducted face-to-face in-depth individual interviews with R-BGs raising GOTHA. • used probing technique to elicit more & additional data.
Confirmability	1. Audit trail	The reseacher: • described the entire methodology. • documented recruitment process of unit of analysis. • audio taped raw (interviews) data. • Transcripts in *siSwati*. . • documented field notes - observational notes, personal notes. • audio taped interviews
	2. Data reduction and analysis products	The reseacher: • documented selected method of analysis and its implementation. • developed categories and sub-categories.
	3. Process notes	The reseacher: • documented theoretical notes • documented methodological notes. • described notes on trustworthiness. • engaged phenomenological bracketing. • received feedback

		developed gramme from: R-BGs raising GOTHA, • received feedback from linguist, peer and internal independent co-coders.
	4. Materials relating researcher's intentions and dispositions	The reseacher: • took note of supervision remarks and comments from Study Promoter. • used reflexive notes such as personal experiences, reflections and progress while in the field.
	5. Instrument development	The reseacher: • used exploratory interview notes • made field notes
	6. Data reconstruction	The reseacher: • developed of conceptual framework and health education programme, • submitted the various chapters to the Study Promoter for checking and guidance throughout the entire research and programme development process. . • compiled the final draft of the study.
Transferability	1. Purposive sampling	The reseacher: • hand picked the R-BGs raising GOTHA with help of rural health motivators.
	2. Comparing the demographic data	The reseacher: • described the research setting

	3. Thick and thorough descriptions	The reseacher: • described in detail the study context (Silverman, 2000: 125), • described the unit of analysis, • made observational notes. • summarised of the health states of R-BGs raising GOTHA.
Dependability	1. Internal audit 2. External audit 3.Thick descriptions of study research methods	The reseacher: • described all four phases of the study step by step planning and implementation. • received input from peer and colleagues on the study methods. • described the development of this study from proposal to the final project and the health programme evaluation instrument, The reseacher: • sought the services of co-coding services by one external independent co-coder. • Study submitted to external examiners for checking & grading. The reseacher: • received feedback from colleagues after checking formulated categories and compared • received constant feedback from Study Promoter, • Meeting with stakeholders in issues of the elderly and

	4.Peer examination	The reseacher: • received feedback on developed programme colleagues who held graduate & PhD degrees. They were given the complete study to read and evlaute the programme & thereafter give feedback in order to strengthen the reliability aspect of the study.
	5. Co-coding process	The reseacher: • sought and obtained the services of two independent co-coders (in Swaziland and one in Namibia) and post data analysis & development of categories and sub-categories..

2.5 PHASE TWO: A DESCRIPTION OF THE CONCEPTUAL FRAMEWORK

A conceptual framework was defined by Polit and Beck (2004:115) as a less well formal attempt at organizing phenomena than theories.

Phase two is also known as the post phenomenological part. The identified central finding in phase one, was the springboard for phase two whose main purpose was to develop the conceptual framework that guided the development of the proposed health education programme to empower with self-care R-BGs raising GOTHA in the lowveld.

The conceptual framework was a product of inductive reasoning, critical and creative thinking and also getting ideas from reviewed related literature. The conceptual

framework is described and discussed in great detail in chapter four.

2.6 PHASE THREE(a): A DESCRIPTION OF THE STRUCTURE OF THE HEALTH EDUCATION PROGRAMME

Phase three builds on the conceptual framework that was developed in phase two. The developed health education programme is described and discussed in great detail in chapter five. The content of the programme was evidence informed and is divided into three main areas, namely, old adulthood, identified health problems and other related health issues. The content of the first part, namely, old adulthood and last part, namely, other health-related issues, were generated partly through creative thinking and partly from observations made about the R-BGs while interacting with them in the research setting.

2.7 PHASE THREE(b): A DESCRIPTION OF PROCESS ASPECT OF THE HEALTH EDUCATION PROGRAMME

This aspect of phase two is concerned with describing the guidelines for implementing the health education programme to empower the R-BGs raising GOTHA. The guidelines are divided into two types, namely, culture-focused and adult education focused and shall help the programme implements to empowerment with self-care the R-BGs raising GOTHA in the lowveld. The programme implementing shall be preceded by a workshop for CHNs who are deployed throughout health facilities in the lowveld.

2.8 PHASE FOUR: EVALUATION OF THE PROGRAMME

Bryant, Altpete and Whitelaw (2006:200) pointed out that the process of developing evidence-based health promotion programmes includes a systematic process of planning,

implementing, and evaluation to ensure that the programmes will benefit those for whom it is meant.

Therefore, the fourth phase marked the final part of the development of the health education programme and is described in full in chapter seven. The purpose of this phase was to reveal feedback from selected stakeholders who evaluated the health education programme. An instrument was designed and developed to help evaluate the programme. The stakeholders who evaluated the programme included selected R-BGs who were interviewed, nurse educators from the Faculty of Health Sciences at the University of Swaziland, a group of peri-urban based elderly grandparents who also were bringing up HIV/AIDS orphaned grandchildren and, lastly, a representative from one pro-elderly NGO. The evaluation process was described in more detail in chapter seven together with other final topics about the study.

2.9 CHAPTER SUMMARY

Chapter two was still part of phase one. The purpose of chapter two was to describe the study design and methodology. The study was qualitative, exploratory, descriptive and contextual in nature in order to elicit the day-to-day realities of R-BGs raising GOTHA in the lowveld. The data were collected through face-to-face in-depth interviews by the researcher herself in order to answer the main research question ‘’What are the lived experiences of R-BGs raising GOTHA in the lowveld?’’ Summaries of phases two, three (a) and (b), and four were also presented.

Chapter three is presented next.

CHAPTER THREE

PRESENTATION AND DISCUSSION OF THE STUDY FINDINGS, AND LITERATURE CONTROL

> ***"… I am no longer in good health. I am suffering from a number of ailments … I have pain in my chest ... and my knees ... and my lower back ... and dizziness. All that too, and another big problem is that I get tightness in the chest when I walk the slightest distance ... it tightens up severely. As for the knees, when I stand, they become wobbly. All that, I don't know what to do …"*** **(Grandmother B, 78 & caregiver of one GOTHA aged: 7 years)**

3.1 INTRODUCTION

Chapter two described and discussed the research design and methodology. The purpose of chapter three is to present the findings from the analyzed data. The researcher entered the activity of analysis with data made up of text, field notes, health records and photographs, and exited with a description of the lived experiences of the R-BGs raising GOTHA in the lowveld (de Vos, 2002:340).

The sources of data for the present study were:

- unstructured individual face-to-face in-depth interviews with the R-BGs raising GOTHA
- health records of R-BGs raising GOTHA

- field notes taken by the researcher and
- photographs, also taken by the researcher while in the research setting.

3.2 PRIMARY PURPOSE OF THE STUDY

The primary purpose of the present study was to explore and describe the day-to-day personal encounters of R-BGs who were looking after GOTHA in the Chiefdom of *Nkonjwa* at Sithobela *inkhundla* (constituency) in the lowveld.

3.3 FORMAT FOR PRESENTING THE FINDINGS

Qualitatively designed research usually generates large volumes of data (Burns and Grove, 2005:548). The findings from the present study are presented in two parts. While the first part of the chapter presents the demographic characteristics of both the R-BGs and their GOTHA, the actual lived experiences are outlined in the second part.

In presenting the demographic data of the R-BGs raising GOTHA, descriptive statistics such as range, mean and percentage (Brink, 2003:172) are used, and also tables, figures and summaries are applied. The demographic data of GOTHA are given as summaries.

The actual lived experiences of the R-BGs raising GOTHA, the core of the study, are presented as categories together with sub-categories thereof. Categories were defined in the Oxford Advanced Learner's Dictionary (2000:171) as a group of people or things with particular features in common. According to Strauss and Corbin (1990:65) categories have conceptual power because of their ability to pull together around them other groups of concepts or sub categories. In the present study, '*in vivo*' coding (Strauss and Corbin, 1990:69) was, to a greater extent, applied in the naming of

most of the categories. In vivo coding refers to the process of naming categories using more or less the same words that were utilized by the participants who initially used them to describe their life experiences of looking their GOTHA.

Categories and sub-categories, thereof, are presented, in the present study as (i) short, (ii) embedded and (iii) lengthy verbatim quotations. Categories represent the heart of qualitatively designed research. In addition to describing the lived experiences of R-BGs raising GOTHA, their emotions and language are also taken into account (de Vos, 2002:358) Literature control was conducted in order to compare the study findings with other previous relevant studies (Burns and Grove, 2005:577).

While the verbatim quotations were the exact words that the R-BGs raising GOTHA said, their identity was concealed by use of alphabet pseudonyms, such as Grandmother A, Grandmother B for females R-BGs and the only male R-BG was Grandfather Q.

Since qualitative research is by definition, stronger on long, descriptive narratives than on statistical tables (Silverman, 2001:33), and to avoid ending up with a massive research document, because of excessive use of documenting verbatim quotations in both languages, namely, *siSwati* and English, fewer verbatim quotations in *siSwati* have been documented. Furthermore, where and when verbatim quotations are first documented in *siSwati,* their English translations are provided promptly. Each verbatim quotation that has been documented in this chapter was said by at least two or more R-BGs raising GOTHA (Linsk and Mason, 2004: online).

The categories that are discussed in this chapter were not presented in any particular order. The format for discussing them is that they are first presented together with their sub categories in a summary table (refer to Table 3.3). Thereafter, each category and its sub-categories are first displayed in their individual tables and then described and discussed individually. Both the categories and sub categories thereof, are substantiated with verbatim quotations, since they (verbatim quotations) are the core evidence used by the researcher (Rubin and Rubin, 2005:261). Empirical evidence from other researchers has been integrated in the discussion of the current study findings either to support or show other unique results.

3.4 DEMOGRAPHIC PROFILE OF R-BGs RAISING GOTHA

The target population (Brink, 2003:132) of this research comprised R-BGs raising GOTHA in the Chiefdom of *Nkonjwa* and their demographic profile is displayed Table 3.1.

Table 3.1 Demographic data of the participants

Variable	Percentage (%)
Age dimension (years)	
60 – 69	**29**
70 - 79	**50**
80 - 89	**21**
Range	**60 - 88 years**
Mean	**72.1 years**
Gender dimension	
Female	93
Male	**7**
Marital Status	

Married	7
Widowed	86
Cohabiting	7
Highest attained level of education	
No formal education	71.4
0 – 2 years	7.4
3 – 5 years	14.3
6 – 8 year	
Source of income	
Money for the elderly	86
Widows' pension	7
No source of income	7
Household composition	
R-BG + GOTHA	64.3
R-BG + GOTHA + OTHER ADULT(S)	35.7
Caring pattern	
Custody by maternal grandparent(s)	43
Custody by paternal grandparent(s)	57

3.4.1 Unit of analysis and size

According to Polit and Beck (2004:308) there are no rules about the size of the units of analysis in qualitatively designed studies since such research is largely a function of its purpose. Generally, the size of the unit of analysis in qualitatively designed studies is determined retrospectively (Burns and Grove, 2005:358). Altogether, the data showed that the unit of analysis (Gray, 2004:323), in the present study, had 14 R-BGs who were interviewed individually and face-to-face by the researcher. Other studies that had similar small units of analysis were Thomas (2007:12), Kataoka-Yahiro, Ceria and Yoder {2004: online), Inwood (2002: online) and Poindexter (2001: online).

3.4.2 Gender dimension

From the data, approximately 12 (93%) of the R-BGs raising GOTHA were grandmothers. This finding was consistent with those of Fuller-Thomson (2005: online), Matshalaga (2004:10 – 40) and Whitley, Kelly and Sipe (2001: online) whose study samples were also dominated by grandmothers. The predominance of grandmothers, as primary caregivers of GOTHA in the present study, was to be expected given the fact that Swaziland is a patriarchal society (Simelane, Magongo and Kunene, 2003:5) and, consequently, division of labour is tailored along the lines of gender (Haralambos and Holborn, 2004:99).

It is noted that the majority of the Swazi rural-based population comprises elderly women who are household heads (Musi, 2006: online,). Another factor that contributed to toward grandmothers being in the majority may have been elderly women usually outlive their spouses (Makiwane et al. 2004:50); older men and/or divorced men tend to marry younger wives (Murray and Zentner, 2001:746). Last but not least, the characteristics of the population in Swaziland show a male: female ratio of 86:100 (Population and Housing Census Brochure, 2007),

The data revealed that the unit of analysis had only one male R-BG who was the predominant caregiver of GOTHA in his homestead. This was because his common-law wife suffered from chronic asthma that had almost rendered her into an invalid. This finding is supported by Murray and Zentner (2001:757) who observed that where the wife had impairment, the husband often became the caregiver. Women and the Law Southern Africa (1998:31) pointed out that only on very rare occasions did Swazi men engage in the caregiving role because historically, Swazi men would instead delegate such caring duties to female relatives such sisters, nieces and aunts. However and in light of the of HIV/ AIDS epidemic

the researcher assumes that even those female relatives who would have readily assisted their male relatives have also been affected, directly and/or indirectly by the deadly epidemic and therefore, are not in a position to render further assistance to their male siblings and relatives.

3.4.3 Age dimension

The data revealed that the age range of the R-BGs raising GOTHA was from 60 through 88 years, with a mean of 72.1 years. This finding was expected, since the majority of rural-based households in Swaziland, were said to be headed by elderly women (Musi, 2006: online). This finding is supported by the rural-based Zimbabwe study findings of Matshalaga (2004:10 - 40) whose eight grandmothers who were looking after AIDS-orphaned grandchildren were aged between 70 and 80+ years. Such advanced age on R-BGs raising GOTHA may be attributed partly to the general increase in the elderly population aged 60 years and above, particularly in sub-Saharan Africa, whose increase in the elderly population is rated as the fastest globally (Velkoff and Kowal, 2007:22).

3.4.4 Formal education

From the data, out of the 14 R-BGs raising GOTHA, 10 (71.4%) had no formal education while 4 had achieved between 2 and 8 years of primary school. The range of education for the entire unit of analysis was from 0 through 8 years of primary school, with a mean of 1.4 years. This finding was similar to those of Lukhele (2009:19), Thwala (2009:29), Mabuza (2008:56), Motsa (1999:50) and Sithole (1998:26) in that their participants, who comprised elderly women, did not have formal education at all. On the other hand, this finding is not supported by the study findings from Thomas’s (2007:73) and Fuller-

Thomson’s (2005: online). The elderly participants in those studies had educational attainments that ranged from completion of the first nine years of basic education through graduate studies.

On the whole, this finding, of especially rural-based elderly women with low or no literacy levels at all, is hardly a surprise given the influence of the girl child syndrome (Masilela, Namaganda and Sithole, 1994:6) that was in much practice in the past. Moreover, low literacy levels may be attributed to the philosophy of the colonial rule that did not espouse empowerment of the African population (ULARN, 2003:15).

3.4.5 Marital status

The data revealed married, widowed and cohabiting R-BGs raising GOTHA, all three of which family forms reflected some of the family forms in the Swazi society (Women and the Law Southern Africa, 1998:19 - 40). However, elderly widows raising GOTHA dominated the group. Their duration of widowhood ranged from 12 months through 20+ years. The presence of such a large number of widows in the present study was supported by HelpAge International (2008: online), Makiwane et al., (2004:51) and Matshalaga (2004:10 – 40), whose study findings revealed a strong predominance of widows, too.

The data revealed that the only grandfather in the study sample was cohabiting. According to McEwen (2002:342) cohabiting is when a man and a woman live together without being married. The existence of this type of marriage union, particularly from a rural context perspective, was somewhat unexpected, given that, generally, the Swazi people are relatively traditional in their approach to life

in general and tend to adhere to traditional values (Mkhonta, 2008:89). The participants in the study that was conducted by Women and the Law Southern Africa (1998: 34 – 35) condemned cohabiting on the grounds that it lacked a legal base and thus the woman was not legally protected.

3.4.6 Sources of income

The data also showed that the main source of income for at least 12 (86%) of the 14 R-BGs raising GOTHA was the social grant for the elderly. This social allowance is popularly known in *siSwati* as *imbasha yalabadzala*. The remaining 2 R-BGs did not receive it. Of the 2 R-BGs, one did not receive it because of careless miscalculation of her age. The other one did not receive it because she already was a beneficiary of her late husband's widows' pension of E200 – 00 per month.

It is worth pointing out that this social grant for the elderly is not a pension scheme but an allowance that the elderly receive. Only those elderly aged 60 years and above, and are registered with their *tinkhundla* (constituencies) are eligible for it. According to Lukhele (2009:2) this social grant for the elderly was initiated in 2003 in order to help needy elderly Swazi men and women. While in principle this money is given out every three months in the year, in reality it is not.

This finding was not supported by Makiwane et al, (2004: 57 - 58) whose study findings revealed that the elderly in the Republick of South Africa, were beneficiaries of a pension scheme and got a monthly old age pension from government. Mkhonta (2008:69) revealed that the majority of the grandparents, who were caring for orphans and vulnerable

children and resided in an informal setting in Mbabane, did not have any source of income.

3.4.7 Household composition

The data indicated that in 64.3% of the homesteads, the R-BGs were the only adults living with GOTHA and in the remaining 35.7% the households, there were additional occupants such as sick widowed daughters-in-law, elderly relatives and/or great grandchild/children. This finding was similar to that of Makiwane et al, (2004:50) whose elderly in the Mpumalanga Province in the Republic of South Africa, revealed that the elderly, especially women, were heading and supporting multi-generational households.

3.4.8 Health challenges of R-BGs

The data on the general health of the R-BGs (refer to figure 3.2) shows that all the body systems were involved. The most commonly occurring physical health challenges were related to the following body systems: gastro-intestinal, cardio-vascular, and musculo-skeletal respiratory and integumentary. The two special organs of sense that were most affected in these R-BGs were hearing and sight. The R-BGs reported impaired hearing and vision.

Table 3.2 Health challenges (according to body system) of the R-BGs raising GOTHA

Health challenges by body system	Affected R-BGs	Percentage (%)
Gastro-intestinal tract	Grandmothers: A,B,C,D,E,F,H,I,L, N,O & Grandfather Q	79
Cardio-vascular susytem	Grandmothers BF,G,H,K,L,N&O	57.1

Musculo-skeletal system	Grandmothers A,B,C,G,I,K,L&O	57.1
Integumentary system	Grandmothers A & C	7
Genito-urinary system	Grandmother L	7
Endocrine system	Grandmothers F	7
Respiratory system	Grandmother E & Grandfather Q	14
Central nervous system	Grandmother O	7
Immune system: HIV positive	Grandmother I	7
Special sense: • impaired hearing • impaired vision	Grandmothers: A.B,L&O Grandmothers G,H&C	29 21.4

This finding confirms that the elderly have physical health challenges affecting their entire body systems, such as undernourishment (Skolnik, 2007:online), painful knees joints and arthritis (Mba, 2006:online), being HIV positive (Knodel and van Lantingham, 2002:online), impaired hearing and disturbed vision (McEwen, 2002:315). Mkhonta (2008:69) revealed that the grandparents who were caring for orphans and vulnerable children suffered from a number of physical health conditions that also including asthma, diabetes mellitus and hypertension.

It is worthwhile mentioning that on two occasions when the researcher arrived at two different homesteads to conduct interviews, she found the R-BGs raising GOTHA not feeling well. In both instances, the researcher first applied first aid measures before proceeding with the interviews as these older adults were not feeling well. Both R-BGs raising GOTHA suffered from hypertension and were on treatment for it. While first R-BG raising GOTHA, Grandmother L, was

experiencing the effects of inadvertently overdosing herself with antihypertensive medication, methyldopa, because of lack of adequate instructions on how to self-administer that drug, the second R-BG raising GOTHA had run out of her medication and had not gone for her usual monthly follow up appointment at the health centre because of financial constraints. She needed money for bus fare, community fee and consultation fee.

Thus far, only the demographic data of the R-BGs raising GOTHA have been described and discussed within the context of other relevant studies. The demographics of the GOTHA are presented next.

3.5 THE DEMOGRAPHIC PROFILE OF GRANDCHILDREN ORPHANED THROUGH HIV/AIDS

The GOTHA were not the focus of the present study and their demographic characteristics are briefly outlined. These data were obtained primarily from the R-BGs and when they did not remember all the details clearly, the researcher referred to official documents such as birth certificates of the GOTHA, death certificates of the parent(s). A small fraction of information was obtained directly from the GOTHA themselves.

Altogether, 51 GOTHA were being looked after by the 14 R-BGs who were interviewed by the researcher. This meant that each R-BG looked after 3.57 GOTHA.

While the youngest GOTHA was only 8 months old, the oldest ones were 17 years old, with a mean age of 9.84 years. According to the stage theory of Erik Erikson, children in this age group fall under the developmental stage whose crisis comprises inferiority versus industry, and whose

positive attainments or outcomes are: competence in intellectual, social and physical skills (Rosendahl, 1999:116). Also to note was that the mean age of 9.84 years placed these GOTHA almost at the entrance of the adolescence period which is both a critical and an ideal time to commence talking with them about growing up.

The data revealed that the number of GOTHA under the custody of the R-BGs ranged from one through seven with an average of 3.57 GOTHA per each R-BG. This finding is in contrast to Conway (2007:36) whose rural-based grandparents were looking after an average of 1.9 grandchildren. The differences in the size of children under care for the two sets of rural-based grandparents may be attributed to two things. First, fertility rates (Lamina, 2007:49) in developing countries generally, tend to be higher than in developed countries. Second, because of lack of social security in developing countries, parents generally tend to have larger families since children later become their social security when they become very old and need someone to look after them.

Except for 2 (3.9%) GOTHA, who were of school going age, but not attending school, the remaining 49 (96.1%), were of school-going age and attending local schools. The school going GOTHA were sponsored, primarily by UNICEF, but also by World Vision and, to a certain extent, by government through the orphan and vulnerable (OVC) education fund programme.

The reasons for not attending school by the two GOTHA who were out of school were revealed as lack of sponsorship and inaccessible birth certificate of the deceased mother of the GOTHA. This finding was similar to that of Matshalaga

(2004:68) some of whose orphaned grandchildren who were being raised by their grandmothers did not have money for school fees and others did not have birth certificates. This finding was not supported by Mkhonta (2008:72) who indicated that orphans and vulnerable children had challenges in accessing education.

It must be pointed out that it was quite disturbing to find the two children out of school and also paradoxical, because the Convention of the Rights of the Child was ratified by the Swaziland Government in 1995 (UNICEF Swaziland, 2006 – 2010:19).

Though one of the inclusion criteria stipulated that grandchildren had to be biological children of the deceased adult children of the R-BGs, the data showed that 4 (7.8%) of the GOTHA were not children of deceased adult children but children of deceased siblings of the R-BGs, or other very close relatives. While one R-BG (Grandmother I) looked after one such GOTHA, the other R-BG (Grandmother O) cared for the remaining three GOTHA.

At this point, it is worth mentioning that the 2 R-BGs raising GOTHA had acquired their GOTHA through the traditional process known in *siSwati* as "*ukufakha umntfwana esiswini*" [literal meaning 'putting a child inside one's stomach']. This form of child custody may be likened with informal adopting of a child, but by relatives rather than non relatives as happens in the western culture. Being blood relatives is essential because of sharing common ancestry (*emadloti*).

While one R-BG (Grandmother I) had inherited her deceased sister's daughter, the other R-BG, Grandmothers N, had also taken on her sister's children. The children in the second

situation had initially been taken on by their maternal grandmother who unfortunately died suddenly. These children were then absorbed into the household of Grandmother O.

From the data, it was revealed that while both sets of R-BGs, namely maternal and paternal, looked after the GOTHA, slightly more than half (57%) of the R-BGs raising GOTHA were paternal grandparents, and cared for their deceased sons' children. This finding was found to be in line with the traditional African norm which holds that in the absence of biological parents, a child belongs, primarily, to its paternal grandparents and other paternal relatives (Women and the Law Southern Africa, 1998; 50).

The lived experiences of the R-BGs raising GOTHA are presented.

3.6 THE LIVED EXPERIENCES OF RURAL-BASED GRANDPARENTS RAISING RANDCHILDREN ORPHANED THROUGH HIV AIDS

For analyzing the data that were gathered in this study, the method that was first described by Tesch (1990:93) was applied and yielded altogether six major Categories and 24 sub-categories thereof as displayed in Table 3.3.

Table 3.3 Summary of all identified categories and sub-categories in the study

CATEGORY	Sub-categories
3.6.1 NO SUPPORT	3.6.1.1 Children are dead 3.6.1.2 Raising GOTHA alone 3.6.1.3 Absence of kinship 3.6.1.4 Being abandoned/disowned by children 3.6.1.5 Working even when not feeling well
3.6.2 COMPROMISED HEALTH	3.6.2.1 Physical health problems 3.6.2.2 Emotional pain
3.6.3 RESOURCE AND BASIC NEEDS CONSTRAINTS	3.6.3.1 No money 3.6.3.2 Inadequate parenting skills 3.6.3.2 Inadequate accommodation 3.6.3.3 Inadequate nutrition 3.6.3.4 Inadequate clothing
3.6.4. CONCERNS RELATED TO THE FUTURE OF GOTHA	3.6.4.1 Lack of adult supervision 3.6.4.2 Lack of opportunities for education 3.6.4.3 Inadequate clothing and blankets
3.6.5 FEELING OVERWHELMED	3.6.5.1 Doing housework everyday 3.6.5.2 Parenting small children 3.6.5.3 Role inadequacy
3.6.6. SACRIFICING	3.6.6.1 Sacrificing money, food and personal effects 3.6.6.2 Borrowing of money 3.6.6.3 Begging for food 3.6.6.4 Income generating activities 3.6.6.5 Buying food on credit 3.6.6.6 Reliance on food relief 3.6.6.7 Doing piece meal jobs 3.6.6.8 Divine intervention

3.6.1 CATEGORY NO SUPPORT

From the data the category NO SUPPORT (refer to Table 3.4 below) means that the R-BGs raising GOTHA did not have any support at all either from their children or community. Most R-BGs had lost adult children through ADIS-related illnesses and were left behind with grandchildren to care for. While three R-BGs had children who were still alive, their whereabouts were not quite known because of lack of contact on the part of the children. Lack of significant relatives who made up part of the kinship network was also obvious. As a consequence of not having any one to assist them with looking after GOTHA, the R-BGs continued to engage in housework and other tasks as deemed even when they were not feeling well.

Table 3.4 Summary of CATEGORY: NO SUPPORT

Category	**Sub-categories**
3.6.1 NO SUPPORT	3.6.1.1 Children are dead 3.6.1.2 Raising GOTHA alone 3.6.1.3 Absence of kinship 3.6.1.4 Being abandoned/disowned by children 3.6.1.5 Working even when not feeling well

3.6.1.1 Sub category Children are dead

The data showed that all R-BGs raising GOTHA had lost between one and several adult children, through AIDS-related illnesses. Many of the R-BGs had lost sons and daughters-in-law together. The deceased sons were their life support. A widowed R-BG who had lost all her sons through the AIDS epidemic put it thus:

> ***I know where my children went*** [meaning sons] went***. I am complete as you see me here!*** (Grandmother H, 65 & caregiver of 3 GOTHA aged from 5 through 17 years).

A number of studies, especially those that were carried out in countries where HIV and AIDS have high prevalence rates (Ntozi, 2002: online) have revealed that the majority of the elderly were caring for children orphaned through AIDS-related illnesses (Fouad, 2005: online; Agyarko, Madzingira, Mupedziswa, Mujuru, Kanyowa and Katoroka, 2002: online).

3.6.1.2 Sub category Raising GOTHA alone

As a result of losing their adult children through HIV/AIDS-related illnesses, most R-BGs lived alone with their GOTHA whom they cared for single-handedly. Raising GOTHA alone was captured in the following statement by one of the senior R-BGs:

> ***I do take care of them because it is just I alone. There is no other [person] who can look after them. When their father passed on, they were left under my custody. There is no one else*** (Grandmother E, 82 & caregiver of 2 GOTHA aged: 5 and 8 years).

This finding was consistent with the finding from Matshalaga (2004:10 - 40) whose rural-based grandmothers in Zimbabwe raised grandchildren orphaned by HIV/AIDS, also single-handedly.

When asked to describe her day-to-day personal realities of bringing up GOTHA, the oldest participant in the study replied thus:

> ***Nami nginesidzingeko sekutsi nginakekelwe. Kube benginabo bantfwana bebatanginakekela. Kube benginaye malukwatana ngabe uyangiphekela"*** [*I, actually, am in need of being looked after too. If only I had children [son], they would fend for me. If only I had a daughter-in-law, she would be cooking for me*] (Grandmother), 88 & caregiver of 2 GOTHA aged 9 and 11 years).

McEwen (2002: 314) pointed out that approximately 55% of the elderly aged 85 years and above, need help with their activities of daily living (ADL), since the older one gets, the more challenged general health becomes. It is also worth mentioning that in the Swazi traditional practice, daughters-in-law play a crucial role in the general welfare of, particularly, their aging mothers- and fathers-in-law (Maya, 2003: 20; Women and the Law Southern Africa, 1998:52).

3.6.1.3 Sub category Absence of kinship

The data also revealed that most of the R-BGs raising GOTHA had also lost a number of significant relatives who formed part of their kinship network system. Such social networks are an essential backbone for and backups to traditional family types. Describing how it was, not having anyone with whom to share her problems, especially concerning the one GOTHA she was raising, one older R-BG, who was on the verge of tearing, explained thus:

> ***Usually, other people would say," Let me go to so and so since they may give me assistance". You see, as for me, there is no such thing! When I have a problem, it is only this tree here*** [pointing to a small tree next to the house] ***that knows my problems*** (Grandmother B, 78 & caregiver of one GOTHA aged: 7 years).

Having lost a number of significant relatives over the years, then all her sons and more recently, having become widowed, one R-BG lamented:

> [In high pitched voice, shaking her head slightly and facing down] ***To whom can I say we are hungry? There is no one I can go and ask for assistance. Even my home of birth, the situation is equally bad. There is nothing there. My home of birth has ceased to be. My brother died, my sister-in-law died, my mother died and that was the end. Oh yes, that was the end! Usually, one should be able to ask for assistance from one's mother or home of birth or sister-in-law.*** **[**carrying both hands on her head] ***My Lord, not a person like me*!** [long

silence] (Grandmother G, 76 years & caregiver of 7 GOTHA aged: between 3 through 17 years).

This finding was supported by (Mabuza, 2008:78; Population Council, 2006: online; Howard, Phillips, Matinhure, Goodman, McCurdy and Johnson, 2006: online). The participants in those studies also had elderly persons who had lost adult children and in addition to that they lacked kinship support. In a study that was carried out by the NGO named Children in Distress (CINDI) (2007: online) in the kwaZulu-Natal province, the findings revealed that though the majority of the elderly had lost adult children through HIV/AIDS-related illnesses, they received support, among others from significant family members.

3.6.1.4 Sub category Being abandoned and/or disowned

To abandon someone refers to leaving or deserting someone one is especially responsible for (Longman Dictionary of Contemporary English, 1995:3). In accordance with the Swazi tradition, sons, especially, the first and last one, have an everlasting filial obligation to look after their parents, particularly in their golden years (ULARN, 2003: online). However, the data showed that though two R-BGs raising GOTHA, each had one living son, they had abandoned their mothers and did not support them in any way. The whereabouts of the sons were not known to the R-BGs though some community members has seen them in other communities. Showing no emotions at all, one of the two R-BGs raising GOTHA said:

> ***My son long left home and there is nothing he helps me with*** (Grandmother D, 63 & caregiver of 5 GOTHA aged: from 8 through 17 years).

According to du Toit and van Staden (2005:236) elderly mistreatment or abuse, of which elderly abandonment is a

part thereof, may be a result of their being totally dependent upon their children who feel overwhelmed with too many demands of their own leave alone those of their parents. Mba (2006: online) pointed out that perhaps, the challenging socio-economic context of many African countries, may partly be responsible for elderly abandonment by offspring, through rural-urban migration.

The data also revealed that one R-BG raising GOTHA had four children, two daughters and two sons who had disowned her. With a mixture of both sadness and bitterness in her tone, the R-BG made the following remark:

> ***Nginabo bantfwana lengabatala abangisiti ngalufto … kuyanafanana emantfwombatana nebabafana … Bayafanana.*** [hitting the palms of her hands together and uttering hmm] ***Kungatsi baloyiwe. Kwenta kwabo kuyafanana. Angiboni umehluko emukhatisini wabo nasemantfombataneni*** *[I do have children of my own but they do not support me … neither my daughters nor sons. They are the same! [hitting the palms of her hands together] …hmm hmm … It is as if they were all bewitched! Their behaviour is the same. You cannot even see the difference in the girls*] (Grandmother I, 70 & caregiver of one GOTHA aged 16 years).

The phenomenon of parental maltreatment/abuse, through abandonment, was also reported locally in studies by Mabuza (2008:63), ULARN (2003: online) and Magagula (2002:28), and internationally, by Thomas (2007:109).

Elderly abandonment is generally subsumed under the broad category of human violence, in particular elderly abuse. Elderly abandonment and neglect, has been documented extensively world-wide, particularly through print media (Chadwick, 2008: online, Fatah, 2008: online; Singh, 2008: online; Dhillon, 2007: online; The Saturday Star, 2007: online). In particular, in India, parental abandonment has been attributed to the relinquishing of the traditional

religion by the younger generation, in favour of the Western culture and its values that, seemingly, offer more of materialism, individualism and personal space (Goering, 2007:online).

3.6.1.5 Sub category Working even when not feeling well

Owing to living alone with their GOTHA and not having anyone to help and/or support them with looking after their GOTHA and house chores, the data revealed that most R-BGs had no other choice but to continue with domestic work all the time even when they were not feeling well.For instances, the second oldest participant said:

> ***Like now,, I am si ck but I still wake up early … they ned to wash before they go to school and they must drink their tea*** (Grandmother L, 86 & caregirver of 7 GOTHA aged:7 through 15 years)

The only male R-BG raising GOTHA in the present study and also predominant caregiver of such children in his homestead had a physical health problem which he described thus:

> ***When I am cutting up the logs, after lifting the axe once or twice, I have to stop as it comes on*** [pointing to his chest) ***and I have to stop … sit down and rest and cool down and then I start again … because if my heart beats too much, I become unsteady.*** (Grandfather Q, 62 & caregiver of 5 GOTHA aged: 3 through 10 years).

This finding was supported by a number of studies that have investigated the elderly and found that they persevere with their caring duties despite their compromised health challenges (Fouad, 2005: online; ULARN, 2003: online; Agyarko, et al., 2002: online; Joslin and Harrison, 2002:623).

3.6.2 CATEGORY COMPROMISED HEALTH

This category included in particular the physical and emotional health dimensions of the R-BGs health (refer to Table 3.5). Generally, the R-BGs were suffering from a number of chronic physical illnesses that were a function of aging combined with knowledge deficit about self-management of their health challenges.

Table 3.5 Summary of CATEGORY: COMPROMISED HEALTH

Category	Sub-categories
3.6.2 COMPROMISED HEALTH	3.6.2.1 physical health problems 3.6.2.2 Emotional pain

3.6.2.1 Sub category Physical health problems

From general observation, while 11 (79%) of the 14 R-BGs appeared undernourished, 3 (21%) looked overweight. Both under and over nourishment are generally classified as malnutrition and associated with not eating adequately. The R-BGs were affected by the state of chronic drought that pervaded in the lowveld.

3.6.2.1 (a) Loss of strength

A number of the R-BGs raising GOTHA informed the researcher about their physical health challenges. For instance, when she was asked to describe her day-to-day encounters of caring for her GOTHA, with a tone of irritation, the R-BG answered thus:

> ***I c-a-n-n-o-t manage ... because all my strength is gone! It is better when you still have strength because then you can try your best to look after your children. When all strength is gone, there is nothing, hmm."*** [Grandmother A, 70 & caregiver of 2 GOTHA, aged: 9 and 11 years].

This finding was supported by a number of studies globally, such as Australia (Lang, 2006: online), New Zealand (Backhouse, 2006: online), South Africa (Norushe, 2005:168) and Zimbabwe (Agyarko et al., 2002: online), have indicated that declining general physical health levels was one of the major challenges among grandparents raising children, a second time.

Murray and Zentner (2001:771) pointed out that older adults experienced gradual loss of muscular strength and endurance as a result of the process of getting old and its impact on the musculo-skeletal system. In particular, ambulating is a challenge among the elderly owing to the inevitability of physical health decline with aging.

According to Hajjar, Kamel and Denson (2004: online), malnutrition adversely affects virtually every organ system, and therefore, associated with functional decline. Skolnik (2007: online) highlighted that there was a link between weight and nutritional status of the elderly with limited functional ability. It is worth noting that, in particular, women in developing countries have a tendency toward malnutrition as a consequence of the interplay between various factors such as cultural practice, food taboos and knowledge deficit, all of which may be attributed to self-care disempowerment (Masilela, Namagand and Sithole 1994:34).

3.6.2.1(b) Impaired mobility

Owing to food insecurity, many R-BGs raising GOTHA shopped around first for low food prices before buying, in order to maximize their purchases with the little money they had. Therefore, time and again these R-BGs rode on public transport to access shops in urban settings where food

prices were lower than in their rural grocery stores. With regards to mobility challenges experiences while using public transport, the oldest R-BG raising GOTHA made a complaint and said:

> ***It is difficult to ride buses now because the legs are stiff. It is better to use one's own transport if you have it or get someone to go with you ... Oh it is difficult, my Lord*** (Grandmother O, 88 & caregiver of 2 GOTHA aged 9 and 11 years).

A similar finding was reported from a Mpumalanga-based study that investigated the experiences and needs of the elderly and found that elderly persons aged 80 years and above, were more likely to report more physical health challenges than younger and middle 'old adults' such as those who are in their 60s and 70s (Makiwane et al., 2004:83).

In a West Africa based study, 72% of peri-menopausal women who resided in Accra, the Capital City of Ghana complained of pain in and around their knee joints, particularly when climbing steps in buildings (Mba, 2006:online). Makiwane et al. (2004:87), also found in their study, that the elderly, most of whom were women aged 80 years and above, had difficulty with ambulating owing to generalized aches and pains in their lower extremities.

3.6.2.1(c) Pain around the knee joints

From the data, it was also revealed that the majority of the R-BGs, experienced bouts of acute painful attacks around their knee joints time and again. For instance, one RGB raising GOTHA was found ambulating with aid of two improvised sticks from a nearby field because of such pain in one of her knees. Referring to the discomfort in her knee joints she said:

> … ***and these knees of mine, my child,*** [gently patting on her knees] ***are also a problem to me. They have been giving me problems. This one*** [pointing at the right knee] ***is more painful than the other one*** (Grandmother G, 76 & caregiver of 7 GOTHA aged: 3 through 17 years).

Similar findings were reported by Mabuza (2008:60) in her study that investigated the basic needs of the elderly in the Hhohho region in Swaziland. According to Murray and Zentner (2001:770) loss of calcium from bones is responsible for some of the major challenges of age-related changes in the skeletal system. Such bone loss is associated with the process of menopause and therefore, this problem is more evident in older women.

Older adults suffer from a variety of joint disorders that are a result of degeneration of the articular cartilage accompanied with hypertrophy of bones (Haggar and Brocopp, 2009:490; McEwen, 2002:315). These conditions are a common cause of premature disability, especially among elderly women, and also cause functional challenges, such as interference with activities of daily living as well as instrumental activities of daily living.

McEwen (2002:315) further highlighted that persons aged 65 years and above, constitute approximately 33% to 90% of those elderly who suffer from osteo-arthritis. Most of the pain they experience is felt, particularly, in the joints that carry weight such as knees, hips and spine and also those that are used on a daily basis such as fingers, wrists and feet (Rosendahl, 1999:197).

3.6.2.1(d) Stress-related elevated blood pressure

The data also revealed that quite a number of R-BGs raising GOTHA were forever thinking about not having

adequate resources with which to look after their GOTHA. Thinking too much was inevitable and it cost their health too. The link between elevated blood pressure and thinking too much was explained by one R-BG thus:

> ***The problem is, I have elevated blood pressure.*** [she repeated] ***I have elevated blood pressure. I have just recovered from an attack of* elevated *blood pressure*. *It was elevated because of thinking too much*** (Grandmother H, 65 & caregiver of 3 GOTHA aged: 5 through 17 years).

This finding was consistent with Inwood (2002:online) who found that the excessive demands of grandparenting on elderly Canadians was sufficiently strenuous to cause elevated blood pressure that warranted medical treatment.

3.6.2.1(e) Insomnia

The data also revealed that owing, primarily, to resource constraints, coupled with other factors, the R-BGs raising GOTHA could not sleep because of thinking too much. The oldest R-BG in the study put is thus:

> ***Thinking too much is another thing especially when you are old… you don't sleep. People might think that when you are inside your room you are sleeping and yet you are not sleeping. You are busy talking to yourself continouosly. There is nothing like sleeping my child. You hear all the cocks crowing because of thinking of problems* (Grandmother O, 88 & Caregiver of 2 GOTHA aged: 9 and 11 years).**

Mason (2004: online) highlighted that physical stress was one of the stressors in elderly caregivers of HIV and AIDS-affected children.

3.6.2.1 (f) Sores in the stomach

The data also revealed that as a result of worrying too much, some of the R-BGs had developed stress-related clinical manifestations in their gastro-intestinal tracts.

One R-BG who looked after grandsons only was particularly stressed because of gender socialization. She could not bring herself to ask her grandsons to assist with housework because they were males and culturally, they were not expected to take part in female designated chores. Therefore, she suffered alone in her silence. She described her physical health problem thus:

> ***I have sores in my stomach. They are burning in nature. They become worse when I eat*** (Grandmother K, 72 & caregiver of 5 GOTHA aged from: 5 through 17 years).

Whitley et al. (2002: online) and Thomas (2007:121) reported stress related manifestations too on the elderly who were looking after grandchildren because of parental absence due to substance abuse.

3.6.2.1(g) Diabetes mellitus

The data also revealed that one of the R-BGs suffered from diabetes mellitus. This finding was similar to the findings reported from a Uganda-based study by Najjumba-Mulindwa (2003: online) and also a Swaziland-based study by ULARN (2003: online). Both these studies investigated the elderly and among them were those who had this metabolic-endocrine disorder.

3.6.2.1(h) Being HIV positive

One R-BG raising GOTHA had recently been diagnosed as having HIV infection. The deadly infection had been diagnosed following a complaint to the doctor about not feeling well by the R-BG raising GOTHA. She voluntarily shared the following with the researcher:

> ***I went and had my blood tested and they said that my* immune system *was still alright. They said that they will not give me any tablets ... I was told to stay for three months before returning to the clinic and***

> ***then on the fourth one go back again and test my blood to see whether on not `I need the tablets.***

Thereafter, she attempted to describe her general health and said:

> ***However, I am wondering*** (looking puzzled) ***because I am shriveling away, I am not making any progress, I am not well, I am not dying, and I continue to dry up*** (Grandmother I, 70 years old & caregiver of one GOTHA age: 16 yeas).

Though the elderly are regarded as having low risk of contracting HIV infection (Knodel and van Lantingham, 2002:online), UNAIDS Swaziland and NERCHA (2008:15), reported that approximately 7% of the Swazi population, aged 60 years and above, were infected with HIV.
Even though only one R-BG had tested positive to HIV infection, this is very significant because, one area of concern with regards to the HIV and AIDS epidemic and the elderly in Swaziland, is their exclusion from HIV and AIDS-related programmes and activities. The majority of the elderly in Swaziland are affected by the HIV/AIDS epidemic, through either informal caregiving of sick children at home and other relatives or raising orphaned grandchildren whose HIV statuses are not known (Maziya, 2005:4).

According to the hierarchy of needs by Maslow, sex is a physiological need (Murray and Zentner, 2001:256). It is noted that culturally, elderly Swazi women who are in their peri-menopausal period, are discouraged from indulging in sexual intimacy while their counterparts are not. Older Swazi men, on the other hand, are free to date and even marry very young girls, sometimes as young as girls in their teenage years (Mabuza, 2008:6).

From a Swedish longitudinal study that investigated the population group of cohorts aged 70 and above, the findings suggested that elderly Swedes remained sexually active well into their old age (BBC News, 2008: online). Therefore, one of the implications of the findings from the Swedish study on the Swazi elderly is, among others, the need to empower the Swazi elderly about their reproductive health (Grobler, 2003:158) so that they will be protected from any sexually transmitted infections, including HIV infection.

3.6.2.1(i) Multiple physical health complaints

The data showed that some of the R-BGs, had more than one complaint about their physical health problems. For instance, one R-BG raising GOTHA presented with the following number of physical problems at the same time and said:

> ***Even I, am no longer in good health. I have some ailments. I have pain in my chest ... and my knees ... and my lower back ... and dizziness. All that and another big problem is that I get tightness in the chest even when I walk the slightest distance ... it tightens up severely. As for the knees, when I try to stand, they become unstable and wobbly. All that, I don't know what I will do with.*** (Grandmother B, 78 years & caregiver of one GOTHA aged: 7-years).

Venter (2004:38) highlighted that among black patients who complain of many physical manifestations such as: abdominal pain, chest pain, cough, general body/joint pains, dizziness, headaches, genital-urinal complaints and general body weakness, this is indicative of some underlying mental health challenges. Venter went on to say that, if three of the afore-mentioned manifestations were present, that was indicative of some underlying mental health challenge. Some of the major stressors found among the R-BGs raising GOTHA were, resource constraints, the state of caregiver's own health (Conway, 2004:61- 63) and lack of personal time (Mason, 2004: online).

3.6.2.1(j) Impaired vision

The data also revealed that a number of older R-BGs raising GOTHA had vision challenges, as described by one R-BG who narrated as follows:

> ***Otherwise, I am still quite well. I am still in reasonable health … However, what is painful to me is that my eyes do not see very well. They are kind of cloudy. I do not understand what they are up to. When I look at things, the objects are not clear. This one*** [pointing at the left eye] ***is cloudy in the morning. It is very dark in the beginning and then improves slightly as the day goes by. They are like that my eyes I can see that these eyes will play me up very soon. How will these children be able to feed me****?* (Grandmother G, 76 & caregiver of 7 GOTHA aged: 3 through 17 years)

This finding was supported by Murray and Zentner (2001:765) who pointed out that vision disturbance, especially through cataracts and glaucoma, occurs frequently in older adulthood. Impaired vision was reported as a major cause of functional impairment among elderly Cambodian grandmothers who looked after AIDS-orphaned grandchildren (Population Council, 2006: online).

Eighty percent of elderly women, aged 60 years and above, in the study by Gwebu (2002:26 – 27) suffered from cataracts. An interesting finding in that study was that 85% of the participants lacked knowledge about their vision challenges. While 25% did not know the cause of cataracts, the remaining 60% attributed it to witchcraft. This has health education implications.

In a study that explored the experiences and needs of both rural and urban elderly in the Mpumalanga Province in the Republic of South Africa, only 4% of the rural-based

elderly out of the entire sample of both rural and urban based elderly were be-spectacled for medical reasons (Makiwane et al., 2004:91). The main reason why fewer rural-based elderly wore prescribed spectacles was that essential health services were not as readily accessible in rural areas as they were in urban ones. Furthermore, these rural grandmothers had financial limitations since the majority of them were heads of multi-generational households and looking after all members within those households.

3.6.2.1(k) Impaired hearing

The researcher observed that the majority of the R-BGs she interviewed had difficulty in hearing. Often there was need to repeat statements. When the interviews were about to commence, the R-BGs raising GOTHA informed the researcher to position herself on the side with better hearing. Murray and Zentner (2001:705) pointed out that there is gradual change in auditory nerve and bones of the inner ear during older adulthood.

3.6.2.2 Sub category Emotional pain

From the demographic data, it was revealed that all R-BGs who were interviewed had lost between one and several of their adult children, through HIV and AIDS-related illnesses. The sudden loss of adult children was obvious and traumatic to all the R-BGs since under normal circumstances, parents expect to die before their offspring.

The following verbatim quotations depict the emotional challenges the R-BGs were undergoing:

> **There *is nowhere I am going to ever see the car approaching anymore! I Hu-ha! I am not going to see it (*son's car) *approaching the homestead again!***

(Grandmother L, 86 & caregiver of 7 GOTHA aged from: 7 through 15years).

There is n-o-t-h-i-n-g! There is n-o-t-h-i-n-g! I have no past, I have no future! I am complete as you see me here! (Grandmother H, 65 & caregiver of 3 GOTHA aged 5 through 17 years).

[Speaking in a low and tired-like voice] ***You see*** [pointing at the grave that was located approximately 10 m across the homestead yard], ***God has done His Will. There is nothing I can do. I cannot accuse Him because for me to be where I am today, it is He. He gave her to me in the first place and He has taken her away. I should not accuse Him*** (Grandmother B 78 & caregiver of one GOTHA aged: 7 years).

Everything is at a standstill! Oh my Lord. My Jesus. Thou Holy One. It is only the Lord who knows. His Majesty is never defeated by anything. He has ALL the Power! Eeh-eeh. (Grandmother L, 86 & caregiver of 5 GOTHA aged: 7 through 15 years

Oh Prince of Peace. It is You, who knows. I do not know anything. It is Jehovah Who is in the clouds who knows the day and time of one's departure from this planet earth! (Grandmother L, 86 & caregiver of 5 GOTHA aged: 7 through 15 years).

This finding was consistent with some of Mabuza's (2008:62) and Matshalaga's (2004:10 - 40) studies whose findings revealed that the elderly who had lost sons through HIV and AIDS-related illnesses, were affected emotionally since they depended emotionally and financially on their deceased sons.

According to the Swazi culture, sons are very significant family members as they are the ones who look after aging parents. Therefore, the death of a son is a great loss indeed, since it has implications on the social welfare of parents in the golden years.

According to the Swazi, ***''umntfwana ungumliba loya embili''*** [a child is an investment for the future]. Maziya (2005:90) investigated rural-based parents who were looking after adult children with full blown AIDS at home and pointed out that, grieving for a child with chronic illness generally commenced while the parent was still nursing the child, and watching the graual deterioration of of her/his condition with each day that went by.

3.6.3 CATEGORY RESOURCE AND BASIC NEEDS CONSTRAINTS

The R-BGs raising GOTHA did not have adequate resources and basic needs for themselves and their GOTHA.There was not enough food, accommodation was overcrowded and they did not have adequate suitable clothing. This category and sub-categories are summarized in table 3.6, below.

Table 3.6 Summary of CATEGORY: RESOURCE AND BASIC NEEDS CONSTRAINTS

Category	**Sub category**
3.6.3 RESOURCE AND BASIC NEEDS CONSTRAINTS	3.6.3.1 Financial constraints 3.6.3.2 Inadequate housing 3.6.3.3 Inadequate nutrition 3.6.3.4 Inadequate clothing 3.6.3.5 Lack of adolescent parenting skills.

3.6.3.1 Sub category Financial constraints

The data indicated that the R-BGs raising GOTHA did not have money and yet needed it to procure some of their personal requirements and also basic needs for their GOTHA.

The social grant allowance they received once every three months, whenever it was distributed, was not sufficient to cater for the needs of the R-BGs, let alone the added needs of their GOTHA. The following excerpts reflect the financial constraints of the R-BGs:

> ***I have no money. I cannot afford to even buy a bar of soap or a candle or a box of matches*** (Grandmother B, 78 & caregiver of a GOTHA aged: 7 years).

> ***Government has stopped supporting them*** [orphans in schools]***. I do not have money to send her to school*** (Grandmother I, 70 & caregiver of a GOTHA aged: 16 years)

> ***Whenever I ask for help*** [from the community]***, they ask for money and I don't have it. Right now, they*** [government] ***expect us to construct latrines but I cannot afford it*** (Grandmother H, 65 & caregiver of 3 GOTHA aged: 5 through 17 years).

> ***I walk to and from the clinic with the baby on my back because there is no money for bus fare. I cannot even afford to buy relish*** (Grandmother C, 61 & caregiver of 3 GOTHA aged: 8 months through 15 years).

According to McKenzie, Pinger and Kotecki (1999:279), income is one of those instrumental needs of seniors, since aging means increased expenses for health care and also home maintenance.

Lack of financial resources by the R-BGs was not supported by Makiwane et al. (2004: 57 - 58) whose Mpumalanga-based study revealed that the elderly in that study were beneficiaries of a monthly old age pension, as well as receiving child aid grants to enable them to adequately look after themselves and their orphaned grandchildren.

3.6.3.2 Sub category Inadequate housing

The data revealed that housing was inadequate, both in construction quality and capacity. The majority of the houses in which the R-BGs lived were poorly constructed from the beginning and over the years, their stability had deteriorated. In addition to bad housing, the influxes by their GOTHA created overcrowding as well as lack of privacy.

While overcrowding was not so obvious during the day, since both R-BGs and GOTHA spent most of the daytime busy outside, however, night time was rather a stressful time, owing to lack of adequate sleeping space. Referring to lack of room and overcrowding, especially at night, one R-BG exclaimed:

> ***There is no room for them to sleep! My Lord, as you can see*** [pointing at the only sleeping hut she had]***. There is nothing. I really do not know what to do, my Jesus!*** (Grandmother H, 65 & caregiver of 3 GOTHA aged: 5 through 13 years)

Still referring to overcrowding, another R-BG who slept in one small room together with 11 children, out of whom 4 were her own and 7 were GOTHA, said:

> ***If you had to come and find us sleeping, you would be surprised at the number of people who are crammed in one room. We sleep so uncomfortably*** (Grandmother N, 60 & caregiver of 7 GOTHA aged: 3 through 17 years).

Inadequate accommodation, in general, was also reported by Mabuza (2008:73), Matshalaga (2004:53) and Agyarko et al. (2002: online) whose elderly also looked after grandchildren who had been orphaned by AIDS. .

From her observational notes, the researcher observed that most R-BGs had houses that were

constructed in the traditional style, known as 'stick and mud', namely made with small interlaced wooden branches/sticks that formed the framework of the house, then the walls were smeared with plenty of mud/soil and had a thatched roof. This finding was consistent with Dlamini (2003:25 – 27) who reported that 75% of the houses in the Lubombo region were traditionally built.

However, the quality of a number of traditionally built structures was poor as they had many structural faults (refer to figure 3.1) such as no windows, non plastered walls, gaps between the interlacing wooden framework and faulty doors. This finding was supported by Dlamini (2003:233-27) who observed that 25% of the traditional structures had serious structural faults and approximately 60% had ventilation problems.

Figure 3.1 A traditionally built structure/room. Its framework is made up of interlaced sticks that usually are plastered with special mud.

Note that there are no windows, all the plastering mud has dissolved and there are gaps between the sticks. The roof is leaking hence the large piece of canvas in place on the roof.

Such poor housing construction also had implications for safety and health needs of the R-BGs and their GOTHA. For instance, the lowveld region is infested with dangerous reptiles such as cobras (refer to chapter two Figure 2.3). Poor housing ventilation is a health risk factor leading, among others, to communicable airborne diseases such as pulmonary tuberculosis (Smeltzer and Bare, 2004:533). Cracks in the dry mud walls and gaps in the non-plastered wooden framework were ideal medium for vectors and microorganisms to cause harm to the occupants of these dwellings.

Harker (2006:online) pointed out some of the long-term effects of bad housing on children. For instance their physical and mental health, and academic performance are affected and that in turn contributes toward physical health problems and low educational attainments, thus increasing the likelihood of unemployment or working in low paid jobs.

As a consequence of faulty housing construction, some of the R-BGs raising GOTHA reported that, in times of very bad weather such as heavy rains and/or strong winds, they, together with their GOTHA, sought refuge at their neighbours' whose houses were structurally stronger. This finding was also revealed by Mabuza (2008:73) whose elderly in that study reported that they slept outside their houses because it was safer as their houses had become so dilapidated to the point of being detrimental to life.

According to McKenzie, et al. (1999:280) housing is a basic necessity in life and it ought to fulfill some of the following functions:

- it is much more than a place to live in,
- housing is a symbol of independence,
- it is a place for family gatherings,
- it should be a source of pleasant memories and
- it is a link to friends, the neighborhood and the community.

An important point to raise here is that, traditionally, the grandparents, particularly grandmothers, shared their sleeping quarters with young children of both sexes, until such time that these children had reached the pre-pubertal developmental stage, when they got separated (Thwala, 2009:4). This was to avoid, among other things, incestuous relationships among siblings, especially during the adolescent period. However, in the present study, owing to shortage of accommodation the R-BGs slept with all their GOTHA in the same room, regardless of age and sex. Such practice was viewed as potentially dangerous, since there are reports of sexual abuse on, in particular, elderly women and young girls in local print media. For instance, an 85-year old grandmother who had offered her adolescent grandson to share her sleeping quarters overnight was raped for most of the night by the very grandson (Lukhele, 2008:1–2).

3.6.3.3 Sub category Inadequate nutrition

Though food is a basic need in life, the data revealed that there was serious food insecurity and not many households ate adequately all the time. Their staple food was known as *palishi* (soft porridge made out of maize meal) and was eaten with or without relish depending on whether the R-BGs

could afford relish or not. Emphasizing the desperate state of food insecurity, one R-BG raising GOTHA narrated:

> ***The issue of food, my child, the issue of food, as you can see the state of the country I do not know… my mind is boggled up since I do not know how I am going to survive with my children. The greatest problem is with feeding them. Feeding them! Feeding them!*** (Grandmother G, 76 & caregiver of 7 GOTHA aged: 3 through 17 years).

To help nourish affected families in the lowveld, some local and external NGOs distributed food handouts. The following quotation reflects dependence on food relief by the R-BGs:

> ***I prepare them food that I receive from Save the Children Fund … then my children eat. When it gets finished I really do not know what to do and I ask myself what I will prepare for them because the rains do not fall in this part of the country. We are always hungry. They have no food*** (Grandmother E, 82 & caregiver of 2 GOTHA aged: 6 and 8 years).

The data revealed that, at times, there was no food at all in some of the homesteads and therefore, in such times, the R-BGs had to be very innovative. One R-BG said:

> ***I look for leaves from trees and take them home and prepare them for my children and they eat*** (Grandmother G, 76 years & caregiver of 7 GOTHA aged: 3 through 17 years).

Another way of meeting their nutritional needs when they ran out of food was explained thus:

> ***When we do not receive food rations, we eat wild roots*** that I go and look for in the veld (Grandmother O, 88 & caregiver of 2 GOTHA aged 9 and 11 years).

Similar findings of inadequate nutrition at household level were reported in the studies conducted by Mabuza (2008:69) and Matshalaga (2004:48). At the same time, this finding was not supported by Makiwane et al. (2004:102) whose Mpumalanga Province-based study findings revealed that

there was no food insecurity in those elderly-headed households. Most elderly ate at least once or twice a day, if not all three meals.

According to McEwen (2002:305), persistent intake of less than required amounts in quantity and quality of nutrition, interferes with the capacity of the elderly to perform both activities of daily living and instrumental activities of daily living. According to Skolnik (2007:online), elderly persons who do not eat adequately are likely to have severely compromised immune systems, can easily sustain fractures should they fall sick and are likely to take longer to heal if they have surgery.

McEwen (2002:315) also pointed out some of the factors that contributed toward nutritional challenges among the elderly as: economic hardships reduced social contact, involuntary weight loss or gain, needing assistance with activities of daily living and instrumental activities of daily living and being very old, namely 80 years and above. All the afore-mentioned were applicable to the situation of R-BGs raising GOTA.

3.6.3.4 Sub category Lack of clothing

Through observing the researcher noted that some of the R-BGs wore old torn clothes. The data revealed that at times the R-BGs were given clothes by good Samaritans, and also by the two pro-elderly NGOs, namely *Philani MaSwati* and *Umtfunti weMaSwati* as expressed by one R-BG that:

> ***We old ones get our clothes from those people who feel for us. That is how we get our clothes.*** **We are also grateful to the Queen Mother for the clothes and blankets she gave us.** (Grandmother, D, 63 & caring for 5 GOTHA, aged: 8 through 17 years).

This finding is consistent with that of the elderly in Mabuza's (2008:68 – 69) who admitted to not having adequate clothing as one elderly man revealed that he did not have any *emahiya* [traditional cloth attire for Swazi men].

Another observation made by the researcher was that the clothes that were worn by R-BGs raising GOTHA were very dirty. Such states of compromised personal hygiene suggested that the R-BGs may not have had enough clothes with which to change regularly, and therefore, could not wash them as frequently as necessary. One of the key informants in the focus group discussion of Mabuza's (2008:68) study expressed the need for more clothes for the elderly with which to change, while dirty ones were being washed.

3.6.3.5 Sub category Lack of adolescent parenting skill

From the demographic profile, the data showed that some of the GOTHA who were being cared for by the R-BGs were in their adolescent stage. The adolescent is said to be neither a child nor an adult, and psychologically, she/he has a mind of her/his own (Meyerhoff, 2004: online). Raising such GOTHA was quite challenging for the three R-BGs.

One R-BG raising 4 GOTHA, among whom there were two young children and also two mid adolescent GOTHA, a female and

male, was asked to describe her daily encounters of raising them. While she had no problems with the two younger GOTHA, this was what she said about the two adolescent GOTHA. In a raised voice tone she started:

> ***Kwekuchala abangilaleli. Uma ngibatfuma, abafuni kuthunywa*** *[First and foremost, they do not listen to me. When I try to send them to do something, they refuse]*.

Then, referring to the female adolescent GOTHA, the R-BG continued:

> ***At first I used to beat her myself until my arm became painful. I even asked my brothers to beat her on my behalf and they did but they ended up saying that they (children) might have us arrested. I thought I was administering discipline. The girl is now pregnant and has stopped going to school. She is a problem in my heart*** (Grandmother F, 60 & caregiver of 4 GOTHA aged: 7 through 17 years).

Lang (2006: online) pointed out that raising children for the second time by grandparents is harder because their disciplining techniques are usually outdated. This statement is true, because the application of corporal punishment to children, in contemporary society, is generally interpreted as child abuse, and therefore has legal implications. Linsk and Mason (2004:online) alluded to the fact that grandparents raising adolescent grandchildren, found it quite challenging because they were rebellious, and also they had emotional problems that affected their general behaviour.

Upon probing (Polit and Beck, 2004:342) the behaviour of the male adolescent, the same R-BG reported the following:

> ***Whatever he sees he demands it forcefully from me. He wants everything that other people have, he demands, he does not ask for things. His grandfather bought him a bicycle but he will not ride it instead he wants money for bus fare. He says he would rather stop***

> ***school than walk to school. I am forced to give him money for bus fare.*** (Grandmother F, 60 & caregiver of 4 GOTHA aged: 7 through 17 years)

Adolescents, often defy authority, including their own parents, and are more responsive toward peer and selected reference groups/opinions (Meyerhoff, 2004: online). Backhouse (2006:9) reported rebellious attitudes among adolescent grandchildren who were being raised by their grandparents because of parental incarceration due to substance abuse.

Studies that have been conducted elsewhere on bereaved children, especially among adolescents, have indicated that dysfunctional behaviour is a manifestation of trying to deal with parental loss, for which professional guidance is recommended in order to avoid a dysfunctional adult life (Sussilo, 2005:online). The death of a parent was said to be particularly devastating because this frequently necessitates change in environment and such changes disrupt the quality and stability of the child's support network (Hansen, Heath, Lawrence, Levy, Ryan and Sonntag 2008:online),

With regards to childrearing, it is worthwhile mentioning that, generally, according to the African tradition, children are expected to always be obedient and conformist. The researcher was not able to find any studies that have investigated the emotional aspect of, especially, HIV-affected children in Swaziland. Such a gap in research was not altogether a surprise, since, in the Swazi culture, children are generally 'seen' more than 'heard'.

3.6.4 CATEGORY CONCERN RELATED TO THE FUTURE OF GOTHA

One of the major concerns of all R-BGs revolved around fear of what would happen to their GOTHA in the event they (R-BGs) died sooner rather than later because there would be no grown ups to look after them (GOTHA). Other concerns included lack of educational opportunities for their GOTHA and also not having enough clothing and blankets for their GOTHA. This category and sub-categories thereof are displayed in Table 3. 7, below.

Table 3.7 Summary of CATEGORY: CONCERN RELATING TO THE FUTURE OF GOTHA

Category	**Sub category**
3.6 CONCERN RELATING TO THE FUTURE OF GOTHA	3.6.4.1 No adult supervision for GOTHA 3.6.4.2 Lack of opportunities for education for GOTHA 3.6.4.3 Inadequate clothing

3.6.4.1 Sub category No adult supervision

The data indicated that the R-BGs were afraid to die very soon and leave their GOTHA with no one, especially someone who was mature to look after those children. Because of this, the R-BGs constantly prayed and asked for longer lives so that they could be with their GOTHA al little bit longer. For instance, one R-BG put it thus:

> ***I really do not know who can look after them. I sometimes wonder to whom my grandchildren will go the day I die. Where will my grandchildren go to when I die? I really do not see … They will remain here, remain here forever and ever as they have nowhere to go*** (Grandmother L 76 & caregiver of 5 GOTHA aged: 7 through 17 years).

This finding was consistent with some of those of Norushe (2005:157) who discovered that the caregivers of children orphaned by AIDS in the Eastern Cape Province of the

Republic of South Africa were not in favour of their separating as it would not promote development. Kawewe (2006:online), in a Malawi-based study that investigated the situation of children whose parents had passed away because of AIDS found that these children experienced emotional distress and trauma when they had to separate and live with different families. However, this finding is contrary to one of Simelane's (2004:33) findings that revealed that an older sibling was overwhelmed by looking after a younger sibling and was considering abandoning them (younger sibling].

The data also revealed that the R-BGs feared that with their demise, the GOTHA would split up or be separated. Though still addressing the researcher, one concerned R-BG, put it simply to God and said:

> ***It is you God who knows. You created me. I am asking you to make them not to separate from one another even when I am dead*** (Grandmother L, 86 & caregiver of 5 GOTHA aged: 7 through 17 years).

Mbugua (2004:online) argued that while institutionalized care for orphans whose parents have passed on through AIDS in developing countries is widespread, it is not developmentally ideal because it deprives these children the opportunity to grow up in a family environment. On the other hand,

One R-BG who was very sensitive and also very protective of her GOTHA, issued the following warning:

> *[In a high pitch voice and with both hands placed around her waist]* ***For sure if I die now, and leave them like this, my ghost [releasing the right hand and pointing with and shaking her right index finger] will return because I won't be able to see anything [where I will be] no matter how much of a Christian I am. If I die now now, my spirit will not rest as I will have a strong will to return especially if I look behind***

> ***and see them, eeh.*** (Grandmother G, 76 & caregiver of 7 GOTHA aged: 3 through 17years)

While, initially, child-headed households were perceived as an ideal solution to the problem of children who have lost parents because of AIDS, since these children would presumably not leave their natural environments, empirical evidence has since revealed that such families are not safe without adult supervision in their communities. Simelane (2004:32 - 33) found that children who lived alone in child-headed households, were subjected to maltreatment (Kibel and Wagstaff, 2001:514 – 521) by among others, relatives and also the community at large. Francis-Chizororo (2007:online) reported that children in child-headed households because of parental deaths through AIDS preferred to live alone in spite of the challenges encountered, because of fear of cruel treatment by relatives.

3.6.4.2 Sub category Lack of educational opportunities for GOTHA

Even though most of the GOTHA attended schools, the R-BGs always feared that there was no equal opportunity to access education. Though the majority of the
R-BGs could neither read nor write, they valued education for its benefits, and wished their GOTHA to become educated so that they could become self-sufficient and independent and also help look after one another. For instance, one R-BG put it thus:

> ***I wish for my children to be educated so that when it is time for me to die, they will be mature and can fend for themselves so that they do not get beaten by people when they go begging food from one homestead to the next because of hunger. Well, when there is no one to fend for them people will beat them up. What will they eat because I know how to go to people's homesteads and ask for food. That is what I am crying***

> ***for my child.*** (Grandmother G, 76 & caregiver of 7 GOTHA aged: 3 through 17years)

This finding was supported by a Zimbabwe-based study that investigated elderly women who looked after AIDS-orphaned grandchildren and these grandmothers worried very much about their grandchildren's education (Howard et al. 2006:online).

Kawewe (2006:online) found in her Malawi-based study that children who were orphaned through AIDS, were less likely to be in school than non-orphaned children, and double orphaned children were the most severely affected. According to Abeldinger, Paxon and Case (2004:online) and in line with Hamilton's rule that postulates that closeness of biological ties governs altruistic behaviour, orphaned children are less likely to be enrolled in school than non-orphans because most of the orphans are likely to stay with non-relatives than non-orphaned children. In a Zimbabwe-based study, Francis-Chizororo (2007: online) found that older siblings in child-headed households dropped out of school in order to mind younger siblings.

The data also revealed that R-BGs raising GOTHA were aware of the existence of 'fake or bogus orphans' whose presence in schools denied genuine cases of GOTHA the opportunity to be admitted into schools. The following statement reflects one
R-BG's complaint about the existence of bogus orphans in schools:

> ***…I don't know whether or not they will be admitted. There are those people who spoil things for us and enroll 'orphans' who have mothers and fathers. A person will come to school and say that this one has nothing, he/she has no mother no father and yet the parents are alive. That is what will deprive our children from government sponsorship. Other people have spoiled it for us. We, who have real orphans feel***

the pains. Is it nice to have orphans? (Grandmother E, 82 & caregiver of 2 GOTHA aged between 6 and 8 years)

This finding was consistent with a news radio broadcast release that was reported in Liberia about some orphanages that were full of bogus AIDS orphans in order to obtain money for their education from international donors (Kaiser News, 2007:online). Hall (2008:online) reported about a Swazi MP, an ex-headmaster, who was charged with fraud for keeping a register of non-existent OVC at the high school where he was headmaster in the year 2003.

3.6.4.3 Sub category Inadequate clothing

The data revealed that most of the GOTHA was left with only those clothes with which their parents left them when they died. These clothes had since become too small and old. The thought of winter coming on and her GOTHA not having sufficient clothing, caused one R-BG to say this:

> ***… and the state of being very poor … my children will suffer in the coming cold weather until they turn white and the people will laugh at them … they will laugh … they will laugh their lungs out when they see my children putting on … eeh … what will I put on them? They will turn white from sitting around the fire in order to remain warm*** (Grandmother G, 76 & caregiver of 7 GOTHA aged: 3 through 17 years).

Inadequate clothing for their orphaned grandchildren was consistent with the findings of Zimmerman (2005: online) and Mbugua (2004: online) who investigated AIDS-orphaned children in Malawi and Kenya, respectively. Orphaned children had far less clothes than non-orphaned children.

3.6.5 CATEGORY FEELING OVERWHELMED

A sense of feeling overwhelmed was identified as a major category through the way the R-BGs were expressing themselves about their grandparenting role. According to

the Longman Dictionary of Contemporary English (1995:1013) a person who is feeling overwhelmed is one who is affected by something that they cannot think clearly. Among other activities that caused such a feeling were: engaging in daily domestic activities, attending to the needs of small children and experiencing role inadequacy (refer to Table 3.8).

Table 3.8 Summary of CATEGORY: FEELING OVERWHELMED

Category	Sub category
3.6.5 FEELING OVERWHELMED	3.6.5.1 Engaging in daily domestic activities 3.6.5.2 Parenting small children 3.6.5.3 Role inadequacy.

3.6.5.1 Sub category Engaging in domestic activities everyday

While some of the GOTHA were still too young to assist with house chores, the older ones attended school all day long. Therefore, the R-BGs did most of the housework alone. Some of the routines the R-BGs engaged in were waking up early to get the GOTHA ready for school in good time, preparing meals, work in the garden, go and fetch watch water, do laundry and collect firewood with which to preparing meals and boil water for GOTHA to bath. This finding was supported by Mkhonta (2008:71) who found that grandparents who cared for orphans and vulnerable children in an informal setting were burdened.

As if to show that she could do it, the second oldest R-BG in the study narrated the following:

> ***Oh yes, I do the cooking. Me, I do the cooking haa! I wake up early at the same time as a young girl would wake up. By the time the chickens fall from the trees***

> [between 4 and 5 am]***, I will have long gotten up. I do not like the sun to rise before the children are fed*** (Grandmother L, 86 & caregiver of 5 GOTHA aged: 7 through 17 years)

Once the GOTHA had gone to school the R-BGs remained doing housework. Some of the chores they occupied themselves with were included by one R-BG who said:

> ***After they have gone to school, I go and fetch water. When I return home from fetching the water, I grind maize grain so that I can cook them palishi. I also wash the plates and pots*** (Grandmother C, 61 & caregiver of 3 GOTHA aged 8 months through 15 years).

While some of the R-BGs raising GOTHA carried 10 – 20 litre water containers on their heads, others used wheelbarrows to go and collect their water. Dlamini (2003:22) discovered that the participants in his Lubombo region-based study walked an average distance of approximately 1 – 2 km to get to their nearest water source.

3.6.5.2 Parenting small children

The data showed that a number of R-BGs were looking after GOTHA who were still very young. The younger the GOTHA the more physically demanding it was for these
R-BGs. For instance, the oldest R-BG in the study described her routine with her two young grandsons:

> ***I wake them up to go to school. I keep reminding them that they must leave for school before the school bell rings. There is nothing else that I do for them except to cook for them. Just cook for them and they eat. That is all. I do not want to tell lies that there is anything else I do for them'*** (Grandmother O, 88 & caregiver of 2 GOTHA aged: 9 and 11 years).

Another R-BG said:

> *I wash her clothes. No one else can do the laundry for her except for me.* (Grandmother B, 78 & caregiver of one GOTHA aged: 7 years).

This finding was supported by Matshalaga (2004:10 – 40) and Howard et al. (2000: online) who also had elderly grandmothers who were raising young grandchildren.

3.6.5.3 Sub category Role inadequacy

The data showed that each R-BG looked after between 1 and 7 GOTHA or an average of 3.57 GOTHA. The mean age of the GOTHA was 9.84 years which meant that though these children were in their late childhood developmental phase they were still very young and demanded a lot of attention. The following statements that were made by the R-BGs and were reflective of burden and suffering owing to role inadequacy:

> ***My trouble is mostly this child. I am very much troubled in my heart. She is my responsibility alone. I cannot say anything. That, I can look after an orphan, … how can I do such when I, myself, actually need someone to look after me? But now, I have a burden to carry! What will I do with her? That is what is in my heart, especially when I am alone. I remember that I have problems of my own and then God gives me more on top of that!*** (Grandmother B, 78 & caregiver of one GOTHA aged: 7 years).

> ***You see, my child, I am suffering a lot. As I see it, this suffering will kill me sooner than later and leave these children alone because I keep thinking about for how long I will keep on living like this? Oh you see my girl, this will cause me to have what they call a stroke and leave my orphans alone. I do not know how God can assist me to persevere and not think too much … and yet again one cannot live without thinking. Such thinking stems from suffering and then I think a lot … in my heart I cry tears and wonder why God left me with these children.*** (Grandmother G, 76 & caregiver of 7 GOTHA aged: 3 through 17 years).

> ***I just don't know what to do and wish this house had another door so that I can disappear through it so that when she/he wakes up, I am nowhere to be found… yet again, when she does not find me, to whom will she turn because there is no other*** (Grandmother N, 60 & caregiver of 7 GOTHA aged: 3 and 17 years).

> ***The woman who brought them into this world has sinned because why did she bring them forth and then not look after them. If she had remained here and struggled also, it would be better. It would not be like it is hmm (some silence) … Lord, oh, this is Planet Earth and I am here to suffer. Blessed is he who will never experience such. Indeed, blessed is that person***. (Grandmother A, 70 & caregiver of 2 GOTHA aged: 9 and 11 years).
> ***Having to do all the work single-handedly, at times I wish these children could marry soonest*** [some light-hearted laughter] ***so that they*** [wives] ***can help in the kitchen*** (Grandmother K, 72 & caregiver of 4 GOTHA aged: 7 through 13 years).

Similar findings of feeling overwhelmed by caregivers of children orphaned by AIDS were reported by Norushe (2005:146) in one City in the Republic of Soth Africa. The caregivers, among which some were grandparents and other non-relatives, felt overwhelmed by the demands of caring for such children, mostly because they lacked the necessary resources. Other findings from that study revealed that some of the caregivers had expressed suicidal ideations because of feeling overwhelmed by looking after children orphaned by AIDS.

3.6.6 CATEGORY SACRIFICING

According to the Longman Contemporary English Dictionary (1995:1252), sacrificing is the act of willingly stopping something an individual wants or doing something one likes in order to get something more important. This category represents mechanisms that the R-BGs used in order to look after their GOTHA. To a greater extent, the data revealed

that they managed to do it through sacrificing almost everything and anything they had (refer to Table 3.9).

Table 3.9 Summary of CATEGORY: SACRIFICING

Category	**Sub-categories**
3.6.6 SACRIFICING	3.6.6.1 Sacrificing of social grant, food and personal effects 3.6.6.2 Borrowing money 3.6.6.3 Begging for food 3.6.6.4 Income generation activities 3.6.6.5 Buying food on credit 3.6.6.6 Relying on food relief 3.6.6.7 Engaging in piece meal jobs 3.6.6.8 Divine intervention

3.6.6.1 Sub category Sacrifice their money, food and personal effects.

The data revealed that the R-BGs used their social grant allowances to secure the needs of their GOTHA. At times, they even sold their personal effects such as clothing and also domestic animals in order to raise funds for the needs of their GOTHA. The following quotations reflect the various types of sacrificial acts performed by the R-BGs for the benefit of their GOTHA.

3.6.6.1(a) Financial sacrificing

The R-BGs used their social grant allowance on the needs of their GOTHA.

> ***When I receive the money*** [social grant for the elderly], ***I then go to the store and buy maize-meal and make sour porridge*** [*incwancwa*] ***for them and they eat it'*** (Grandmother A, 70 & caregiver of 2 GOTHA aged: 9 and 11 years).

This finding was not supported by the findings of Makiwane et al. (2004:66) whose findings revealed that elderly South African grandparents who were raising AIDS-orphaned grandchildren received child aid grants which went toward acquiring the needs of the children.

3.6.6.1(b) Nutritional sacrificing

Most of the time, the R-BGs did not eat adequately so that the GOTHA would have more food to eat.

> ***The greatest problem I have is with feeding them. Whenever I have managed to secure food for them, I cook it in the morning and they also eat it in the evening. As for me, I tie around my abdomen a cloth*** [abdominal binder]. ***I like to see them eat and yet I will be starving to death*** (Grandmother G, 76 & caregiver of 7 GOTHA aged: 3 through 17 years).

This finding was consistent with Dlamini (2001:25) whose elderly deliberately avoided eating some of their food, such as fruit and vegetables, instead, gave these to their young grandchildren, because of the belief that children needed such food more since they were still growing up. Skipping meals and not eating the whole day was reported by Caldwell (2005:8) as one of the coping mechanisms among poor households because of food insecurity. This finding was not supported by Makiwane et al. (2004:102) whose findings revealed that the elderly in that study had at least to two meals a day.

3.6.6.1(c) Personal effect sacrificing

The R-BGs sold some of their own moveable and/or non-moveable property such as clothing and domestic animals.

> ***When she is sick, I do not have any money. I take out whatever I will have been given by people and sell and then take her to the hospital as there is nowhere to report her*** **[that the child is sick]** (Grandmother B, 78 & caregiver of one GOTHA age: 6 years).

> ***I sell some of my personal effects* [goats]. *I sell them and then get what they* [GOTHA] *need such as shoes, T-shirt. I buy them*** (Grandmother O, 88 & caregiver: 2 GOTHA aged: 8 and 9 years),

This finding was consistent similar to those of Matshalaga (2004:52) and Agyarko et al. (2002: online). Both studies were carried out in Zimbabwe and revealed that the grandparents sold their livestock in order to raise funds for the needs of their AIDS-orphaned grandchildren.

3.6.6.2 Sub category Borrowing money

The R-BGs borrowed money from their neighbours or others in the community in order to provide for the needs of their GOTHA. This was revealed by one R-BG who said:

> ***I borrow money from people when I run out of money for their*** [GOTHA] ***exercise books and pencils. When I receive my social grant for the elderly, I am able to provide their needs*** (Grandmother D, 63, physically disabled & caregiver of 5 GOTHA aged: 8 through 17 years).

Borrowing of money from others was also reported by Caldwell (2005:5) and Makiwane, et al 2004:61), since these women had financial constraints and yet needed the money to meet some of the needs of their grandchildren. Borrowing money by elderly women was to be expected because most female-headed households were reported as being poorer than those that had both spouses (Musi, 2006: online).

3.6.6.3 Sub category Begging for food

Owing to the chronic drought, and no harvests at all from their fields, the R-BGs raising GOTHA benefited from food relief services of certain NGOs. However, at times food relief services were delayed, and families ran out of food in the meantime. In the absence of any food in those homesteads, the R-BGs went around to neighbours and the

community at large, asking for food, as reflected in the following statement:

> ***When we run out of food, I go and ask for it from other women in the community*** (Grandmother L, 86 & caregiver of 5 GOTHA: aged: 7 through 15 years).

This finding was found to be consistent with those of Matshalaga (2004:26) and Agyarko et al. (2002: online), whose elderly in their studies went around their communities begging for food. This finding was not supported by Makiwane et al. (2004:101), since the elderly in that study had better food security in their homes. None in those households spent s full day without something to eat since needy families received relief from the Social Welfare department.

3.6.6.4 Sub category Income generating activities

Except for one R-BG who had been employed as a civil servant for a short time, all the others had never been employed and neither were they self employed. In trying to raise funds, trying to look after themselves and also meet the needs of their GOTHA, a number of R-BGs engaged in various small cash generating activities as reflected in the following selected quotations:

> ***I sometimes make fat cakes 'emafethi'*** [flour dough that is deep fried in hot oil until golden brown and crispy] ***and they*** [GOTHA] ***go around selling them'*** (Grandmother F, 62 & caregiver of 4 GOTHA aged 6 through 17 years).

> ***I chop trees and make firewood bundles that I sell for E6 – 00*** [R6 – 00]***. I use it to buy relish*** (Grandfather Q, 62 & caregiver of 4 GOTHA aged: 3 through 10 years).

> ***This year my child, people are saying that we must collect and process the maganu fruit and then sell it. I was busy preparing the fruit when you came. I am doing it in order to feed us*** (Grandmother G, 76 & caregiver of 7 GOTHA aged: 3 through 17 years)

> ***When schools are about to open, I slaughter the piglets and sell the pork'*** (Grandmother N, 60 & caregiver of 7 GOTHA aged: 3 through 17 years).

> ***… their grandmother makes reed mats, without her making the mats , haa … She is responsible for bringing in money for food*** **[meaning maize meal]** (Grandfather Q 62 & caregiver of 5 GOTHA aged: 3 through 10 years)

The above findings were consistent with those found in a Uganda-based study by Najjumba-Mulindwa (2003:online) some of whose elderly participants in that study, were caring for AIDS orphans, did handicraft such as weaving of baskets, while others sold vegetables and fruits. It must, however, be pointed out that not only were these income generating activities physically demanding, but they did not alleviate the R-BGs' financial needs because very little cash was earned.

3.6.6.5 Sub-category Relying on food relief.

From being subsistence farmers, the R-BGs raising GOTHA now relied on food donations from NGOs as mentioned earlier such as WFP, WV and DTF because of chronic drought, especially, in the lowveld. The following quotation confirms such dependence on food relief programmes.

> ***We had ploughed … the sun did us down … We are greatly indebted to them*** [non governmental organizations] ***because otherwise there would have been a corpse. If it were not for the food we receive, I tell you that there would have been a corpse*** (Grandmother L, 86 & caregiver of 5 GOTHA aged: 7 and 15 years).

This finding was consistent with Matshalaga (2004:51) whose Zimbabwe-based study revealed that grandmothers, who were raising AIDS-orphaned grandchildren, were dependent on food donations from both government and NGOs.

3.6.6.6 Sub category Buying food on credit

Though there were food relief services, at times there food was not distributed and they ran out of it. Sometime they ran out food before the next delivery date. Therefore, in such situations, the R-BGs were forced to buy food on credit and then they would use their social grant allowance to clear the debt. One R-BG explained thus:

> ***By the time I receive my money*** (social grant allowance) ***it will already be finished, because I will have gone in advance and taken on credit, buckets of grains from people in the neighbourhood*** (Grandmother A, 72 & caregiver of 2 GOTHA aged: 9 and 11 years).

This finding was also reported by Caldwell (2005:8) and Najjumba-Mulidwa (2002: online) who pointed out that buying on credit contributed more towards the impoverishment of the elderly in those studies.

3.6.6.7 Sub category Doing piece meal jobs

One way of obtaining food for the GOTHA was to look for small jobs to do in other people's homesteads and then be rewarded in kind. Lack of rains in the lowveld had caused many families not to cultivate and this meant no piece meal jobs for this one R-BG, who explained her situation, thus:

> ***Providing them with food is a challenge to me. Like, when it rains, I normally go and help people with weeding their fields and return home with donated grains of maize which I grind, prepare and offer to my children and they eat*** (Grandmother G, 76 & caregiver of 7 GOTHA aged: 3 through 17 years).

The elderly in the studies conducted by Matshalaga (2004:41) and Caldwell (2005:8) also engaged in piece meal jobs in order to provide for their, especially AIDS-orphaned grandchildren.

3.6.6.8 Sub category Divine intervention

The data revealed that most R-BGs raising GOTHA managed to look after their GOTHA through God whose interventions were beyond human imagination. These R-BGs believed that God had a plan for them, and even said that the researcher's scientific efforts were all God's plan of divine intervention.

The most senior R-BG raising GOTHA in the study put in her view of divine intervention too and said:

> ***We are thankful to God who sent those people*** *(NGOs)* ***to give us food. We really are grateful to God for caring for us. They*** *[NGOs]* ***did not do this on their own, but it is God's Will that they are caring for us. It is God. We are thankful to Him day and night …*** **even your coming to see us is because of God** (Grandmother O, 88 & caregiver GOTHA aged: 9 and 11 years).

Sithole (1998:49) found that rural-based grandmothers who were looking after grandchildren with mental retardation, in the northern Hhohho region, managed to look after grandchildren by putting their trust in God who was their inner strength. In her discourse, Vilakati (2003:159) documented that by virtue of being the Creator, God was the provider and sustainer of the created order.

3.7 SPECIMENS OF FIELD NOTES

For each and every R-BG that was interviewed, the researcher took down various field notes as deemed. Below are specimens some of the field notes that were documented.

3.7.1 Descriptive notes

These are also known as observational notes that are documented by the researcher describing what happened or

what she/he saw (Polit and Beck, 2004:382). An example of such notes is given below.

Table 3.10 Limited finacial resources

Observation at Grandmother D's homestead	Interpretation
Date: 28th January 2007 Time: 9AM *As I walked toward the 4th participant's (Grandmother D) homestead, I noticed that the maize field near the homestead was surrounded by small sticks instead of the usual thick poles and also that barbed wire between the sticks was attached to the sticks by means of sisal threads instead of nails (refer to figure 2.5, below).*	Limited financial resources

3.7.2 Theoretical notes

Table 2. Change in traditional values

Grandmother H	**Interpretations about Grandmother H's unhappiness**
It would seem that the grandparents are not happy with the way things are done these days. So far three grandmothers have complained about their daughters not being married but living out there in other people's homesteads. The R-BGs raising GOTHA expected their daughters to get married so that umsulanyembeti (a cow that has not produced any calves yet and is usually given to the mother of the bride) would be given to them by the prospective son-in-law.	Change in value system Unlike old traditional practice Societal expectations

3.7.3 Personal notes

Table 3.12 Personal feelings

Grandmother O	Interpretations about personal notes
Today, I interviewed, so far, the most senior R-BG raising GOTHA in the study. She was 88 years old and looking after two GOTHA (both boys) aged 9 and 11 years. G-O complained of having: difficulty with walking. I noticed too that she had impaired hearing and was on treatment for elevated blood pressure. She was not feeling particularly well when I got to her homestead but insisted that the interview went on. It is quite painful seeing such an old person looking after grandchildren single-handedly and when she is not in good health, This is not fair to our elderly.	Grandparenting pre-adolescents Researcher personal feelings/Unethical of society in general

3.8 SUMMARY OF IDENTIFIED CATEGORIES

As documented in chapter one, the primary purpose of this phenomenological research was to explore and describe the day-to-day subjective realities of R-BGs raising GOTHA in the Chiefdom of *Nkonjwa*. The data were collected and analyzed utilizing the method of Tesch (199:93).

The activity and process of analyzing the data culminated in the development of six major categories. These categories were:

- NO SUPPORT
- COMPROMISED HEALTH
- RESOURCE AND BASIC NEEDS CONSTRAINTS
- CONCERNS RELATED TO THE FUTURE OF GOTHA
- FEELING OVERWHELMED
- SACRIFICING

Having identified these six categories, the primary purpose of the study had been achieved. The goal of phase one had also been accomplished.

From the above-mentioned categories that represent the lived experiences of R-BGs raising GOTHA in the lowveld, it can be seen that the magnitude of the challenges need an approach that is collaborative in order to address them. Appropriate measures to address categories effectively addressed, especially categories such as RESOURCE AND BAIC NEEDS CONSTRAINTS, NO SUPPORT and CONCERNS RELATED TO THE FUTURE OF GOTHA would cancel out other categories such as FEELING OVERWHELMED and SACRIFICING as these were consequences of the former.

The one category that is directly connected with the R-BGs raising GOTHA and impacting on their day-to-day realities of interacting with their GOTHA was that of COMPROMISED HEALTH. This was perceived as an area that fell within the scope of nursing, in particular, community health nursing practice. Based on the fact that this was nursing research (Brink, 2006:4) and concern for the R-BGs as an a population group whose health has ample challenges, their remarkable contribution in the AIDS-orphan crisis and that their needs have, to a greater extent, been sidelined, the researcher decided to formulate a strategy t address their health challenges in trying t promote their health and general wellbeing. However, a brief discussion of the other five categories is given below.

3.9 BRIEF OVERVIEW OF WAYS OF ADDRESSING THE FINDINGS.

Based on the afore-mentioned findings, the ultimate goal of the study was to develop a strategy to address them.

The findings in the present study suggested that the lived experiences of the R—BGs raising GOTHA in the lowveld would be more appropriately addressed by using a strategy that used collaboration of various stakeholders including government as the biggest stakeholder.

It is noted that two Swazi nurse researchers have already made some suggestions to the effect of trying to ameliorate the situation of the elderly (Mabuza, 2008) and that of grandparents who are looking after orphans and other vulnerable children (Mkhonta, 2008).Therefore, it would be a waste of time and resources to ignore their valuable inputs of strategies to address their findings which are more or less similar to the ones of the current study.

3.9.1 **CATEGORY: CONCERNS RELATED TO THE FUTURE OF GOTHA**

One of the lived experiences of R-BGs raising GOTHA was that of unequal opportunity to access education by their grandchildren. Mkhonta (2008) investigated grandparents who resided in an informal setting in Mbabane and were looking after orphans and vulnerable children. Some of the major findings from that study were that the grandparents had severe constraints with regards to any kind of resources. These grandparents also were worried about their grandchildren's future. The researcher suggested that the capacity to look after such children by their grandparents needed strengthening through having in place policies that addressed this social situation.

For instance, the concern of the R-BGs may be more effectively resolved through collaborative efforts by relevant ministries and departments, such as the Ministry of Education in collaboration with the Ministry of Health

and Social Welfare, the Department of Social Welfare and Ministry of Finance and Economic Planning. While the Ministry of Education takes the full responsibility for the education aspect of GOTHA, the Ministry of Health and Social Welfare focuses on the health and social welfare needs of the GOTHA as well as the R-BGs themselves. The Ministry of Finance and Economic Planning ought to look into the logistics of child grants in order to help ease the burden of caring for GOTHA by the R-BGs.

3.9.2 CATEGORY: NO SUPPORT

The data also revealed that most of the R-BGs had lost one or several adult children most of whom were supporting them. With the demise of these adult children the R-BGs raising GOTHA were left with no family and therefore, no one to support them.

This category would be effectively addressed through local rural administration, namely, *Umphakatsi* (Official residence of the Chief) together with *Bandla ncane* (Small Inner Council) taking full ownership and responsibility of the elderly in their communities. There is need for collaboration and cooperation within the communities themselves in helping out the R-BGs raising GOTHA. In the kwa Zulu-Natal based study by CINDI(2007:online)the findings revealed among others that with assistance from government, community-based workers, the church and NGOs, the grandparents who looked after HIV/AIDS orphans managed to look after their grandchildren adequately.

3.9.3 CATEGORY: RESOURCE AND BASIC NEEDS CONSTRAINTS

The data revealed among others that the R-BGs raising GOTHA did not have money to purchase their own personal needs and also those for their GOTHA. They also did not have adequate

basic needs such as food, shelter and clothing. In redressing and/or addressing this challenge of resource and basic needs constraints, it would be advisable that instead of trying to re-invent the wheel, and coming up with new plans, the very same strategy of mobilizing resources in the Hhohho region community that Mabuza (2008:149 – 179) recommended in her study, could be applied to the situation of these R-BGs raising GOTHA in the lowveld. Mabuza conducted a study that explored the needs of the elderly in the Hhohho region of Swaziland and summarized her findings as:

- Need for resources because of poverty.
- Lack of grant for social support by the government.
- Poor access to water and electricity services.
- Need for clothing, especially winter clothes.
- A need for food security.
- Poor housing accommodation.
- Lack of transport.

For these findings, the researcher developed a very comprehensive strategy for mobilizing resources to meet the needs of these elderly. The researcher formulated a strategy that involved government, communities, NGOs, faith-based organizations and charitable organizations. What was striking about the strategy was that the resources would be generated from within the country and therefore sustainable. Community health nurses were the ones who would facilitate the mobilization of the various resources.

The lived experiences of the R-BGs raising GOTHA, were comparable with many of the findings of Mabuza. Developing another strategy to address the findings for the present study would be like trying to re-invent the wheel.

3.9.4 CATEGORY SACRIFICING

The data revealed that because of being poor and lacking those things they needed to care for their GOTHA the R-BGs sacrificed a lot of things including not eating adequately for the sake of their GOTHA. This affected their general health. With assistance from government and the local community, the R-BGs raising GOTHA would not be sacrificing on a continual basis as revealed in the data.

3.9.5 CATEGORY FEELING OVERWHELMED

From the data, the R-BGs appeared overwhelmed in their grandparenting role because the demands of looking after their GOTHA that exceeded the available resources (material and financial) including the health of the R-BG). As pointed out in the category SACRIFICING, interventions that can provide R-BGs raising GOTHA with sufficient materials to look after their grandchildren would take away this negative feeling.

In summing up of the brief suggestions on how to address the identified categories, it is quite clear that there is need for a strategy with multiple stakeholders, including government.

3.9.6 Identification of category to address

This research was prompted because of concern for R-BGs raising GOTHA in the lowveld. The analyzed data revealed that the lived experiences of the R-BGs, among others, included compromised health and self-care deficit.

While the other identified categories need various stakeholders to help solve the situation, the health challenges of the R-BGs raising GOTHA were an area that

nursing, especially community health nursing practice could do something about since it belonged to the independent role function of nursing.

Moreover, it is noted that the health-related challenges of the elderly in Swaziland have not been given much consideration. Hence the decision taken by the researcher to develop a health education programme to empower with self-care R-BGs raising GOTHA to promote optimum health and functioning meanwhile they continue to look after GOTHA.

3.10 SUMMARY OF CHAPTER

This chapter has presented the findings from the analyzed data. The data, primarily emanated from face-to-face in-depth interviews with the R-BGs raising GOTHA, their health records, field notes made by the researcher and photograph taken in the research setting. Using the analysis method described by Tesch (1990:93), six major categories emerged from the data.

The majority of the findings need a collaborative approach to address them. It was noted that a number of challenges of the R-BGs raising GOTHA had been address in the strategies that the two researchers Mabuza and Mkhonta had formulated and/or suggested. As the health aspect of the R-BGs and/or elderly in general have not been given much attention before, the researcher, therefore, decided to

develop a health education programme to empower with self-care R-BGs raising GOTHA.

With such a decision made, chapter three ended here and also marked the end of phase one. The second phase, namely chapter four is described next.

CHAPTER FOUR

A DESCRIPTION OF THE CONCEPTUAL FRAMEWORK FOR GUIDING THE DEVELOPMENT OF THE PROPOSED HEALTH EDUCATION PROGRAMME TO EMPOWER WITH SELF-CARE RURAL-BASED GRANDPARENTS RAISING GRANDCHILDREN ORPHANED THROUGH HIV/AIDS

"If you give a man a fish, he will have a single meal. If you teach him how to fish, he will eat all his life." – Kuan Tzer

4.1 INTRODUCTION

Chapter three presented the findings from the analyzed data. Literature control was conducted and findings thereof were compared and contrasted with findings from the current study. Chapter three marked the end of phase one.

Chapter four represents phase two. Phase two focuses on the conceptual framework that was used to develop the proposed health education programme to empower with self care the R-BGs raising GOTA in the lowveld. Therefore, the purpose of chapter four is to describe in great detail the structure and process aspects of the conceptual framework.

4.2 PHASE TWO: DESCRIPTION OF THE CONCEPTUAL FRAMEWORK

Phase two seeks to describe and discuss the conceptual framework that guided the development of the proposed health education programme to empower with self-care R-BGs raising GOTHA in the lowveld.

Brink (2003: 206) defined a conceptual framework as a less well-developed structure that communicates the main ideas of a phenomenon. The concepts in a conceptual framework are related to one another in a logical manner and thus act as building blocks of the framework. Thus, the interrelatedness of the concepts creates a specific way of looking at that particular phenomenon. The structure and components of the conceptual framework are described next.

4.2.1 The six guiding principles of activity in a practice discipline

The designing and development of the conceptual framework was influenced by the six principles/survey list ingredients of a theory of a practice discipline described by Dickoff, James and Wiedenbach (1968:425). The six principles are displayed in table 4.1, below.

Table 4.1 The six guiding principles for nursing activity

Survey list ingredients	Special application questions
4.2.1 Agency	Who is responsible for carrying out the proposed activity?
4.2.2 Patiency	Who is the recipient/beneficiary of the proposed activity?
4.2.3 Terminus	What is the desired outcome of the proposed activity?
4.2.4 Framework	What is the context in which the proposed activity is going to take place?
4.2.5 Dynamics	What is the driving force or motivation behind the implementing of the proposed activity?
4.2.6 Procedures	What established way/ways of carrying out the intervention /innovation is going to be utilized to implement the proposed activity?

The structure and components of the conceptual framework as well as the application of the six principles/survey list ingredients are demonstrated. The first of the six principles of described by Dickoff et al (1968), namely, agency, is outlined next.

4.2.1.1 Agency

Who is responsible for carrying out the proposed activity? The agency is shown below in figure 4.1.

CHN

Figure 4.1 Agency - The community health nurse

In accordance with Dickoff et al. (1968:423), the principle of agency, refers to the person who executes an activity or plan that is meant to bring about change to the recipient, or beneficiary, of that activity or plan. Agency is interchangeable with agent of change. Therefore, in this conceptual framework, agency shall refer to the community health nurse (CHN) as depicted in figure 4.1 above. The CHN is the one who shall facilitate the programme.

The colour yellow that surrounds CHN, is symbolic of the vast professional knowledge the community health nurse possesses and is expected to be ready share with clients, as part of her/his professional obligation in promoting the health of those clients. Community health nurses (CHNs) are ideally suited for the task of implementing the proposed health education programme, particularly because they do not work in the traditional therapeutic institutions (Dreyer, 1999:26), and also, because health education is an integral component of nursing practice. According to Clark (2008:5) the focus of community health nursing is the care of the aggregate, a population with some common characteristics. In this case, it is the R-BGs raising GOTHA.

The CHN is an independent health practitioner who takes responsibility of her own actions (Dreyer, 1999:26) and within her/his independent nursing function role, she/he has six interrelated nursing activities (refer to figure 4.2) to execute (McEwen, 2002:14–19 ; Dreyer et al, 1999:26–38). The six interrelated functions of the professional nurse are outlined, below.

4.2.1.1 (a) Practitioner

According to Dreyer (1999:36) the role of the CHN covers a wide scope and in providing care, she/he uses the three levels of prevention, namely, primary, secondary and tertiary prevention throughout the life span, namely, from before birth to death, in various settings such as clinics, public health units and at home, through mobile units in the rural area. It is very important for the CHN as a practitioner to assess the client and her/his environment first before planning for any nursing interventions. Since the goal of community nursing is to prevent illness, and promote and maintain health, the CHN is expected to engage more in the primary level of care, which emphasizes health education of clients who may be individuals or families.

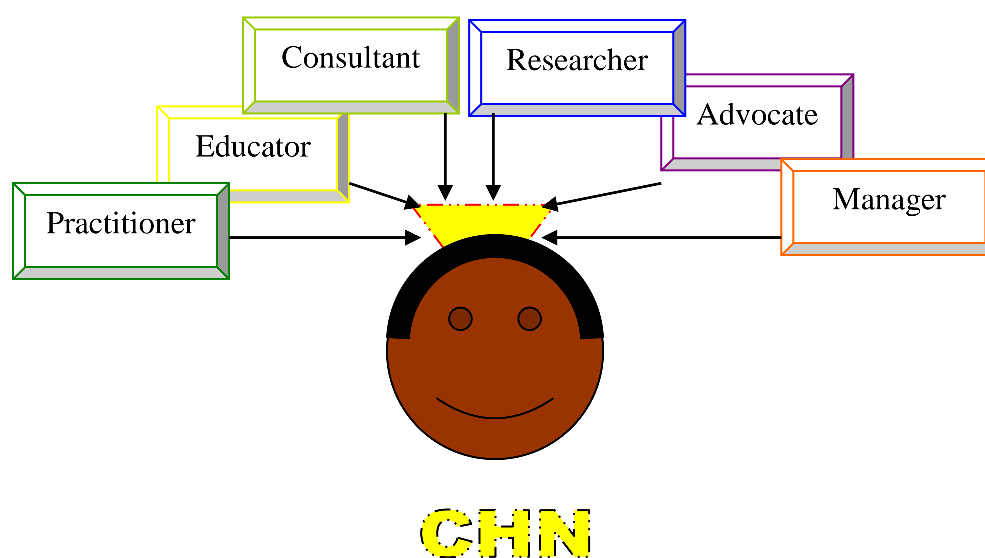


Figure 4.2 The various roles of the community health nurse

4.2.1.1 (b) Educator

Dreyer (1999:33) pointed out that health education was one of the most important areas of responsibility of the CHN. Primarily, the CHN is an educator and in Swaziland she/he is guided by the principles and elements of the PHC since the Ministry of Health and Social Welfare utilizes the PHC

strategy (refer to table 4.2) to promote the health of the Swazi people.

The PHC strategy emphasizes the element of education so that people may become empowered with health-related knowledge, attitudes and skills and thereby be in a position to look after themselves all the time and enjoy good health.

Table 4.2 <u>List of principles and elements of the PHC strategy</u>

PRINCIPLES	ELEMENTS
• Equity • Affordability • Accessibility • Availability • Effectiveness • Efficiency • Involvement • Participation	• **E**ducation about prevailing health problems and methods of preventing and controlling them. • **L**ocal endemic disease prevention and control • **E**xpanded immunization programme • **M**aternal/child health and family planning and care of high risk groups • **E**ssential drugs provision • **N**utritional promotion and supply • **T**reatment of common ailments • **S**anitation of the external environment and adequate water supply to drink

All the principles of the PHC strategy take into account that health is a birthright and therefore needs to be promoted across the lifespan.

CHNs are expected to teach individuals, groups, families and also entire communities in order to promote health and prevent illness. McEwen (2002:16) highlighted that health education goes beyond simple dissemination of information; it is a process whose main purpose is to help people to make health-related decisions about their own lives. Some of the decisions people may make about their own lives include: refraining from eating fast foods such as quick fried foods, giving up smoking of cigarettes, engaging in healthy lifestyles such as exercising regularly and relinquishing risky sexual behaviour such as engaging in unprotected sexual intercourse especially in this era of HIV and AIDS and if one has more than one sexual partner.

4.2.1.1 (c) Researcher

According to Brink (2006:2) research is the hallmark or lifeblood of any profession because it helps, among others, to generate new facts and verify information, and all that contributes toward expanding the theoretical base of that profession (Brink, 2003:4). Research offers the public evidence-based practice rather than the traditional or common practice (Joel, 2003:288). Therefore, research is an integral part of community nursing practice (Dreyer, 1999: 35). CHNs may conduct research independently or as part of a research team both of which have the common goal of promoting health whether at individual and/or family level.

4.2.1.1 (d) Manager

The CHN is a manager because she/he plans, organizes, markets, controls and evaluates care and care delivery (McEwen, 2002:17). In order to effectively execute the role of manager, the CHN needs to be in possession of sound philosophy (Hattingh, et al, 2006:2) and knowledge of

values and traditions of the community that is to be served (Dreyer, 1999:29). Commune was defined as being in close touch with (DK Illustrated Dictionary1998:172. Therefore, being manager has the implication that the CHN works in close touch with the community members.

4.2.1.1 (e) Advocate

Often, nurses use the word advocacy without deep thought of its true meaning. According to the Longman Dictionary of Contemporary English (1995:23), to advocate refers to proclaiming publicly one's support for a particular way of doing something. Pera and van Tonder (2004:148) described a nurse who is an advocate as one who will and can enter into a relationship with a patient with the intention of helping to resolve those confronting/presenting health-related challenges. The role of client advocacy in nursing practice has ethical implications. In describing the advocacy role of the CHN, Dreyer (1999:27) highlighted that the CHN aims at supporting through providing the client with relevant and correct information.

4.2.1.1 (f) Consultant

Though the role of a consultant is not readily associated with nursing practice in general, especially in developing countries, a consultant was defined by the Longman Dictionary of Contemporary English (1995:293) as someone who has a lot of experience and whose job it is to offer information and advice, and training, in a particular area. Through working with the community over long periods of time and also teaching nursing and medical students, CHNS are consultants in their own right.

The second of the six principles of Dickoff et al. (1968) is presented next.

4.2.2 Patiency

Who is the recipient or beneficiary of the proposed activity? It is patiency as displayed in figure 4.3.

R-BG

Figure 4.3 Patiency – Rural-based grandparent (R-BG)

According to Dickoff, et al. (1968:427), patiency refers to the beneficiary or recipient of the activities performed by the agent of change in order to bring about change. The recipients of the proposed health education programme are R-BGs raising GOTHA in the lowveld. The R-BGs are depicted in the colour red that denotes the many physical health challenges they experience as revealed in the analyzed data in phase one.

The R-BG raising GOTHA is first and foremost a human being, and deserves to be treated with all the respect as a senior citizen, as well as senior member of the family and community. The R-BG raising GOTHA has many roles she/he plays, for instance, grandparent, parent, an elder in her/his church, a widow/widower, homemaker, a pensioner, an informal caregiver, community leader and casual labourer. The CHN needs to recognize the fact that people, including the R-BGs raising GOTHA, occupy multiple social roles that they bring into the teaching-learning environment(Meyer, Naude and van Niekerk, 2004:85).

The third of the six principles of Dickoff et al. (1968) is presented below.

4.2.3 Terminus

What is the desired outcome of the proposed activity? Terminus refers to the end result. The huge yellow circle shown as figure 4.4, below represents the terminus of the proposed activity of educating the R-BGs raising GOTHA, in the lowveld.

Knowledge

Attitudes

Skills

Figure 4.4 Terminus in the proposed health education programme

Dickoff, et al. (1968:428-430) described terminus as a final point in space or the outcome of the activity that is performed by the recipient. In this conceptual framework, terminus is the state of acquisition of self-care (refer to figure 4.4) that shall be facilitated through the proposed health education programme for R-BGs raising GOTHA. The R-BG shall be equipped with knowledge, attitudes and skills to look after their own health and thus have self-care.

Self-care is one of the several constructs in Orem's general self-care nursing theory and was defined by Foster and Janssen (1990:91) as the practice of activities individuals initiate and perform on their own behalf on a daily basis in maintaining life, health and wellbeing. Unless the R-BGs are taught how to look after their own

health they cannot initiate and perform those activities on their own behalf on a daily basis in maintaining life, Clark (2003:214) pointed out that self-care is an outcome of health education and equips individuals with the ability (agency) to make any of the following three health-related decisions about:

- self-care
- the use of health resources and
- societal health issues.

The fourth of the six principles of Dickoff et al. (1968) is described next.

4.2.4 Framework

In what framework or context is the proposed nursing activity going to take place? The proposed health education programme to empower with self-care R-BGs raising GOTHA shall be implemented in the lowveld of Swaziland as displayed in figure 4.5.

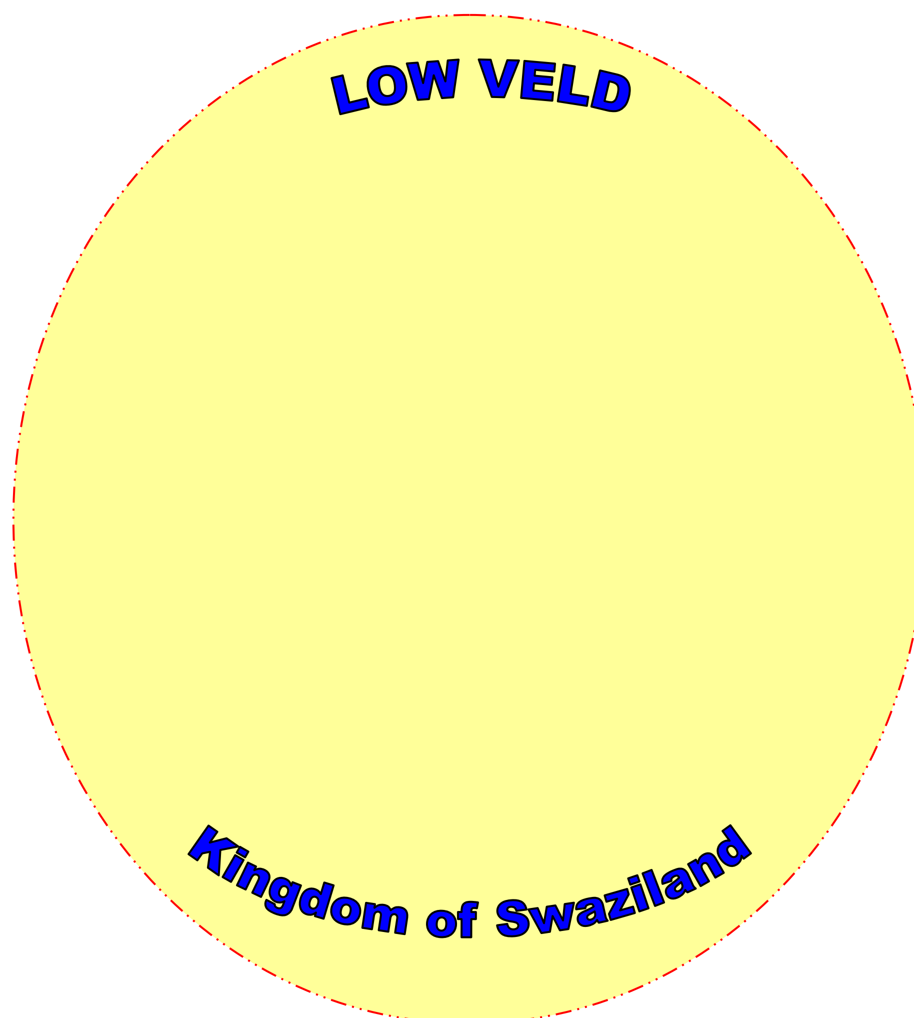


Figure 4.5 Framework of the health education programme

According to Strauss and Corbin (1990:101) no activity takes place in a vacuum. Things usually occur within a context of some kind whether simple or complex (Dickoff et al., 1968:428).

As the present study was conducted in the lowveld of Swaziland, that area formed the context (Babbie and Mouton, 2005:272) within which the R-BGs shall also be taught the proposed health education programme. Some of the major contextual challenges confronting individuals and families including the R-BGs raising GOTHA in the Chiefdom of

Nkonjwa, were described in chapter two, under the sub-heading study context (refer to sub-section 2.2.4).
The fifth of the six principles of Dickoff et al. (1968) is explained next.

4.2.5 Dynamics

What is the driving force or motivation behind the development of the proposed nursing activity? What was the motivation for developing the health education programme to empower with self-care the R-BGs raising GOTHA in the lowveld?

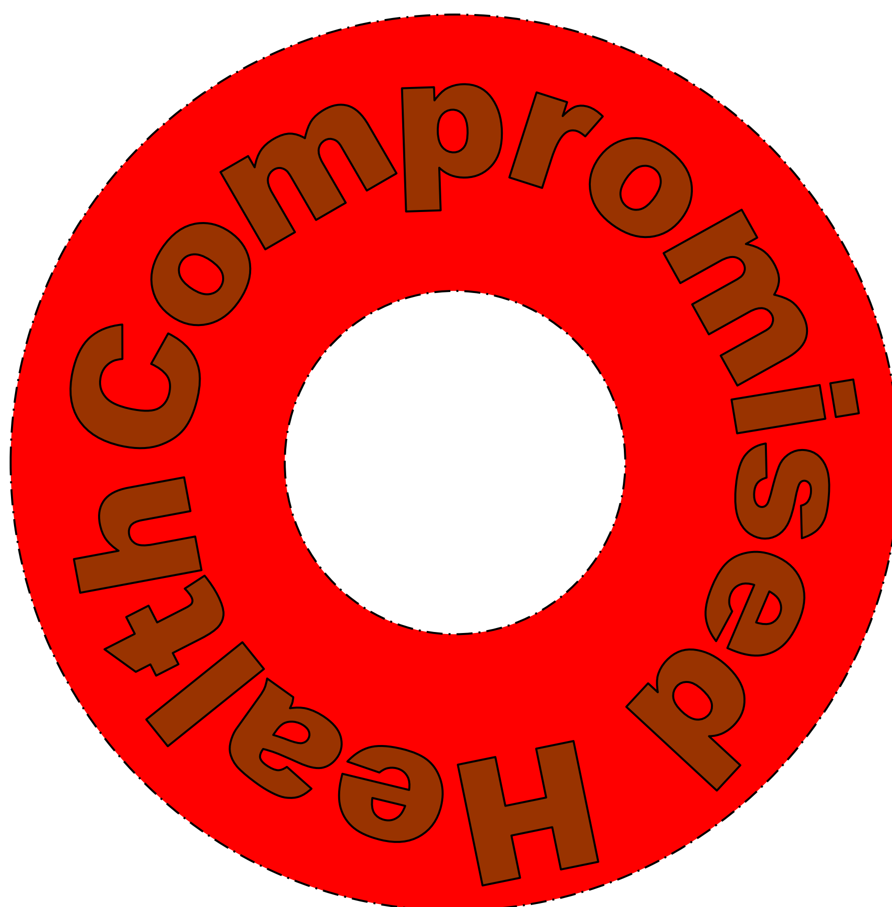


Figure 4.6 Dynamics of the proposed health education programme

According to Dickoff et al. (1968: 431), dynamics refers to the source of power or motivation for carrying out the activity in question. The central finding from the data was the category of COMPROMISED HEALTH (refer to figure 4.6). The red background in the circle in figure 4.6 represents chronic health problems that were manifest in all the R-BGs raising GOTHA. Their states of compromised health therefore, became the motivating factor behind the development of the proposed health education programme. Dickoff et al. (1968:422) pointed out that traditionally, in nursing, service motivation has always been a strong power input for the nursing profession.

The last of the six principles of Dickoff et al. (1968) is described below.

4.2.6 Procedures

What established way/ways of carrying out the activity or innovation shall be used to implement the proposed nursing activity? What established principles, rules, routines or protocols governing the activity are going to be used to develop the proposed health education programme?

Table 4.3 Procedures included in the self-care health education Programme

Procedures used
4.2.6.1 The self-care deficit theory 4.2.6.2 Self-care three-step nursing process 4.2.6.3 Supportive-educative nursing

system
4.2.6.4 Adult learning principles
4.2.6.5 Therapeutic relationship

According to Dickoff et al., (1968:430) the procedures of an activity include the following: principles, rules, routines or protocols governing the activity/activities. Owing to the fact that the progamme is grounded in nursing, the procedures for the proposed health education were predominantly influenced by a nursing theory/m, (self-care deficit nursing theory) its inherent nursing process (the three-step self-care nursing process), nursing system (supportive-educative nursing system and also by educational principles, namely, adult learning principles and lastly communication (therapeutic communication) as shown in Table 4.3.

The self-care nursing theory was selected for the following reasons: it was relatively simple to use, it followed logical thought and it focused on nursing as a helping art (Foster and Janssens, 1990:108). Fawcett (1989:210) pointed out that Orem's self-care theory was grounded in nursing and not borrowed from other disciplines. This nursing theory was therefore appropriate since the researcher desired to generate nursing related knowledge that would contribute toward the common body of nursing knowledge in Swaziland.

4.2.6.1 The self-care deficit theory

The self-care nursing theory is generally known to include three theories: (i) the self-care theory, (ii) self-care deficit theory and (iii) nursing systems theory. However, for the purpose of the proposed health education programme, the theory of self-care deficit was selected because of the

self-care deficit that was detected among the R-BGs raising GOTHA.

According to Foster and Bennett (2202:129), the theory of self-care deficit is the basic element of Orem's general theory of nursing and indicates when nursing is required, namely, when adults are incapable of or limited in their ability to provide continuous effective self-care. The findings from the data in phase one indicated that the R-BGs raising GOTHA had self-care limitations which they were not aware of. They seemed not to also be aware of the developmental stage in which they were and its implication on their health and general wellbeing. Hence the choice the self-care nursing theory/model to guide nursing activity in the proposed health education programmed.

Foster and Bennett (2002:129) pointed out the five methods that could be utilized to assist in restoring self-care in adults with self-care deficit. Among those methods was teaching. Using the self-care deficit theory, usually the nurse conducts a comprehensive assessment of the client including the client's area of self-care need and also formulating the nursing diagnoses. Thereafter, the methods for facilitating the restoration of self-care are determined by the nurse in collaboration with the client.

4.2.6.2 Self-care three-step nursing process

The conceptual framework utilizes Orem's three-step nursing process as the vehicle through which the CHNs shall implement the proposed health education programme to empower with self-care R-BGs raising GOTHA. According to Orem (2001:309), nursing process is a term nurses utilized to refer to nurses 'hands on' activities of professional-technologic operations of nursing practice. In simple

words, it is the things nurses engage in on a day-to-day basis when caring for clients.

Orem presented with the nursing process in three steps that are interrelated, namely, step 1, step 2 and step 3 as shown in figures 4.7, 4.8 and 4.9. The components of the three steps are outlined, next.

4.2.6.2(a) Step 1

Step 1 (refer to figure 4.7, below) sets the base and starts by focusing on the therapeutic self-care demands, assessment of self-care agency and identification of self-care deficit of the client. In this case, the CHN shall be interacting with the R-BGs raising GOTHA.

Step 1

Figure 4.7 Orem's nursing process – Step 1

According to Foster and Bennett (2002:135) step 1 comprises the following major activities:

- diagnosis and prescription: determine why nursing is needed.
- sub-processes: analysis and interpreting.
- nursing diagnoses.

4.2.6.2(b) Step 2

Step 2 (refer to figure 4.8) represents the second step and focuses on planning.

Step 2

Figure 4.8 Orem's nursing process – Step 2

Step 2 includes the following activities that were described by (Foster and Bennett, 2002:135):

- identification and selection of the most appropriate nursing system(s) to use in order to address the client's self-care deficit area.
- planning for a delivery of care.

Based on the analyzed data in step 1, the CHN identifies and selects the most appropriate nursing system that will meet, especially, the self-care deficit needs of the R-BG raising GOTHA.

4.2.6.2(c) Step 3

This is the third and last step of the self-care nursing process (refer to figure 4.9, below).

Step 3

Figure 4.9 Orem's nursing process - Step 3.

Step 3 combines production and management (Foster and Bennett (2002:135) and has the following activities:

- implementing and
- evaluating.

The CHN shall execute the nursing orders in accordance with the plan that shall have been made in Step 2. Nursing orders are also refered to as prescriptions since they are made by the nurse. They are similar to doctors' orders only that these are made or prescribed by nurses as part of their independent role function. The CHN is therefore expected to put into action the plan in which she/he also monitors the activities thereof, and determines whether or not the outcomes are consistent with the stipulated expected outcome(s).

4.2.6.3 The supportive-educative nursing system

The theory of nursing systems is the third theory of the general self-care nursing system by Orem. According to Foster and Bennett (2202:130) the three nursing systems that may be used individually or combined in order to address the identified self-care needs are:

- wholly compensatory nursing system,
- partial compensatory nursing system and
- supportive-educative nursing system.

While the wholly compensatory nursing system is used on clients who have no self-care ability or agency at all, such as the unconscious and/or quadriplegics, the partial compensatory nursing system is applicable to situations whereby the client is able to do some of the activities her/him self but needs the nurse (the other self of the client), to assist with those activities that she/he cannot perform because of the existing self-care deficit. In the supportive-educative nursing system, the client is able to do things for her/him self, but mostly lacks knowledge and skills. That is where education shall come in to empower the client. According to Sebastian (2004:1012) the concept of empowerment is congruent with Orem's theory of self-care as this theory is about seeking to empower the client by strengthening her/his self-care agency with help of the identified most appropriate nursing system/nursing systems
.

4.2.6.4 Adult learning principles

As the consumers of the proposed education programme are going to be adults, namely, R-BGs raising GOTHA, it is imperative that the programme implementers utilize adult learning principles in order to enhance learning. Therefore, principles of adult learning (Crawford, 2004:

online) have been included into the supportive-educative nursing system activities. Chapter discusses these learning principles in greater depth than in this chapter.

4.2.6.5 Therapeutic partnership

According to Orem (2001:19), basic to promoting health on clients, there needs to be nurse-client partnership. Therefore, in order for the proposed health education programme to accomplish its mission, the CHN needs to first enter into a special relationship of partnership with the R-BG raising GOTHA. Since this relationship is being created for therapeutic reasons, it is known as a therapeutic partnership.

Partnership is one of the principles of the PHC strategies that the CHN shall should achieve the goal of the proposed health education programme to empower with self-care R-BGs raising GOTHA in the lowveld. The therapeutic relationship is depicted by the light green triangle-structure (refer to figure 4.10, below).

Figure 4.10 Therapeutic partnership

There are three essential qualities to the therapeutic partnership between the CHN and R-BG raising GOTHA and these are trust, confidence and openness. The colours of the qualities have no special meanings attached to them.

4.2.6.5 (a) Trust

Trust (refer to figure 4.11, below), is represented by the orange-coloured small circle.

Figure 4.11 Partnership quality: Trust

Trust is a strong belief in the honesty and goodness of someone or something (Longman Dictionary of Contemporary English, 1995:1549). According to Blackburn (2005:370) trust is an attitude of expecting good performance from another party, whether in terms of loyalty, goodwill, truth or promise. The importance of trust as a kind of invisible glue that binds society is mostly visible when it is lost. Therefore, implied in the two definitions, is that the CHN and R-BG raising GOTHA, need to have trust in one another, in order for the one (CHN) to be able to effectively assist, and the other one (R-BG) to be assisted.

4.2.6.5 (b) Confidence

Confidence is depicted as a purple circle as reflected in figure 4.12 below.

Figure 4.12 Partnership quality: Confidence

Having confidence in someone infers that you can trust someone to do good and produce positive results (Longman Dictionary of Contemporary English, 1995: 284). Through

having trust in the CHN, the R-BG develops confidence (see figure 4.13) in her/him. The CHN needs to persistently and constantly demonstrate high professional standards when interacting with the R-BG raising GOTHA in order that the latter remains with confidence in the former.

4.2.6.5 (c) Openness

The third quality in the therapeutic partnership is openness and is portrayed as olive green circle (refer to figure 4.13, below).

Figure 4.13 Partnership quality: Openness

Openness was defined by the Longman Dictionary of Contemporary English (1995: 993) as the quality of being honest and not keeping things secret; the quality of being willing to accept new ideas or people. Both the CHN and R-BG need to demonstrate openness to each other in order for the partnership to be nurtured thrive and be effective.

So far in chapter four, the components of the conceptual framework have been presented and described. The next sub-section outlines the process dimension of the conceptual framework.

4.2.6.6 Directional arrow

The pink arrow (refer to figure 4.14, below) marks the direction of movement of the activities that take place especially in the educating stage. Its pink colour bears no specific significance. It has a round shape because it is process focused like the nursing process which also is ongoing.

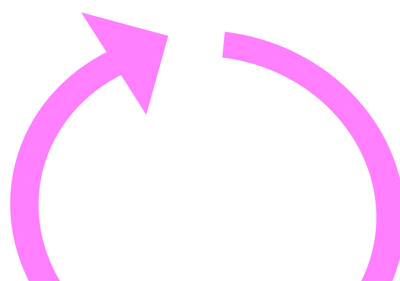


Figure 4.14 Directional arrow

4.2.7 THE PROCESS ASPECT OF THE CONCEPTUAL FRAMEWORK

The process dimension of the conceptual framework has two parts to it, namely, the pre-educating and educating stages. The two stages are relatively self explanatory and interdependent in that the one depends of the other to perform certain activities before it can do its own part. Thus, the educating stage depends on the successful outcome of the pre-educating stage.

4.2.7.1 Pre-educating

This stage is depicted in figure 4.15. Primarily, to start teaching the R-BGs, the CHN and R-BG have to enter into a special foundational relationship (du Toit and van Staden, 2005:170) known as the therapeutic partnership, whose qualities are trust, confidence and openness.

Though it is the R-BG is in need of self-care, it is the duty of the CHN to initiate this relationship since it is her/his professional obligation to promote the health of the clients. Therefore, the therapeutic partnership is a precursor and an essential ingredient (Foster and Bennett, 2002:134) in the proposed health education programmer for empowering with self-care R-BGs raising GOTHA.

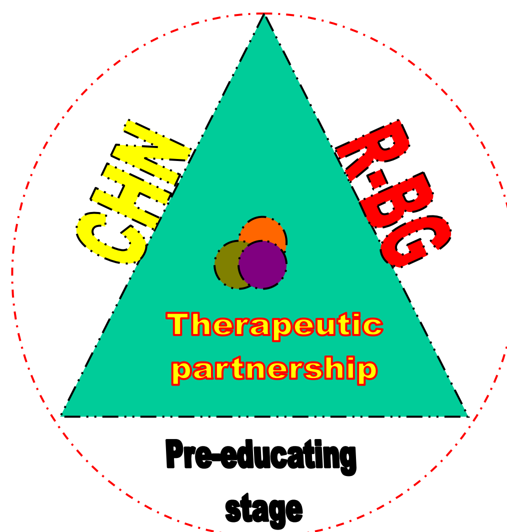


Figure 4.15 The therapeutic triad.

Though in this programme, the therapeutic partnership is initially between one CHN and one R-BG, the R-BGs themselves may interact between themselves. They may form support groups among themselves. According to Clark, 2008:509) social support is another socio-cultural influence on the health of the elderly population. This is applicable to the R-BGs in this research.

The client could be any of the following combinations:

- R-BG being seen by the CHN as part of home visiting
- R-BG being attended to in the out-patient department of a health centre
- a group of R-BGs raising GOTHA at the *Umphakhatsi* (the Chief's official residence).

Once the therapeutic partnership has been initiated and established between the CHN and R-BG, the educating shall have commenced.

4.2.7.2 The educating stage

This stage is represented by figure 4.17 and includes all the activities of the self-care three-step nursing process

and adult learning principles. The educating stage is the heart of the proposed health education programme as shall be seen in chapter six, since it is where CHN puts into action the teaching plan ensuring that R-BGs learn.

4.2.7.2(a) Step 1

Following the successful completion of the pre-education phase, the CHN starts in Step 1 and collects the data from the client, who may be an R-BG raising GOTHA. The client could also be a group of R-BGs raising GOTHA. After collecting the data and utilizing the analytical strategies of analyzing and interpreting, the CHN makes her/his own clinical judgments that culminate in nursing diagnoses. Nursing diagnoses are the base for entry points into Step 2 where planning takes place.

4.2.7.2(b) Step 2

Based on the nursing diagnoses that will have been formulated, then in Step 2, the CHN selects the most appropriate nursing system that shall effectively address the area of deficient self-care of the R-BG. Since this is a health education programme, the CHN shall make use of the supportive educative nursing system (Foster and Bennett, 2002:132 – 133) as the planned way of care delivery. The CHN shall draw a teaching plan that will guide the health education sessions with the R-BGs raising. This will also help to delineate the roles played by the two, namely, CHNs and R-BGs.

4.2.7.2(c) Step 3

In this last stage of the three-step nursing process, once the nursing plan is ready, the CHN implements it by actually teaching the R-BG or a group of R-BGs. The CHN shall follow the teaching plan but be guided by intended

learning objectives that shall have been carefully formulated according to the needs of the learner, namely the R-BG or R-BGs raising GOTHA.

The teaching plan shall also include a variety of teaching strategies that are recommended for adult learning. Some of the teaching methods shall be lecture-discussion, role-play and drama. While teaching the R-BGs, the CHN also conducts formative evaluation by asking the R-BGs prepared questions to ensure that they are grasping what is being taught. Foster and Bennett (2002:141) pointed out that evaluation is an ongoing process in Step three and essential for both the nurse and client.

Based on the degree with which the intended learning objectives shall have been achieved by the R-BGs, the CHN may need to either repeat the lesson in a more effective way if the intended learning objectives were not achieved or proceed to the next content if the intended learning objectives were met.

Step 2
Educating stage

Figure 4.16 Educating stage

Figure 4.16 represents the educating stage of this programme. The pronounced red circle signifies the physical health challenges of the R-BGs raising GOTHA, the reason why the programme exists. The wording COMPROMISED HEALTH is symbolic of the physical health conditions from which the R-BGs are suffering. Step 1, Step 2 and Step 3 are part of the three-step nursing process that the CHN utilizes in implementing this programme. The pink arrow, as already explained, represents the direction of the process of the empowering process, namely start with data collection in step 1 and proceed to the other steps.

4.4 THE COMPLETE CONCEPTUAL FRAMEWORK

The complete conceptual framework is displayed in figure 4.17. Its shape is very significant. The round shape or

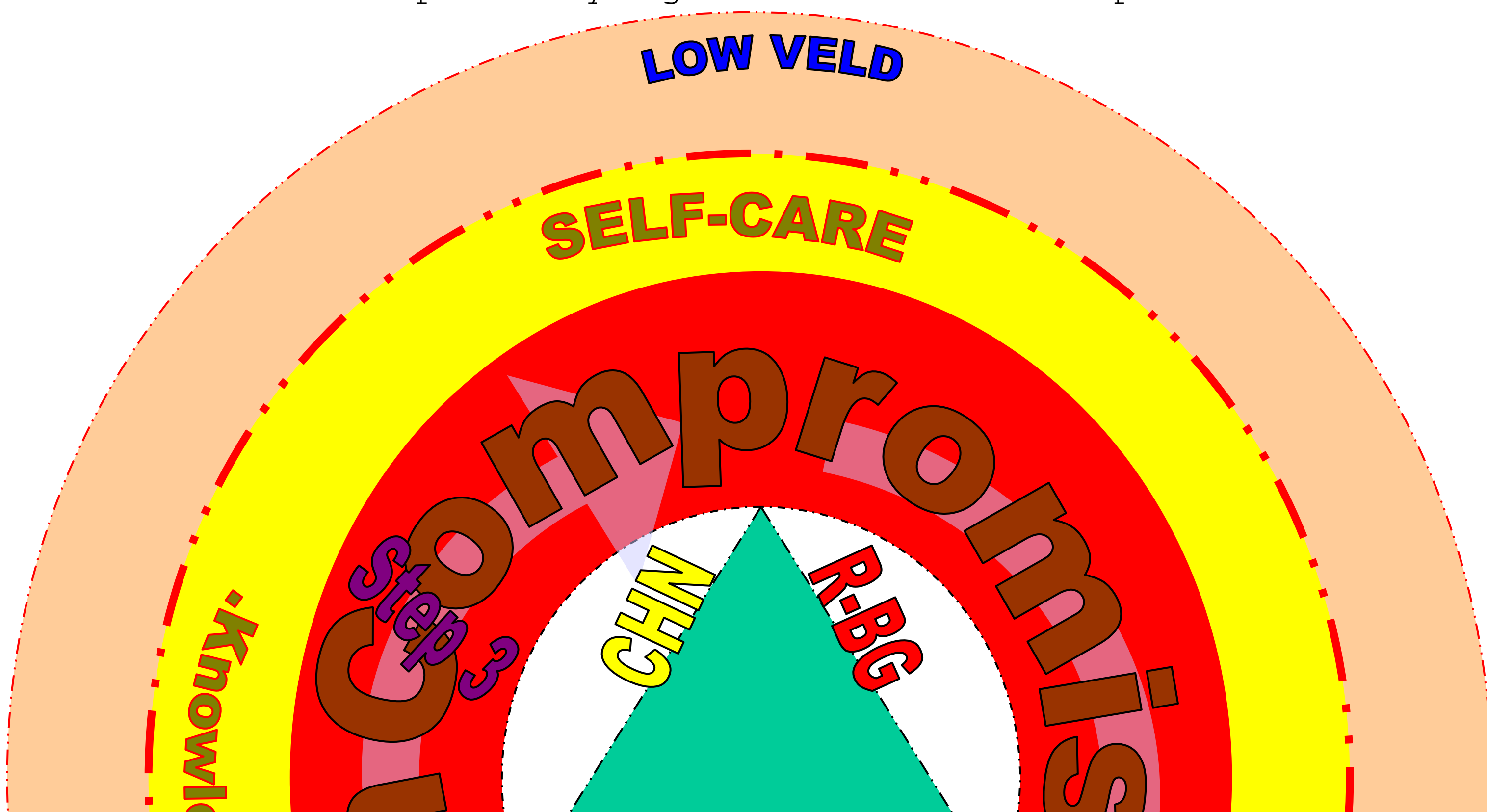


Figure 4.17 The complete conceptual framework for empowering with self-care rural-based grandparents raising grandchildren orphaned through HIV/AIDS

circle generally denotes continuity of a phenomenon. It has neither a definite starting or entry point nor a definite ending point. It is ongoing.

The round shape of the conceptual framework was symbolic of the ongoing nature of both education and the nursing process. Education has neither lower nor upper age limits. Learning takes place all the time throughout the life span, namely, from the cradle to older adulthood.

The nursing process with its four phases is another activity that is ongoing. The CHN may choose to start from

any of the three phases of the three-step nursing process. Nursing interventions may start any where in the nursing process.

Finally, the interrupted lines surrounding all the circles represent interactions that take place between every aspect of the conceptual framework and the surrounding environment. Learning takes place continually in the environment as well as in special environments such as through the proposed health education programme.

4.5 CHAPTER SUMMARY

Chapter four represented phase two of the process of this research. In particular, the chapter focused on describing the conceptual framework that guided the development of the proposed health education programme. The conceptual framework was conceived from the category COMPROMISED HEALTH that was identified as an area of need for the R-BGs raising GOTHA in order to improve their self-care agency.

The conceptual framework was a product of integrating the following:Orem's self-care deficit theory, self-care three-step nursing process, supportive-educative nursing system and also adult learning principles and interpersonal communication. The process aspect of the stages of the conceptual framework, namely, pre-educating and post educating, was described. The relationships of the conceptual framework were explained.

The next chapter presents phase three.

CHAPTER FIVE

A DESCRIPTION OF THE STRUCTURE AND CONTENT OF THE PROPOSED HEALTH EDUCATION PROGRAMME TO EMPOWER WITH SELF-CARE RURAL-BASED GRANDPARENTS RAISING GRANDCHILDREN ORPHANED THROUGH HIV/AIDS IN THE LOW VELD.

'Education is a very powerful instrument for people empowerment '- Paulo Freire

5.1 INTRODUCTION

Chapter four presented the conceptual framework that was utilized to develop the proposed health education programme to empower with self-care R-BGs raising GOTHA in the lowveld. The various components and processes of the conceptual framework and their interrelationships were explained and discussed.

Chapter five marks the third phase and its purpose is to present the content and structure of the proposed health education programme to empower R-BGs raising GOTHA in the lowveld. Glick and Stanhope (2004:497) defined programme as an organized approach to meet the assessed needs of individuals, families, groups, populations and communities by reducing or eliminating one or more health problems. The proposed health education programme is based on the findings from the analyzed data from phase one or the phenomenological part of the study.

5.2 HEALTH EDUCATION-RELATED CONCEPTS

Prior to describing the actual proposed health education programme to empower with self-care R-BGs raising GOTHA, the following three concepts, namely health education, empowerment and self-care, are outlined briefly.

5.2.1 Health education

According to Rankin and Stallings (2001:4), health education is an integral component of nursing practice. Swanepoel (1999:148) described health education as a strategy that is used by professional nurses to equip the

consumers of health care services with appropriate knowledge, attitudes and skills, with which to bring about positive difference in their health and wellbeing.

Kibel, Seloojee and Westwood (2007:82) defined health education as structured, planned learning opportunities that are aimed at improving health literacy, including improving knowledge or developing life skills conducive to individual and community wellbeing. Implied in this definition are two important points. First, providing health education should not be taken as a single or isolated activity, but serial, ongoing and lifelong. CHNs shall teach series of lessons continually, especially, to the R-BGs since they lack health-related information. Second, health education is deliberate action and not done haphazardly. Therefore, the implementers of the proposed health education programme ought to invest time in preparing well for the education sessions that shall be guided through teaching plans (Swanepoel, 1999:161).

With regards to giving of health education in clinics, the researcher observed on several occasions in the past that CHNs in most clinics did not plan their sessions as evidenced, to a greater extent, by lack of teaching plans, content that was too shallow, use of lecture method to teach, non use of teaching aids and giving the clients information in the forms of do’s and don’ts. According to the American Association for Health Education (AAHE) (2005: online) educating clients constitutes offering information and not threatening them.

In their definition, Rankin and Stallings (2001:133), referred to health education as a process that is employed to influence behaviour, produce change in knowledge,

attitudes and skills in order to maintain and improve health. Similar to that of Kibel et al. (2007:82), the afore-mentioned definition underpins the ongoing nature of client teaching about health-related issues and this process culminates in change of behaviour in the client, who may be an/a individual, group, family or entire community (Swanepoel, 1999:161). The goal of the programme is that the health of the R-BGs raising GOTHA in the lowveld shall move forward toward optimum wellness (AAHE, 2005: online; Potter and Perry, 2003:133).

5.2.2 Empowerment

The concept of empowerment is associated with the works of the Brazilian born social scientist, Paolo Freire (Rankin and Stallings, 2001:80; McNeil, 1990:29 – 49), who argued that ignorance, especially among the poor, may be eradicated by imparting knowledge through teaching them. The R-BGs raising GOTHA, are part of a population group that is disadvantaged, poor (Fouad, 2003: online), marginalized (ULARN, 2003:online) and disempowered.

The Longman Dictionary of Contemporary English (1995:446) described to empower someone, as giving that person more control over her/his life or situation. Hattingh et al. (2006:43) pointed out that individuals in the community need to be empowered so that they can be able to take full control of their lives. Therefore, the proposed health education programme seeks to educate R-BGs raising GOTHA and empower them with self-care, so that they shall be able to take more control over their lives.

According to Friedman, Bowden and Jones (2003:202) empowerment has become the ‘buzzword’ for many a helping profession, including nursing. According to these authors empowerment has the following four attributes, it:

- is a helping process.
- involves partnership that values self and others.
- is characterized by decision making.
- includes freedom to make choices and accept responsibility.

Therefore, it is expected that the proposed health education programme shall help by equipping with self-care knowledge, attitudes and skills to the R-BGs raising GOTHA in the lowveld.

5.2.3 Self-care

Self-care is one of the constructs of the general self-care nursing theory whose proponent is Orem. According to Foster and Bennett (2002:125), an individual who is able to take care her/him self has self-care and self-care agency, and does not require nursing. On the other hand, the adult who is not able to take care of her/him self has self-care deficit and lacks self-care agency. Therefore, this individual needs nursing in order to restore self-care agency.

Clark (2003:214) pointed out that self-care is an outcome of health education and helps to equip individuals with the ability (agency) to make any of the following three health-related decisions about

- self-care
- the use of health resources and
- societal health issues.

The next sub-section presents the actual programme.

5.3 PHASE TWO: THE STRUCTURE OF THE PROPOSED HEALTH EDUCATION PROGRAMME TO EMPOWER WITH SELF-CARE RURAL-BASED GRANDPARENTS RAISING GRANDCHILDREN ORPHANED THROUGH HIV/AIDS IN THE LOWVELD

According to Swanepoel (1999:150), a programme is a standing arrangement that provides a social service and health education programmes are planned opportunities for people to learn about and to undertake voluntary changes in their behaviours with regard to health. A programme usually has a vision. Mission, philosophy, aims and objectives and content. These are outlined next.

5.3.1 Vision statement

A statement of vision seeks to inform explicitly about the future outlook of an organization. The vision of the Ministry of Health and Social Welfare (Ministry of Health Policy, 1983:1) of the Kingdom of Swaziland is:

Health for all citizens in the Kingdom of Swaziland

In line with the vision of the overall Ministry of Health and Social Welfare in Swaziland, the vision of this programme is:

'*Health for all elderly in the Kingdom of Swaziland*''

5.3.2 Mission statement

The mission statement of the Ministry of Health and Social Welfare reads thus:

To improve the health and social welfare of the people of Swaziland by providing preventive, promotive, curative and rehabilitative services that are of high

quality, relevant, accessible, equitable and socially acceptable.

The Mission of this programme is:

'*to empower with self-care all elderly in the Kingdom of Swaziland*'

5.3.3 Programme philosophy

A philosophy is a statement that reflects values, goals or opinions and beliefs of an individual (Hattingh, et al., 2006:2). The philosophy of the proposed health education programme espouses the principles of PHC and health education as a discipline in its own right. Though not exhaustive, the following are some of the beliefs, opinions and values of the proposed health education programme, that:

- *Every elderly person is a unique and special entity in the eyes of God and therefore, deserving to be treated with respect and dignity at all times.*
- *Every elderly person, regardless of gender and education is a full citizen of the universe and specific country within which she/he resides and therefore must enjoy all her/his individual rights, in particular, the right to health care.*
- *Nursing exists primarily to respond to the needs of all human beings from birth to older adulthood and the needs of the elderly shall also be attended to alongside the needs of other population age groups in the communities.*
- *Health education is an integral component of the nursing process and shall be used to empower with self-care the elderly in order to assist them to attain optimum health and levels of functioning.*

- *Health education influences development, knowledge, attitudes and behaviour and therefore, it shall be used to improve the health and wellbeing of the elderly.*
- *Quality gerontological nursing practice includes health education that is evidence informed.*

5.3.4 Programme aims

Ornstein and Hunkins (1993:210) defined aim as the starting point that suggests an ideal or inspirational vision of the good and is usually stated in broad terms that are not measurable. Aims attempt to give the purpose for the programme (Ornstein and Hunkins, 1993:213). Aims are stated very broadly unlike in goals and objectives.

> *The aim of the proposed health education programme is to enhance the health of the Swazi elderly by empowering them with relevant knowledge, attitudes and skills to care for themselves and enjoy optimum life, thus delay disability and immobility.*

5.3.5 Programme goals

The programme goals are developed from the aim or aims of a programme. According to Ornstein and Hunkins (1993:214) goals, like aims, are timeless and statements of purpose with some outcome in mind. They are not open like aims but have specific statements written down so that those responsible for programme creation can use them as guidelines to achieve those particular purposes. The goals of the proposed health education programme are to:

- assist the elderly to enjoy optimum level of health and functioning.
- to ensure the elderly understand the importance of engaging in health promotion activities all the time.

- ensure that health services are available, accessible and affordable to the elderly at all times.

5.3.6 Programme objectives

According to Ornstein and Hunkins (1993:215) objectives can be of two types, namely: (i) those that describe the programme-wide outcome and (ii) those that are more specific and describe behaviour to be attained in a particular unit or a subject course by the learner. While the former are associated with summative evaluation, the latter are associated with formative evaluation.

Specific objectives are generally referred to as learning objectives (Banks, 2000: online) or intended learning outcomes (Ornstein and Hunkins, 1993:216). In their discourse, Ornstein and Hunkins used specific action verbs to describe the intended learning outcomes of the learners. Therefore, CHNs shall use appropriate action verbs for the different domains of learning. Intended learning objectives also help to evaluate whether their teaching which id guided by a teaching plan achieved its objective for that session and cumulatively they also help to evaluate the programme process as well as the overall summative evaluation of the programme.

5.3.7 Content of the programme

The content for the proposed health education programme was evidence informed and has been divided into three sections. The first section (see column 5.5.8) has four old adulthood-related topics, namely, conceptualizing aging, myths about aging, theories on aging and body systems. While the first three sub topics explore the nature of old adulthood, the one on human body systems seeks to lay a foundation of knowledge of their own anatomy and

physiology. The topic on human body systems cover all the systems in the human body. The entire content of this first section shall set the base upon which subsequently content will be built.

The second section (see column 5.5.9) addresses health problems that were identified through the health records of the R-BGs and interviews data. These are some of the chronic conditions the R-BGs were suffering from. The third and last section (see column 5.5.10) comprises other health-related issues that were identified through field notes, mostly observations by the researcher as she moved from one homestead to the next. These health-related issues were potentially detrimental to health and wellbeing primarily to the R-BGs raising GOTHA and also to the GOTHA themselves.

All three levels of care or prevention, namely, primary (prevention and promotion), secondary (curative) and tertiary (rehabilitative) levels of care are implicated in this health education programme. The structure of the proposed health education programme is presented next.

Table 5.1 Summary of programme structure and content

5.3.7.1 **OLD ADULTHOOD**	**5.3.7.2** **IDENTIFIED PHYSICAL HEALTH PROBLEMS**	**5.3.7.3** **OTHER IDENTIFIED HEALTH-RELATED ISSUES**
5.3.7.1 (a) Conceptualizing aging 5.3.7.1 (b) Myths about aging	5.3.7.2 (a) Respiratory system 5.3.7.2 (b) Endocrine system	5.3.7.3 (a) Basic human needs 5.3.7.3 (b) Impaired basic hygiene measures 5.3.7.3 (c)

5.3.7.1 (c) Theories about aging 5.3.7.1(d) Human body systems Nervous systems Cardio-vascular system Gastro-intestinal tract Respiratory tract Reproductive system Urinary System Integumentary system Musculo-skeletal system Endocrine system Immune system Special senses	5.3.7.3 (c) Cardio-vascular system 5.3.7.4 (d) Cardio-vascular/ Respiratory systems 5.3.7.5 (e) Special organs of sense 5.3.7.6 (f) Musculo-skeletal system 5.3.7.7 (g) Gastro-intestinal tract 5.3.7.8 (h) Immune system	Mental health needs 5.3.7.3 (d) Physical fitness 5.3.7.3 (e) Inadequate external environmental sanitation 5.3.7.3 (f) Inadequate human waste disposal 5.3.7.3 (g) Miscellaneous 5.3.7.3 (g.i) Elderly abuse 5.3.7.3 (g.ii) Knowledge deficit about individual rights 5.3.7.3 (g.iii) Older adulthood and human sexuality

5.3.7.1 Old adulthood

Growing old is a normal process of life contrary to all myths that have been said about it (Clark, 2003:447). While it is a normal process of life, the aging individual is said to undergo multi-dimensional challenges, physiologically, psychologically, socio-culturally and spiritually (Fletcher, 2008:668). It is noted particularly in developing countries, that aging is also a time of many health challenges and is associated with hardships that

emanate from the hardships suffered during early life (Fouad, 2005:online) loss of support from children (Knodel and van Lantingham, 2002:online) and also a decrease in resources with which to meet their basic life needs.

The broad topic of old adulthood has the following sub-topics: conceptualizing aging, myths about aging, theories of aging and body systems, and they are each described next.

5.3.7.1(a) Conceptualizing aging

Though aging is generally defined chronologically and said to occur from the age of 60 years, Murray and Zentner (2001:706) pointed out that it sets in already at conception and ends when the individual dies. The purpose of this topic is to engage these R-BGs raising GOTHA in a discussion that is meant to elicit perceptions, feelings and attitudes about their own aging. In addition, this topic shall help to establish a base upon which subsequent content/topics for health education sessions shall build. The content for this first unit in this first section shall include the following sub-topics:

- Defining aging
- Onset of aging
- Fear of aging
- The beauty of aging
- Culture and aging

5.3.7.1(b) Myths about aging

According to the Oxford Advanced Learner's Dictionary (2000:776) myths are things many people believe about but in reality these things do not exist. McKenzie, et al. (1999:264) pointed out that like other forms of prejudice and discrimination, ageism is a result of ignorance,

misconceptions and half-truths about aging and the elderly. This topic shall be taught through a frank discussion between CHNs and R-BGs with the objective of exposing and correcting any current myths and misconceptions about older adulthood as these may have implications on the health of the R-BGs as old adults.

5.3.7.1(c) Theories about aging

A number of theories have attempted to describe the phenomenon of aging from various perspectives. In this programme, it is important to determine the perceptions of the R-BGs themselves about their own aging. The purpose of this topic, therefore, shall be for CHNs to share with the elderly selected theories that have been put forward concerning how people become old (Murray and Zentner, 2001:748 - 754). CHNs shall and in very simple language and terms explain to the R-BGs, the following selected content that was documented by Fletcher (2008:667 - 668):

- Biological clock theory
- Wear and tear theory
- Disengagement theory

Having described the first three sub-topics of old adulthood, the CHNs shall endeavour to teach the R-BGs about the various body systems as prescribed below.

5.3.7.1(d) Human body systems

According to Cohen and Wood (1996:3 - 4) the human body is organized according to individual systems (refer to figure 5.2). In order for the R-BGs raising GOTHA to have maximum benefit from the health education sessions, CHNs shall, whenever teaching about an illness, be it acute or chronic, start by briefly outlining the relevant anatomy and physiology aspect of that illness in order for the R-BGs to

have an idea about the basic structures and functioning of the body parts involved (refer to figure 5.2) and also the pathophysiology. The format for presenting the body systems to the R-BGs shall remain standard, and generally include the following sub-topics:

- Location (where in the body the organs are situated)
- function (how these organs work or function)
- changes in older adulthood and implications thereof.

Utilizing the afore-mentioned format, for instance Grandmother K (G-K) suffered and complained of pain around her finger joints. This pain was suggestive of pain experienced when one has an arthritic condition. In teaching the R-BG, the CHN would then start by pointing out the area or areas that are affected, namely, joints and then go on to explaining the function of joints. Thereafter, the CHN should explain the changes that take place as well as how to effectively look after oneself in trying to alleviate such pain.

The body systems are not going to be taught as a series of independent lessons but shall be selectively taught in conjunction with the physical health problem that will be presenting in the R-BG.

5.3.7.2 Identified physical health problems

According to Fletcher (2008:672) maintenance or improved self-care capacity and effective disease management are the priorities and concerns of chronic health in older adults or gerontological nursing. A summary of physical health problems (refer to table 5.2) that were identified from the data is given below. The format for presenting these health

problems shall vary depending on the prevailing condition, and extent of self-care deficit and educational needs (Potter and Perry, 2003:135) of the R-BGs raising GOTHA.

Table 5. 2 Selected identified health problems of R-BGs raising GOTHA

5.3.7.2 Identified Physical Health Problems
5.3.7.2(a) Asthma (Grandfather Q's wife)
5.3.7.2(b) Diabetes mellitus (Grandmother: F)
5.3.7.2(c) Elevated blood pressure Grandmothers: B, I, G, O, N & L)
5.3.7.2(d) Chest tightness (Grandmother: B)
5.3.7.2(e) Chest pain (Grandmothers: B, E & Grandfather Q)
5.3.7.2(f) Pain in the knees (Grandmothers: A, B, G, H, I, K,& O)
5.3.7.2(g) Painful back (Grandmothers: B, H, I, K, L & O)
5.3.7.2(h) Skin rash (Grandmothers: A & C)
5.3.7.2(i) Sores in the stomach (Grandmother: K)
5.3.7.2(j) HIV infection (Grandmother: I)
5.3.7.2(k) Impaired hearing (Grandmothers: H, I, K, L, & O)
5.3.7.2(l) Impaired vision (Grandmothers: B, C, G, H, K, L, N & O)

5.3.7.2(a) Asthma (Grandfather Q's wife)

Though none of the R-BGs raising GOTHA had it, the common-law wife of the only male participant, namely Grandfather Q, had severe chronic asthma. Asthma is a common chronic airway condition whose acute bouts are reversible (Hattingh, et al., 2006:236 – 237). It is very important for persons living with asthma to possess self-management

ability, in order to reduce the number of acute attacks of asthma. The sub-topics that shall be taught by CHNs include the following:

- Definition
- Causes
- Predisposing factors
- Management (diet, drug and compliance with treatment, breathing exercises and special stress relieving exercises).

5.3.7.2(b) Diabetes mellitus (Grandmother: F)

Grandmother F suffered from diabetes mellitus of adult onset. She demonstrated a lack of knowledge about the disease and had no self-management. In a study that was conducted by Dlamini (2003:37) the findings revealed that lack of self-management ability among patients who had diabetes mellitus had negative effects on their health and well-being. On the other hand, Nhlabatsi (2004:19) found that those clients who were taught about the condition had lowered levels of blood sugar. Therefore, lessons pertinent to this condition shall, among others, include the following sub-topics:

- Definition
- Types
- Signs and symptoms in elderly people
- Management (diet, drugs, care of hands and feet)
- Manifestations and prevention of hypoglycaemic coma
- Complications

5.3.7.2(c) Elevated blood pressure (Grandmothers: B, I, G, O, N and L)

Also known as hypertension, this is a common age-related cardiovascular condition in the elderly. Elevated blood

pressure is a major health problem with multiple causations, including lifestyle (Hattingh, et al., 2006:241). Six R-BGs had elevated blood pressure as evidenced by their clinic cards and were on treatment for it. The content to be taught shall include the following sub-topics:

- Definition
- Types
- Risk factors,
- Management (diet, exercise, drugs and compliance to treatment)
- Complications.

Mabuza (2008:171) advised that all elderly persons with hypertension ought to be managed first with non-pharmacological measures and determine the response.

5.3.7.2(d) Chest tightness (Grandmother: B & Grandfather Q)

The chest cavity contains among others two vital organs, namely, the major blood vessels, heart and lungs both of which undergo changes with aging (Breslin and Lucas, 2003:693).

5.3.7.2(e) Chest pains (Grandmothers: B, E & Grandfather

Three R-BGs complained of pains in their chests. There are many factors that may cause chest pain. Therefore, any complaints of chest pain, regardless of severity, should ideally be taken seriously and investigated. CHNs must stress to the R-BGs the importance of seeking medical treatment as early as possible in order to receive prompt medical attention and thus avoid complications. The content of this topic shall include:

- Definition of pain

- Types/nature of pain
- Causes of pain
- The importance of seeking early medical interventions

5.3.7.2(f) Pain in the knees (Grandmothers A, B, G, H, I, K, & O)

Osteoarthritis has been associated with pain and discomfort in the knee joints of the elderly (Clark, 2003:461) and is a debilitating chronic condition that needs tertiary prevention level of care. Just under 50% of the R-BGs complained of ambulating challenges, particularly those who were 75 years and above and also those who were overweight. The objective of teaching this topic shall be to help the R-BGs to have better control over their discomfort and/or pain to prevent from premature disability and instead promote optimum level of comfort and functioning. The following sub-topics shall be discussed:

- Causes of pain in the knees
- Management (rest, local pain relief, weight control, exercise and drugs)
- Role of food in osteoarthritis

5.3.7.2(g) Painful back (Grandmother B, H, I, K, L and O)

According to Breslin and Lucas (2003:694) older women have musculo-skeletal changes that are associated with bone density and muscle mass. Therefore, pain in back and knees may be influenced by such changes in the R-BGs. Herlihy (2007:133) listed the following that occurs with adding:

- Loss of calcium and other materials makes bone become less strong.
- Sex hormones decrease and there is decrease inner bone formation.
- Tendons and ligaments become less flexible causing less range of motion.
- Intervertebral discs shrink; there is less bone mass, height decreases and thoracic spine curves.

Approximately 50% of the R-BGs raising GOTHA in the study complained about *licolo* (back pain). Though this problem is not unusual in older adulthood, it needs to be addressed by CHNs in their educational encounters so that the R-BGs can be taught the different modalities of relieving their pain. The content for teaching shall include:

- Causes of back pain
- Management (rest, appropriate diet, exercise and drugs)
- Good posture and correct use of muscles.
- Prevention of back pain – Do's and don'ts
- Complications.

5.3.7.2(h) Skin rash (Grandmothers: A & C)

According to Breslin and Lucas (2003:691) some of the changes in the skin of the older adult such as altered fat-lean mass ratio can contribute toward, among others, fragile skin. The researcher observed that two R-BGs (Grandmother A and Grandmother C) who were raising small children each had severe skin rash on their arms and legs. As the interview proceeded they scratched themselves as itching arose. The following content shall be taught by CHNs:

- Role and functions of the skin

- Predisposing factors in changes in the skin
- Consequences of broken skin
- Role of personal hygiene in promoting health

5.3.7.2(i) **Sores in the stomach** (Grandmother: K)

The feeling of burning in the abdomen especially in the region where the stomach is situated may be associated with gastro-intestinal conditions such as gastric and/or peptic ulcers. One R-BG (Grandmother K) complained about feeling a burning sensation which at times was relieved by eating, and other times not. Ulcers are known to be associated with stressfulness. The situation of raising GOTHA, especially without adequate resources and no support may have contributed. The purpose of this topic shall be to teach the R-BGs raising GOTHA how to manage heartburn and ulcers, and prevent complications thereof. The following content shall be taught:

- Types
- Pre disposing factors
- Management (role of diet, drugs, stress relieving exercises)
- Preventing development of ulcers
- Complications

5.3.7.2(j) HIV infection (Grandmother: I)

One R-BG had tested HIV positive (Grandmother I). She did not seem to know what was happening to her inside her body and also how to look after herself (refer to excerpt in chapter three 3.6.2.1(h)). This topic is very important to teach to the R-BGs:

- primarily, because studies have reported that most elderly lack knowledge when caring for sick children and other relatives (Motsa, 1999:69)

- secondly, because the HIV statuses of the orphaned grandchildren are most of the time not known.
- thirdly, because many elderly caregivers of chronically sick children have expressed needs for knowledge about precautionary measures (Maziya, 2005:40).
- fourthly, because some of the R-BGs raising GOTHA may still be having sexual intimacy (Fouad, 2005: online). Sex is personal and a basic human need.

The above mentioned are potential areas for contracting HIV infection by older adults. Therefore, some of the content to be taught under this heading are:

- Definitions of HIV and AIDS
- Differentiating between HIV and AIDS
- Modes of transmission of HIV infection
- Prevention from contracting HIV infection
- Standard precautions
- Benefits of testing for HIV.

5.3.7.2(k) Impaired hearing (Grandmothers: H, I, K, L, & O)

Loss of hearing has been associated, among others, with social isolation by affected persons (McEwen, 2002:315). Five R-BGs had obvious difficulty with hearing as evidenced by the way they turned their faces toward the researcher whenever she asked a question or said anything else. The CHNs shall teach the following:

- Physiology of hearing
- Causes of hearing loss
- Screening for hearing
- Care of the ears
- Assistive hearing devices.

5.3.7.2(l) Impaired vision (Grandmothers: B, C, G, H, K, L, and N & O)

Loss of vision in older adults is common and the prevalence increases with age (McEwen, 2002: 315). Eight out of the 14 R-BGs raising GOTHA complained about not being able to see as well as before. The contents of this topic shall cover the following:

- Physiology of seeing
- Causes of vision impairment in older adulthood
- Screening tests available
- Vision correction
- Consequences of vision loss

The afore-mentioned were some of the identified disease conditions that the CHNs shall be teaching about to the R-BGs raising GOTHA in the lowveld.

5.3.7.3 Other identified health-related issues

As the researcher went from homestead to homestead conducting interviews with R-BGs raising GOTHA, she observed in the external environment health-related situations that were potentially detrimental to the health and wellbeing of the R-BGs and their GOTHA (refer to Table 5.3.7.3). According to the American Association of Health Education (AAHE) (2005: online) education in health helps individuals seek that which moves them toward optimum stages of wellness. The CHN is also expected to teach about environment-related issues since the R-BGs and their GOTHA interact with these environments.

Table 5.3 Summary of other health related challenges to R-BGS raising GOTHA.

OTHER IDENTIFIED HEALTH-RELATED ISSUES

5.3.7.3 (a)Inadequate intake and maintenance of food (All 14 R-BGs)

5.3.7.3 (b Inadequate sleep (Grandmothers: O, Q & L)

5.3.7.3 (c)Overweight (Grandmothers: B, F, N & O)

5.3.7.3 (d Inadequate personal hygiene practice (Grandmothers: A, B, C, G,L & O. Grandfather Q)

5.3.7.3 (e Imbalance between activity and rest (Grandmother A, H, K, L, O, N & Grandfather Q).

5.3.7.3 (f)Imbalance between social interaction and solitude all R-BGs)

5.3.7.3 (g) Lack of exercise (All 14 R-BGs)

5.3.7.3 (h) Lack of external environmental sanitation Grandmothers: A, B, C, L, N, O & Q)

5.3.7.3 (i) Ineffective ventilation (All the houses of the R-BGs)

5.3.7.3 (j) Lack of proper ways of disposing human waste (Grandmothers: B, C, I, L & N)

5.3.7.3 (k) Miscellaneous

5.3.7.3 (k.i) Elderly abuse (Grandmothers: B, I and K)

5.3.7.3 (k.ii) Knowledge deficit about individual rights. (Researcher felt need)

5.3.7.3 (k.iii) Older adulthood and human sexuality (felt need by researcher)

5.3.7.3(a) Inadequate intake and maintenance of food

Appropriate nutrition is important at every stage of life for maintaining good health and personal productivity, and it is particularly important to the elderly because of the physiological changes that take place in the body as persons age (Skolnik, 2007:1). The study findings showed that most R-BGs were not eating enough food. At times they went without eating

for the benefit of their GOTHA. The contents of this topic shall include:

- Role of food in life.
- The three food groups.
- Role of micronutrients.
- Eating well – meaning of adequate diet.
- Appropriate old adulthood diet.
- Factors contributing toward not eating adequately.
- Consequences of not eating adequately.

5.3.7.3(b) Inadequate sleep

There is a general misconception that older persons do not need much sleep. Sleep is essential to health and life (Geldenhuys, 2003:2) to all across the life span. The researcher observed that three R-BGs yawned several times during their interviews which took place in the morning between 9AM and 11AM. The CHNs will impart the following knowledge to the R-BGs about sleep:

- The nature of sleep.
- Functions of sleep.
- Stages of sleep.
- Adequate sleep.
- Benefits of sound sleep.
- Consequences of inadequate sleep.
- Sleep inducers.

5.3.7.3(c) Overweight

Good nutritional practice and maintenance of a desirable weight are essential for good health (McEwen, 2002:240). Though culturally, a woman who is well rounded is a sign of

being well looked after, from the point of view of health, being overweight is detrimental to life. Three
R-BGs raising GOTHA were overweight Some of the content that shall be covered in this topic include the following:

- Definition.
- Causes.
- Effects, prevention.
- Weight control/management (diet and exercise).
- Consequences of being overweight).

5.3.7.3(d) Inadequate personal hygiene practice

Personal care is an important aspect of elderly health too and includes personal hygiene (Clark, 2003:460). In about 50% of the homesteads that were visited by the researcher, the R-BGs exhibited sub-standard levels of personal hygiene (such as blowing their noses directly into their palms and then rubbing both palms together) and yet a number of them were caring for small children for whom they cooked. Content that shall be taught shall include the following:

- Definition.
- Benefits of good personal hygiene.
- Factors that contribute towards poor personal hygiene.
- Effects of good personal hygiene.
- Adverse effects of poor personal hygiene.

5.3.7.3(e) Imbalance between activity and rest

Owing to their new social role of surrogate parenthood, 50% of the R-BGs raising GOTHA said that they were unable to rest sufficiently because of looking after their GOTHA, especially younger ones. The CHNs will discuss with the R-BGs the importance of resting to health and wellbeing.

5.3.7.3(f) Imbalance between solitude and social

interaction

Though not interacting with others from time to time is good for personal reflection and growth, perpetual social isolation is detrimental to mental health. Loneliness was documented among the elderly who were investigated upon by Mabuza (2008:174 - 176). One of the researcher's strategies to counter their loneliness was to assist them build social networks within their communities. All R-BGs raising GOTHA revealed that they did not have time to go and visit others because of the care burden of looking after GOTHA. This topic shall be delivered in the form of a discussion as it has implications on mental health promotion.

5.3.7.3(g) Lack of exercise

Health and optimum functioning is promoted among others through regular exercising of the body parts. While some of the R-BGs walked to and from the water souces, they still need to be taught exercises that involve all their body parts. They need to be taught joint stretching exercises. All R-BGs did not engage in any types of exercise, most probably because of lack of knowledge about the importance of keeping fit. According to Lysycia (2008:8), exercising, especially stretching has anti-aging effects. There are ample benefits to life and living with exercises on a regular basis. This topic will include the following content:

- The role of exercise in health and wellbeing.
- Types of exercises as for various body parts.
- Benefits of exercising regularly.
- Consequences of not exercising on a regular basis.

5.3.7.3(h) Lack of environmental sanitation

According to Dreyer (11999:5) the foundations of community nursing, primarily, lies in disease prevention and health

promotion. The yards of many homesteads were not sanitary. While some were full of domestic animal droppings, others were covered with general liter, all of which were detrimental to health. Children should be safe in their homes. The content of this topic shall cover the following sub-topics:

- good environmental sanitation.
- how to sweep the yard.
- consequences of unsanitary yards.
- choosing the correct site for a rubbish pit.

5.3.7.3(i) Ineffective ventilation of dwellings

Owing to faulty construction of their dwellings, ventilation was ineffective. Appropriate guest speakers shall be invited, possibly from the Environmental Health Department of the Ministry of Health and Social Welfare and also Ministry of Housing and Urban Development. Some of the content that will be taught is:

- good siting for a house.
- good construction of a house, materials for constructing a good house.
- adequate housing.
- role of ventilation in a house.
- consequences of poor ventilation.

5.3.7.3(j) Lack of proper ways of disposing human waste

In six homesteads, the R-BGs used nearby bushes to relieve themselves. Cholera is still a public health problem in Swaziland and time and again, its outbreaks are reported (Ndlangamandla, 2009b:10). This topic is very important and shall include the following content:

- Reasons for having a pit latrine.
- Benefits of having and using a pit latrine.

- Types of pit latrines.
- How to site a pit latrine.
- Maintenance of a pit latrine.
- The importance of hand hygiene,

5.3.7.3(k) Miscellaneous

The following topics were identified through certain observations that were made in the data and/or while interacting with the R-BGs during data collection.

5.3.7.3(k.i) Elderly abuse

Traditionally, all elderly persons are supposed to be shown respect and treated with dignity. The category of NO SUPPORT comprised, also suggests that there is an element of elderly abuse, primarily at family level because of abandonment by sons. Elements of elderly abuse were seen and felt since the R-BGs had no one to support them. Guest speakers shall be invited as deemed from Swaziland Action Group Against Abuse (SWAGAA) *and Umtfunti weMaSwat*i. Since elderly abuse is on the increase (Landenberg and Campbell, 2008:844), the aim of this topic is to enlighten R-BGs raising GOTHA and other elderly in the lowveld about the nature and manifestations of human violence, including elderly abuse. The content of this topic shall include among others:

- definition, types,
- characteristics of abusers,
- reasons for elderly abuse,
- effects of abuse on the elderly person,
- prevention of elderly abuse,
- steps to take when being abused,
- elderly-focused organizations in Swaziland.

5.3.7.3(k.ii) Knowledge deficit about individual rights

Swaziland now has a written constitution that was brought into effect in July 2005. The constitution emphasizes individual rights. The elderly have both individual rights like all persons as well as special rights by virtue of being older adults. Guest speakers who are experts in the area of human rights issues shall be invited from the Ministry of Justice and also organizations such as Women and Law in Swaziland to address groups of elderly. The content thereof shall include:

- Definition.
- Types of rights.
- Individual rights of the swazi people.
- Human rights-based organizations in Swaziland.

5.3.7.3(k.iii) Older adulthood and human sexuality

Sexuality is an important aspect of elderly health (Hattingh, et al., 2006:206) though a sensitive area, particularly in Swaziland. While some cultures are more open about the subject of sex, others are more prohibitive and therefore, do not encourage people to talk about it. The content of this topic shall have the following sub-topics:

- Meaning of human sexuality.
- Safer sex.
- Available family planning methods.
- Sexual challenges among the elderly.
- Management of sexual problems.

This topic shall be handled by mature nurses who are married and have a diplomacy since it is very sensitive and the audience is a delicate one.

5.4 CHAPTER SUMMARY

The chapter represented phase three (a. A brief discussion of the following concepts: health education, empowerment and self-care. Thereafter, the structure and also content of the proposed health education programme were presented.

The vision, mission, philosophy, aims and objectives of the proposed health education programme were outlined after which the content of the proposed health education programme was revealed. The content was divided into three sections. While the first section discussed the phenomenon of old adulthood which is meant to form the base for subsequent learning from the other two sections, the second section focused on the identified physical health problems from which the R-BGs suffered. The third and last section, addressed other identified health-related issues that were observed in the research setting. Some of the sub-topics for inclusion into the main topics of the programme were suggested.

Chapter six which is still part of phase three is presented next.

CHAPTER SIX

DESCRIPTION OF SELECTED GUIDELINES FOR IMPLEMENTING THE PROPOSED SELF-CARE HEALTH EDUCATION PROGRAMME TO EMPOWER WITH SELF-CARE RURAL-BASED GRANDPARENTS RAISING GRANDCHILDREN ORPHANED THROUGH HIV/AIDS IN THE LOWVELD

Tell me, I will forget.
Show me, I may remember.
Involve me, I will understand.
- Kongfuze

6.1 INTRODUCTION

Chapter five marked the beginning of phase three and also presented the structure and content of the proposed health education programme for empowering with self-care R-BGs raising GOTHA in the lowveld. The purpose of chapter six which is still part of phase three, is to outline and discuss special and unique guidelines that have been selected for CHN to take into account when teaching the R-BGs raising GOTHA.

According to the Oxford Advanced Learners' Dictionary (2000:528) the word guideline refers to official instructions that are given to someone on how to carry out something, especially something challenging. Teaching elderly persons requires special knowledge on the part of the programme implementers. Therefore, the researcher has prepared selected guidelines that are going to be useful to the programme implementers.

6.2 PROGRAMME IMPLEMENTERS

The proposed health education programme to empower with self-care R-BGs raising GOTHA in the lowveld, shall be implemented by CHNs as these nursing health professionals practise nursing in the various non health facilities throughout the lowveld of Swaziland. They are predominantly

community based and therefore interact with community members, including the elderly too.

6.3 TARGET AUDIENCE

The target audience for the proposed health education programme is primarily the
R-BGs raising GOTHA in the lowveld. The study findings revealed that most of the
R-BGs raising GOTHA had many chronic physical health challenges for which they lacked knowledge and self care ability. Implied in the philosophy of PHC is that health is a resource as well as a birthright.

The proposed health education programme addresses the elderly only; because their health needs continue to be ignored despite that it is known that declining health is a function of aging. While the day of the elderly has been celebrated in Swaziland every year for the past decade or so, the social welfare and health in general of the elderly remains neglected (Dlamini, 2009:10) and ignored as evidenced by lack of health promotion programmes that address their health issues. Instead, there are special health programmes for younger population groups such as growth monitoring and immunization for children aged 0 through 5 years, the school health, adolescent health, antenatal services and prevention of mother to child transmission of HIV infection.

6.4 WORKSHOP

Prior to the implementing of the proposed health education programme to empower with self-care R-BGs raising GOTHA, a workshop specifically designed for CHNS who work in the

lowveld, shall be conducted. According to the DK Illustrative Oxford Dictionary, 1998:960), a workshop is a meeting at which a group of people engage in intensive discussion and activity on a particular subject or project. The purpose of this workshop shall be to equip the CHNs with knowledge, attitudes and skills on adult learning so that the proposed health education programme may be effectively implemented. A detailed account of the workshop may be seen in appendix G.

Guidelines for implementing the proposed health education programme to empower with self-care R-BGs raising GOTHA are presented next.

6.5 PHASE THREE (b): GUIDELINES FOR IMPLEMENTING THE PROPOSED HEALTH EDUCATION PROGRAMME TO EMPOWER SELF CARE RURAL-BASED GRANDPARENTS RAISING GRANDCHILDREN ORPHANED THROUGH HIV/AIDS IN THE LOWVELD

Phase three (b) comprises chapter six. In order for the proposed health education programme to be effectively implemented two sets of guidelines have been prepared for the programme implementers to integrate these in the teaching-learning process. The two sets of guidelines focus of certain aspects of the Swazi culture especially with respect to the elderly and also on the teaching-learning process. A summary of the two sets of guidelines are first presented in table 6.1 and thereafter discussed, separately (refer to tables 6.2 and 6.3).

Table 6.1 Summary of guidelines to facilitate the implementing of the proposed health education programme

6.5.1 Culture-Focused Guidelines	**6.5.2 Education-Focused Guidelines**

6.5.1.1 Manner of approach 6.5.1.1 (a) Respect and dignity 6.5.1 1 (b) Language 6.5.1.1 (c) Dress code 6.5.1.1 (d) Prayer 6.5.1.1(e) Communication	6.5.2.1 Theories of learning 6.5.2.2 Learning styles 6.5.2.3 Perceptual learners 6.5.2.4 Gender sensitivity 6.5.2.5 Adult learning principles 6.5.2.6 Implications of aging on old adult learning 6.5.2.7 Setting and timing for health education 6.5.2.8 Teaching-learning environment 6.5.2.9 Objectives 6.5.2.10 Lesson plan 6.5.2.11 Teaching strategies 6.5.2.12 Teaching aids 6.5.2 13 Characteristics of an effective CHN educator 6.5.2.13 Evaluation

6.5.1 Culture-focused guidelines for implementing the proposed health education programme

Culture was defined as a way of life of people (Haralambos and Holborn, 2004:791) and as learned, shared, and transmitted knowledge of values, beliefs, norms and life ways of a particular group that guides an individual or group in their thinking, decisions, and assumptions in patterned ways (Leininger, 1995:60). Like in the rest of the world, the Swazi people too, have their own unique way of life. They have their own norms, beliefs and values that, too, have been passed on through socialization.

Contemporary nursing is a profession with its own culture. Whilst it has a culture of its own, it is at the same time a sub-culture (Haralambos and Holborn, 2004:2) that exists within the larger Swazi culture. It is worthwhile mentioning that some of the beliefs, norms and values of nursing may not necessarily be congruent with those of the main Swazi culture.

Therefore, the success of implementing the proposed health education programme will, to a greater extent, depend on the extent to which CHNs are culture sensitive (Potter and Perry, 2003:125) and culture competent (Stanhope and Lancaster, 2004:153) of the main Swazi culture since being culture insensitive and incompetent by CHNs shall not be productive.

Swaziland has a rich culture in which most Swazi people continue to be rooted (Swaziland Business Year Book, 2005:8). This is even more pronounced in the rural areas where the proposed health education programme is going to be implemented. That is why CHNs need to be cautious and ensure that aspects of their professional behaviour do not pose as barriers (Meyers, Naude and van Niekerk, 2004:127)

to the teaching-learning process of the R-BGs raising GOTHA.

Swaziland is not exempt from the greener pasture syndrome that has seen several Swazi nurses depart the country for international destinations. In the meantime, the Swaziland government has recruited nurses from other countries, mostly African countries. Both the Swazi and foreign nurses need to be sensitized about the Swazi way of life and therefore, a workshop shall be conducted prior to implementing the actual health education programme.

A summary of identified culture-focused guidelines for implementing the proposed programme are displayed in Table 6.2 and thereafter described, individually.

Table 6.2 Summary of selected culture-focused guidelines

6.5.1 Culture-focused guidelines
6.5.1.1 Manner of approach
6.5.1.1(a) Respect and dignity
6.5.1.1(b) Language
6.5.1.1(c) Dress code
6.5.1.1(d)Gender sensitive topics
6.5.1.1(e) Prayer
6.5.1.1(f) Communication
6.5.1.1(f.i) Verbal communication
6.5.1.1(g) Non verbal communication
6.5.1.1(g.i) Facial

expressions
6.5.1.1(g.ii) Eye contact
6.5.1.1(g.iii) Use of make-up and hair styling

6.5.1.1 Manner of approach

According to Haralambos and Holborn (2004:791), culture is a state of mind and therefore, it is very important that these guidelines, particularly, the culture-focused ones, are taken very seriously by CHNs in order to be of real service to these rural-based elderly. Nursing, as a profession, exists to serve the health-related needs of the people.

6.5.1.1(a) Respect and dignity

The elderly are the depositories of various kinds of knowledge that they have acquired throughout their lives (Mabuza, 2008:5 - 7). Their contributions to society are immense and invaluable (ULARN, 2003: online). According to Ajala (2006:181) without the elderly, Nigerian communities and villages would collapse. This statement is correct because elderly people are the most senior members in their communities wherever they may be and are held in high esteem because of their wisdom. Therefore, the R-BGs deserve all the respect and dignified treatment they can get from generations below them, including from the nurses.

6.5.1.1(b) Language

According to Haralambos and Holborn (2004:812) language is a very important vehicle through which people learn about things and make sense out of them. CHNs need to speak in the *siSwati* language when addressing the R-BGs and/or when

speaking with colleagues in their presence. This is, primarily because *siSwati* may be the only language most elderly know, understand and also speak well.

CHNs must by all means refrain from mixing *siSwati* with English and/or medical/technical jargon, as often happens because it will not promote the progranmme. Some of the consequences of mixing *siSwati* with English or any other language may result in the following to the R-BGs:

- data gaps in the subject under discussion,
- feelings of humiliation because of not having formal education and
- passivity, as they will not be active participants in their own learning.

From the afore-gone, inappropriate language use will actually act as a barrier in the teaching-learning process (Meyer, Naude and van Niekerk, 2004:127). Therefore, CHNs are cautioned to speak in *siSwati* only. Every effort must also be made to have all the Swazi and non Swazi CHNs to participate in the workshop in preparation for implementing the proposed health education programme to empower with self-care R-BGs raising GOTHA in the lowveld. Foreign nurses must also be encouraged to attend teaching sessions carried out by Swazi CHNs as part of getting them acquainted with the Swazi way of life.

6.5.1.1(c) Dress code

Depending on their norms, beliefs and values, different societies have preferred modes of dress. Rural and urban ways of dress are, to a greater extent, not similar. Haralambos and Holborn (2004:820) documented that clothes are excellent symbols that signify particular things to various people, Therefore, CHNs need to take heed of this

fact and be groomed appropriately as they interact with this generation of rural audience.

In Swaziland, certain dress codes by women provoke negative perceptions, especially in men. For instance, it is noted that wearing of pants/slacks is not readily acceptable, particularly in rural areas because of sexist ideation gained through primary and gender socialization (Giddens, 2005:112). For instance, according to the rural area dress code in Swaziland, men and boys are the only ones entitled to wear trousers.

While it is noted that wearing of slacks as part of female nurses' uniform is now allowed, however, because of the cultural perceptions about women in general, let alone women in pants and respecting the views of the elderly, it is not advisable to wear pants when going to teach the elderly because of the afore-mentioned reasons.

It then follows that, when female CHNs go to teach the rural-based elderly, they should refrain from putting on slacks and instead, put on their regular dress/skirt uniforms, hats/berets to cover their heads/hair and in addition apply *umugcula* (a piece of cloth measuring 2 m long X 1 m wide) as displayed in figure 6.1.

Figure 6.1 A woman putting on *umgcula* (the blue cloth)

6.5.1.1(d) Gender sensitive topics

It is advisable that some of the topics should be taught according to either the gender of the CHNs or the nature of the subject, to prevent embarrassing the R-BGs. It would also be acting disrespectfully toward them. For instance male nurses should be requested to tackle topics that are male-related such as the male reproductive and urinary systems while female CHNs do likewise with the female R-BGs. In addition to being gender sensitive it is advised that mature CHNs would be more appropriate as implementers of programme since there shall not be a big difference in age between them and the R-BGs raising GOTHA (Meyers, Naude and van Niekerk, 2004:127).

6.5.1.1(e) Prayer

Prayer serves many functions. Primarily it is direct communication with God (Potter and Perry, 2003:432). The Swazi nation is predominantly Christian (Swaziland Business Year Book, 2005:144) and it is noted that the majority of the people generally pray before and after official and social gatherings/functions. Therefore, CHNs need to take heed of this well-established national norm and adhere to it. For instance, a CHN may choose to offer the opening prayer her/him self prior to beginning the teaching session and at the end of the session she/he might ask one of the R-BGs to say the closing prayer or vice versa.

6.5.1.1(f) Communication

Communication is a complex phenomenon. While literature abounds with communication related information, for this programme, communication shall be confined to verbal and non-verbal only.

6.5.1.1(f.i) Verbal communication

Verbal communication involves spoken and/or written words (Potter and Perry, 2003:116) and is another important aspect of implementation of the proposed health education programme. The Swazi people are generally known as a soft-spoken nation. CHNs need to strike a fine balance between not being too soft spoken and thus risking not being heard, for fear of being told that they were shouting at the learners and shouting too much and be misread for being disrespectful to the R-BGs.

Owing to the physical changes in the elderly, Meyers Naude and van Niekerk (2004:129) pointed out, among others, that the nurses should first of all avoid using a high pitched voices and secondly, compensate for those changes. CHNs must be careful and not to interrupt the R-BG while and when she/he is still expressing her/him self as it can be damaging psychologically. This might result in psychological harm to the R-BG who may choose never to speak again and/or even attend such educational fora.

6.5.1.1(f.ii) Non verbal communication

As the English adage goes, "action speaks louder than words", non verbal communication is automatic and easy to pick up. Therefore, CHNs need to be very careful not to emit cues that might be misinterpreted. Some of the non-verbal communication (Potter and Perry, 2003:459 - 462) are: facial expressions, direct eye contact, and excessive make up.

6.5.1.1(f.ii.a) Facial expressions

Grimacing is an ugly, twisted expression on a person's face, typically expressing disgust, pain, or wry amusement

(Longman Dictionary of Contemporary English, 1995:625). It does not promote therapeutic communication. Such negative non verbal cues are capable of destroying the therapeutic partnership between CHNs and R-BGs. Nurses are watched by clients all the time and therefore, they must be very careful of what facial expressions they exhibit (Potter and Perry, 2003:117) especially while interacting with clients.

6.5.1.1 (f.ii.b) Eye contact

While, according to some western cultures, direct eye contact is encouraged as it, among others, signals readiness to communicate and also allows for one to make observations (Potter and Perry, 2003:117). In the Swazi culture, however, it has a different connotation. Looking straight into the face of a Swazi elderly person *(kuhlahlela umntfu lobamdzala emehlo*) is considered impolite and disrespectful. The Asian and IndoChinese societies find direct eye contact very intrusive (Potter and Perry, 2003:118). However, the CHNs in the proposed health education programme will have to see how best to get around this cultural challenge since they need to make observations of the elderly as part of their professional obligation.

6.5.1.1(f.ii.c) Use of make-up and fancy hair styling

Excessive facial make-up such as face powder, lipstick and mascara, and also over done hairstyles are other aspects of non verbal communication that CHNs need to give serious thought about prior to embarking on teaching the elderly rural-based audiences. Make-up in moderation is permissible but when applied excessively, it disturbs people’s attention. All the afore-mentioned cosmetic accessories could act as a barrier to the learning process of the R-BGs (Meyer, Naude and van Niekerk, 2004:127).

The afore-mentioned culture-focused guidelines were not exhaustive. Guidelines pertinent to the actual teaching-learning process of the R-BGs are presented next.

6.5.2 Education-focused guidelines for implementing the proposed health education programme

Education-focused guidelines for the proposed health education programme take into account effective teaching-learning process for the older adult learner. A summary of all sub-topics that are subsumed under education-focused guidelines is first displayed in Table 6.3, below and thereafter, each one is discussed individually.

Table 6.3 Summary of selected education-focused guidelines

6.5.2.1 Theories of learning
6.5.2.2 Learning styles
6.5.2.3 Perceptual learners
6.5.2.4 Gender sensitivity
6.5.2.5 Adult learning principles
6.5.2.6 Implications of aging on old adult learning
6.5.2.7 Setting and timing for health education
6.5.2.8 Teaching-learning environment
6.5.2.9 Objectives
6.5.2.10 Lesson plan
6.5.2.11 Teaching strategies
6.5.2.12 Teaching aids

6.5.2 13 Characteristics of an effective CHN educator

6.5.2.14 Evaluation

6.5.2.1 Theories of learning

Brink (2003:215) defined theory as a set of related statements that describe or explain phenomena in a systemic way. Learning theories help CHNs to understand how learning is likely to takes place (Rankin and Stallings, 2001:100) among the R-BGs who are the consumers of the proposed health education programme.

According to Ornstein and Hunkins (1993: 107 - 138), historically there are three major learning theories, namely, cognitive, behavioural and humanistic. In their discourse, Orstein and Hunkins, pointed out that while on the one hand, cognitive theories of learning emphasize more on internal processing of information by the learner and not the outcome, behavioural theories of learning, on the other hand, emphasize the opposite and are more interested in outcome behaviour that is elicited by the learner and not the internal processes. The third group, namely, humanistic theories (Ornstein and Hunkins, 1993:51), are rooted in the philosophy of third force psychology and place greater emphasis on the affective domain of learning than internal processes and external outcomes. According to Meyers, Naude and van Niekerk (2004:127), lack of knowledge on how adult learning takes place may become one of the barriers to learning among the learners.

6.5.2.2 Learning styles

The word style refers to a way of doing something (Longman Dictionary of Contemporary English, 1995:1432}. People

acquire knowledge in different ways. McNeil (1990: 137 – 138) highlighted four categories of common learning styles, namely, (i) concrete sequential learners, (ii) abstract sequential learners, (iii) abstract random learners and (iv) concrete random learners. While the categories of concrete and abstract sequential learners need to have information presented to them in a logical and orderly manner, the abstract and concrete random learners, on the other hand, are able to process information regardless of the way it is presented to them because they are more capable of abstract thinking. These learning styles have implications on teaching strategy and group assignments. All four categories of learning styles have implications on using different teaching strategies and aids in order to assist the information processing of the R-BGs raising GOTHA who shall be the learners.

6.5.2.3 Perceptual learners

To perceive is the ability to see, hear or become aware of something through senses. Perceptual learners assimilate information through their bodies (refer to table 6.4). Accord to Banks (2000: online) while the majority of learners fall in the category of visual learners (30 – 40%), the remainder are distributed between the other three categories: auditory, tactile and kinesthetic learners. The implication thereof is that there is need to use instructional media that will enhance learning as is depicted in the last two columns of table 6.4. The more instructional aids that are used by the CHNs to teach the R-BGs, the more effective the teaching-learning process becomes (Cornett, 2004: online) and the better the learners learn.

Table 6.4 Learner type and instructional strategies and aids.

Type of learner / % distribution	**Predominant way of learning**	**Effective teaching strategy**	**Appropriate teaching aids**
Visual learners 30% - 40%	Prefer to see new information	Lecture with lots of visual aids	Posters, flash cards, diagrams , and charts
Auditory learners 20% - 30%	Prefer hearing and reciting concepts out loud	Lecture with auditory aids such as singing and reciting	Tape recordings of lectures, audio resources
Tactual learners 20% - 25%	Hands-on experiences, repeated writing of important concepts down several times	Manipulation, simulation, demonstration/return demonstration	Laboratory experiments and models
Kinesthetic learners 20% - 25%	Prefer learning by doing or movement	Role playing activities, drama, group work	Giant wall charts, sits, flip charts

6.5.2.4 Gender sensitivity

According to Potter and Perry (2003:125), gender influences how people think, act feel and also communicate. Being gender sensitive includes recognizing the communication patterns of females and males. CHNs need to be aware that men and women vary in their learning preferences (Banks, 2000: online) as displayed in table 6.5, below.

Table 6.5 Learning preferences for women and men

WOMEN	**MEN**

• mostly auditory learners	• more of visual, tactual and kinesthetic learners
• are self-motivated	• more peer-motivated
• more conformist	• mostly non conforming
• are authority-oriented	• are less authority-oriented
• prefer sitting arrangement that are conventional on a chair with desk	• more mobile and having difficulty sitting still for long periods of time in conventional sitting arrangements.
• function better in a quiet environment	• are more comfortable with informal environments.

The afore-mentioned inter-gender learning dynamics have numerous implications. For instance, there is need for frequent short breaks when teaching men, flexible sitting arrangement for the class, using teaching strategies that will stimulate all three domains of learning, the use of models and striking a balance between authoritarian and democratic leadership style in class.

6.5.2.5 Adult learning principles

The concept of adult learner refers to somebody whose main life task is not related to education/learning and is characterized by bringing into the learning situation multiple roles such as mother, grandmother, aunt, home maker and wife (Meyer, Naude and van Niekerk, 2004:85). Principles are fundamental truths or laws as the basis for reasoning (DK Illustrated Dictionary, 1998: 649). Morland (2003:online) pointed out that children and adults learn in

different ways and that is why the two age groups are ideally not to be taught at the same time together. Child and adult teaching-learning processes are generally associated with the two Greek words *pedagogy* and *andragogy*.

According to Morland (2003: online) pedagogy, also known in Greek as *paidaggos*, refers to the slave who took children to and from school to learn. Owing to the fact that children are not as motivated as adults. Critics of child education maintain that pedagogy is teacher-focused rather than learner-centred because of being forced to go to school. Therefore, a pegagogical approach would be inappropriate for teaching the R-BGs raising GOTHA.

Andragogy is the art and science of teaching adult learners. Historically, andragogy, was coined in 1833 by the German educator Dr Alexander Kapp (Morland (2003: online) and like pedagogy, it is derived from the Greek word *andragogik*. Andragogy was popularized in the 1970s and 1980s by Dr Malcolm Knowles. Dr Knowles distinguished between child and adult learning. According to Knowles Adult learners have specific attributes that are embedded in the assumptions made by Knowles (1990: 57 – 63) and the following are principles about adult learners: self-concept, experience, readiness to learn, and orientation to learning and motivation to learn. These are outlined next.

6.5.2.5(a) Self-concept.

The adult learner is a mature, independent person who is capable of being self-directed, a doer and a producer (Banks, 2000: online). Therefore, CHNs need to acknowledge that the R-BGs are self-directed, allow them to articulate their felt needs, make own choices and show respect to them by leaving them to manage their own lives. CHNs can promote

the self-concept of the R-BGs by avoiding negative psychological environment such as loss of privacy and creating an atmosphere that is charged with anxiety (Meyer, Naude and van Niekerk, 2004:127).

6.5.2.5(b) Experience

By virtue of being older adults, the R-BGs have accumulation of life experiences and these reservoirs of experiences form part of their self-identity (Cornett, 2004: online). This has implications for experiential learning (Meyer, Naude and van Niekerk, 2004:85). CHNs need to create learning opportunities that will enable the R-BGs to share with others some of their life experiences. Teaching strategies such as lecture-discussion, debates, discussions, group projects and drama support experiential learning.

6.5.2.5(c) Readiness to learn

Adults learn what is of value to them since they are pragmatic in their life approach (Cornett, 2004: online). They are ready to learn information will be put to use. The data revealed that the R-BGs raising GOTHA had a lot of physical health challenges for which they lacked knowledge and skills. Therefore, once they are taught those topics that touch on their health challenges, they will be able to make use of their acquired knowledge and skills. CHNs need to teach content such that that which is ‘essential to know’ is taught first before the good to know’ and also nice to know’ information.

6.5.2.5(d) Orientation to learning

Adult learners are life, task or problem-centred in their approach to learning. Most adults want to use in their lives what they learn. They may bring life situations into

the classroom. Therefore, CHNs should demonstrate flexibility and deviate a bit from the planned programme to accommodate the adult learners' life issues. According to McNeil (1990: 140 141), problem solving and creativity are some of the ways learning opportunities may be realized.

6.5.2.5(e) Motivation to learn

Increased self-esteem makes adult learners become more motivated to learn. To reinforce motivation (Banks, 2000: ONLINE), CHNs need to use appropriate rewarding systems that stimulate internal motivation. Such appropriate motivating systems include: nodding, smiling and clapping hands to acknowledge correct responses offered by the elderly learners. External motivation such as giving material rewards such sweets or food should be avoided at all costs as it is not supported by the principles of adult learning philosophy.

6.5.2.6 Setting and timing for health education

Since adult learning can and may take place in a non-traditional place, health education from this programme shall be taught anywhere as deemed. The settings for teaching the elderly may include the following: homesteads during home visits, church buildings during Sunday school classes and market places.

The timing for teaching shall also be flexible. However, the CHNs need to organize one day in the week and as well as one day in the month whereby the elderly are the target of health care services. On those days, elderly focused health information shall be disseminated directly through health education by the CHNs. CHNs must also ensure that they reach out to those who are home bound because of mobility dysfunction by either visiting them or arranging

for transport to bring them to the health facility by ambulance for medical consultation and return them to their homes as well.

6.5.2.7 Teaching-learning environment

CHNs need to provide optimal learning environment for the elderly learners at all times. Owing to the situation in rural areas, the elderly may be taught outside, for instance under a tree. Regardless of where health education is delivered the environment must be conducive both externally (physically) and internally (psychologically and emotionally).

6.5.2.7(a) External environment

External environment refers to everything that is outside the body of the learner. It includes: the physical aspects such as a clinic, homestead or church. According to Rankin and Stallings (2001:261) some of the characteristics of a conducive physical environment are:

- adequate space,
- general cleanliness,
- comfortable room temperature,
- good lighting,
- effective ventilation and
- benches and/or chairs to sit on,

6.5.2.7(b) Internal environment

This type of environment refers to psychological and emotional comfort of the learner. Such an environment includes an individual’s feelings, personhood and self-concept. Pain, anxiety and fear can also be barriers to learning.

6.5.2.7(b.i) Psychological environment

A psychologically conducive environment encourages the learner to ask questions and express her/him self without fear of being belittled or dehumanized (Cornett, 2004: online). Meyer, Naude and van Niekerk (2004:81) described a conducive psychological environment as that the learners and teacher:

- show mutual respect
- have mutual trust
- engage in collaboration
- have support
- have openness and authenticity and
- show humanness

6.5.2.7(b.ii) Emotional environment

An emotionally conducive environment takes into account the feelings of the elderly. The target audience for this programme is relatively illiterate. According to Rankin and Stallings (2001:261) persons with low literacy levels generally do not ask questions for fear of exposing their ignorance or asking questions that may be labeled as stupid. Therefore, in taking the emotional environment into account, CHNs must ensure that content starts from simple to complex, the R-BGs do not become embarrassed in front of the others and the CHNs ask the elderly learners to share some of their life experiences.

Also, CHNs must ensure that topics for health education are taught in ways that do not provoke an atmosphere of negative emotions. For instance, when deliberating on the topic of HIV and AIDS, the greatest of caution must be exercised by CHNs in order not to hurt any of the R-BGs raising GOTHA since many of them have lost one or several adult children through this communicable disease.

6.5.2.8 Educational objectives

According to Banks (2000: online) learning is measured against learning objectives selected during the planning phase. Also known as intended learning objectives (Ornstein and Hunkins, 1993:220 – 229) or behavioural objectives, they state what the learner is expected to 'know', 'do' or 'feel' at the end of the lesson depending on the domain of learning (cognitive, affective and psychomotor) that is stipulated in the teaching plan.

Since education is meant to change all three areas of learning cognitive, affective and psychomotor, CHNs need to ensure that the:

- learning objectives take into account the three domains of learning and
- teaching strategies stimulate the three areas of learning.

While cognitive objectives address the theory aspect of learning, affective ones are concerned with attitudes and lastly psychomotor objectives deal with skills acquisition. Since learning is said to have taken place when all three domains are addressed (Banks, 2000:16), CHNs need to ensure that they formulate intended learning objectives that take into account the three domains of learning, namely cognitive, affective and psychomotor. Among other purposes, intended learning objectives shall help CHNs to first of all identify the content to teach, instructional strategies and aids. Also intended learning objectives shall assist with formative evaluation.

6.5.2.9 Teaching plan

In implementing the programme, the CHNs shall be guided by a teaching plan. According to Swanepoel (1999:163), health

education is deliberate. Implied is that It is not done haphazardly. It requires prior planning. While there is no universal or standard teaching plan, Swanepoel (1999:164) highlighted the following as some of the major components of a teaching plan:

- Title of the teaching plan
- Date of take out the of when teaching shall take place
- Teaching method that will be used to facilitate knowledge acquisition by the learner
- Time when the lesson shall be taught
- The venue for teaching
- Group details:
    - number of learners
    - type of educational session/intervention
    - subject to be taught
    - level of education of learners
- Room arrangement where teaching shall be implemented
- Instructional aids be used
- Evaluation format
    - during the lesson
    - after the lesson
- Aims and objectives of each teaching session
- Allocated time for each session
- Sequence of content to be taught
- Teacher activity in facilitating learning
- Learner activity in own learning efforts.

Some of the benefits of having a teaching plan are that the teacher is guided and does not leave out any content. Another benefit of using a teaching plan is that should the teacher for some reason or another not be able to be there to teach the learners, the replacement teacher may be

guided by the teaching plan. A specimen of a lesson plan is displayed in appendix H.

6.5.2.10 Teaching strategies

According to Banks (2000: online) a teaching strategy is a way that the teacher or educator employs to deliver information and it is determined by the learning needs of the learner. Teaching strategies must be relevant and appropriate to the audience (Clark, 2003:244). In this programme, since the audience comprises older adults, the CHNs shall always strive toward utilizing those teaching strategies that promote active participation since it is in line with the principles of adult learning.

Some of the outcomes of learning through utilizing various instructional media were made by Abruzzese (1992:216) and are displayed in Table 6.6. It is noted that the more teaching strategies that the educator uses to teach, the more information is retained by the learners since they have different ways of processing information.

Table 6.6 Information retention rate through the various senses

Mode of learning	**Retention rate %**
Reading text alone (print media)	10%
Listening alone (lecture)	20%
Observing - seeing (posters, diagrams, charts)	30%
Listening and observing	50%

(lecture and posters, charts)	
Listening, observing and discussing (lecture/discussion, posters, charts, questions)	70%
Listening, observing, discussing and performing (lecture/discussion, slides, film and return demonstration)	90%

In the proposed health education programme, some of the recommended teaching strategies that could be used by the CHNs shall include the following: lecture, lecture-discussion, singing, drama, group discussion, demonstration and return demonstration, and role-play.

6.5.2.10(a) Lecture

Though one of the oldest methods of disseminating information (de Tornyay and Thompson, 1987:95), the lecture method is very effective, especially, when teaching new information to a large group of people. CHNs may use it, especially when addressing large crowds of elderly such as those that assemble at the *Inkhundla* (constituency) or *Umphakatsi* (official residence of the Chief) levels. Topics such as arthritis, heart diseases and elevated blood pressure could initially be taught through this teaching strategy.

According to de Tornayay and Thompson (1987:99) a good lecture:

- is well planned,
- is preceded by an arousal,
- has a systematic introduction,
- follows the prepared outline,

- is done using various voice tones,
- allows for time at the end to ask questions and be answered,
- must be short and students given breaks in between lectures.

However, one of the major disadvantages of the lecture method is that it is teacher-centered and the learner is passive. Therefore, to increase the retention rate of the elderly learners, the CHNs need to integrate the lecture method with teaching aids such as charts, diagrams, and role-playing in order to stimulate the learner more.

6.5.2.10(b) Lecture-discussion

The lecture-discussion method is almost similar to teaching by lecture, only that the learners have the opportunity to ask questions, make comments and ask for clarifications during as well as at the end of the lecture. The lecturer usually has prepared questions to pose to learners during the lecture-discussion. Not only does it make the learner an active participant in their own learning, but it also encourages critical thinking.

6.5.2.10(c) The singing method

According to Chipeta (1997:81) singing can be useful as a classroom instructional method. The teacher may compose a short verse out of historical or scientific facts and sing it with the learners. It is noted that singing traditional songs is a very common way of disseminating information in the Swazi culture since such songs are laden with meanings depending on the occasion and the messages that need to be conveyed. The current older generation is familiar with this method of imparting information since they grew up singing and communicating salient messages through

traditional tunes. Therefore, CHNs may also use traditional tunes to transmit salient health-related messages when teaching the R-BGs raising GOTHA.

The singing method may prove useful when addressing large audiences. This teaching strategy may be combined with the lecture method and selected teaching aids. An advantage of the song method is that the R-BGs are likely to learn and also be entertained, namely, learning through fun.

6.5.2.10(d) Drama

A derivative of the Greek language *draein,* meaning to perform or act, and drama is an act of performing a scene or an event as someone else did it or explained it (Chipeta, 1997:76). Drama was used in ancient Greek schools to teach literature through plays. The students acted out the various roles they were assigned by their teacher

Drama is a very effective and valuable teaching strategy primarily because of its unique ability to engage reflective, constructivist and active learning on the part of the learner in the teaching-learning process (Ashton-Hay, 2005:online). Like the song method, drama has the added vale of entertaining. However, it is time consuming, as it requires some practice before being acted out to the audience.

The school health team may be approached by CHNs with a request to use pupils from nearby schools to dramatize salient health messages that shall be directed toward the elderly learners. Having pupils dramatize for an elderly audience shall help in three ways: (i) it may draw the two generations closer, (ii) it is likely to be entertaining

and (iii) it shall be a good way of introducing the pupils to public speaking.

6.5.2.10(e) Group discussions

Using group discussion is likely to get the R-BGs actively involved because they have to contribute something. CHNs shall divide the class into smaller groups and ask them to discuss on a certain topic and then later ask the groups to give feedback. For this teaching strategy to be effective, the sizes of the groups must be relatively small to ensure that every group member participates in the discussion. According to Banks (2000: online) up to 6 members is a good number for a small group. This method is also recommended to teach the R-BGs raising GOTHA as it espouses the principles of adult learning.

6.5.2.10(f) Demonstrations and return demonstrations

This is a concrete realistic strategy CHNs may use to reproduce a real situation or task by using actual equipment and supplies. After watching the teacher do something, the learner also does what she/he saw the teacher doing.

This teaching strategy is highly recommended as it influences all three domains of learning, namely cognitive, affective and psychomotor because as the learner performs the activity, she/he has to think (cognition), develop an attitude (affective) and master the steps of the task or activity (psychomotor) (Banks, 2000:online). It is an ideal teaching strategy for teaching visual, tactile and/or concrete sequential learners.

6.5.2.10(g) Role-playing

This teaching strategy requires the learner to make up or act out to specific situations (Banks, 2000: online). The primary purpose of role-playing is to help the participants and observers to gain new perceptions about human relationships, in particular, insights and empathy into their behaviour (de Tornyay and Thompson, 1987: 33). It is predominantly affective-learning oriented.

CHNs shall request some of the R-BGs to take part in role-playing. The R-BGs can either act out a scene that is requested by the CHN or they can act out a scene of their own choice either from personal experience or other people’s situations.

According to Banks (2000: online) some of the rules for role-playing include the following:.

- Only willing persons may act. There should not be any coercion.
- The duration of the role-play to be between 5 and 15 minutes.
- There is no need for rehearsals.
- After taking part in the role-play, both the participants and observers analyze what happened and explore their feelings, insights generated and why things happened the way they did.
- When exploring what took place in the role-play, it is important to focus on the actual roles and not the persons acting in those roles!
- After the role-play has stopped, the players must de-role themselves so as to establish contact with reality once again. De-rolling is very important as sometimes the players continue to be associated with the roles they played.

In this programme, role-playing is ideal for teaching, especially, about HIV and AIDS-related topics since it will help to evoke those feelings that translate themselves to negative attitudes about people who are living with HIV and/or HIV/AIDS. In Swaziland, HIV/AIDS are still very much associated with stigma and therefore, in order to explore the attitudes of the elderly learners about HIV/AIDS, the role-play method is highly recommended.

6.5.2.10(h) Learner-centred teaching

According to Liu, Qiao and Liu (2007: online) this teaching strategy represents a major departure from the traditional teacher-centered learning approach that reduced the learner to a mere recipient of knowledge. Learner-centred teaching is an approach to teaching that primarily puts the learner at the centre as opposed to the teacher. It highly recommended in adult learning as it espouses the principles of adult learning, especially the principle of self-directedness.

Chambers (2007 – 2008: online) pointed out some of the characteristics of learner-centered teaching as that:

- there is balance of power is shared between the teacher and students.
- the role of education is to challenge human inequality rather than to socialize students into status quo.
- the role of the teacher is that of coach, maestro and guide.
- students accept the responsibility for learning.

It is worth mentioning that knowledge that is acquired through active participation of the learner (Meyer, Naude and van Niekerk, 2004:86) is likely to be retrieved whenever it is needed since it does not become inert.

6.5.2.11 Teaching aids

These are adjuncts of teaching/instructional strategies and are useful since people have different ways of processing information (Clark, 2003:244). For instance, the pure lecture method alone is not a sufficient instructional method for visual learners, as they need to see e.g. posters or diagrams in order to make sense of what they are learning. CHNs shall combine their teaching strategies with relevant teaching aids such as visual, audio and audio-visual teaching aids in facilitating adult learning for the R-BGs.

6.5.2.11(a) Visual instructional aids

A visual teaching aid helps to process information through seeing things or information. Examples of visual aids that CHNs may use to teach the R-BGs are: posters, charts, slides, photographs, drawings, diagrams, human model and artifacts (Cornett, 2004: online). CHNs must ensure that the information, for example, on posters, is drawn in big letters and very colorful in order to compensate for impaired vision of the aging learners. Each picture must be simple, self-explanatory and convey the message it seeks to put across to the audience.

6.5.211(b) Audio instructional aids

Such instructional aids are good for learners who process information through hearing (Banks, 2000: online). Examples of auditory teaching aids include: song, tape recorded information, radio, musical instruments such as the drums. A role-play or play may be recorded and played to the group of elderly through the tape recorder or radio. CHNs need to

ensure sound quality of either the radio or tape recorder is good.

6.5.2.11(c) Audio-visual instructional aids

Some of the R-BGs may process their information through both seeing and hearing and therefore, audio-visual aids such as sound filmstrip, sound projectors and television are quite effective for this category of learners. Such instructional aids are very effective because of their ability to bring to the learner a situation that otherwise the learner might never have seen or heard. CHN s may combine the lecture method with a sound film. A lecture on the benefits of using a pit latrine may be combined with a sound film that shows the actual pit latrine and all the points raised in the lecture.

6.5.2.11(d) Models and artifacts

Objects, such as models and demonstrations help the learners by becoming actively involved and apply knowledge and skills immediately (Rankin and Stallings, 2001:274).

Models are representations of real life but not reality itself. According to de Tornyay and Thomson (1987:20) models help to integrate data especially when using replica types. A replica is a very good reconstruction of, for example, a piece of art (Longman Contemporary English Dictionary, 1995:1296). Models shall be ideal for teaching the R-BGs the various parts of the human body. Examples of models that may be used to teach the elderly are: organs of sense such as the eye and ear, and also other body parts such as the stomach, heart, lungs and skeleton.

Artifacts, on the other hand, are products of human art (DK Illustrated Oxford Dictionary, 1998:54) and can be anything including household utensils. Artifacts
are familiar may be used to augment the lessons.

6.5.2.12 Implications of aging on old adult learning

Crawford (2004: online) highlighted that human beings begin learning as early as at birth and this continues throughout life. Meyer, Naude and van Niekerk (2004:129) alluded to the fact that intelligence of the elderly does not decrease with age, but the elderly experience physical and psychological degeneration as a function of aging.

Meyer, Naude and van Niekerk (2004:128) listed the following physical effects of aging: declining vision, hearing becomes poorer, psychomotor degeneration and memory changes. All these changes have implications for the e teaching-learning process and environment. Crawford (2004: online) suggested the following when teaching older adults that the teacher must:

- use of very colorful visual aids such as posters,
- avoid using a high pitched voice,
- speak clearly,
- avoid moving about when speaking,
- present information slowly,
- give information in short frequent sessions.
- repeat information frequently.
- re-inforce with audio visual materials, written exercises and practice.
- allow time for self expression and ask questions.
- establish short achievable goals.
- apply teaching to present situation.
- base information on clients’ previous level of learning.

- not take longer than 30 minutes per lesson.
- plan for moments of refreshing exercises to keep the older adult learners awake and alert.
- allow time for the older adult to answer any questions that shall have been posed to them and
- contextualize content to facilitate understanding.

6.5.2.13 EVALUATION

According to Swanepoel (1999:159) evaluation refers to making a judgment on the value of something. Clark (2003:246) defined evaluation as assessing the effects of presentation as it is given. Though evaluation is often mentioned as the fourth phase of the nursing process, it is in actual fact an ongoing process that should be done continuously in each phase. Generally, evaluation is divided into two, namely, formative and summative both of shall be done in the proposed health education programme to empower with self-care R-BGs raising GOTHA.

6.5.2.13(a) Formative evaluation

McNeil (1990:238) defined formative evaluation as one that is performed immediately after teaching the learners though it is not necessary for all the learners to answer the same questions. In this programme, the CHNs shall conduct formative evaluation through asking direct questions as guided by the intended learning objectives, making observations of general behaviour at the end of the lesson or from a return demonstration and asking learners to summarize the lesson (Delaune and Ladner, 2006:426).

Though it more common practice to have the teacher only evaluating the learners, Banks (2000: online) pointed out that it was very important to have learners evaluate all aspects of the teaching-learning process, including: the

timing, teaching strategies, amount of information, environment and whether the objectives of the lesson were met. This information shall be useful particularly in trying to improve teaching activities in the future.

6.5.2.13(b) Summative evaluation

Glick (2004:491) referred to summative evaluation as evaluating the impact of a programme. McNeil (1990:238) defined it as a way of determining whether or not the programme is serving the purpose for which it was developed. Summative evaluation requires extra resources and therefore its implementing shall depend, largely, on the availability of the necessary resources such as human material and finances.

With regards to the evaluation of the proposed health education programme to empower with self-care R-BGs rising GOTHA, it would have been ideal to carry out the first evaluation six months after its commencement and then twelve months later. Six months is suggested because the researcher wishes to determine whether the programme is effective and also what some of the challenges the CHNs as programme implementers are encountering. Any subsequent evaluations shall depend on the results. Conducting the evaluations annually would tie up well with many programmes as that is the time they usually submit annual reports about their activities.

6.6 LEVELS OF TEACHING

Health education may be given on a one-to-one basis, in groups (small large) and at community level (Cornett: 2004: online). The proposed health education programme is meant for R-BGs raising GOTHA as one of the major the study findings revealed that they had chronic health challenges

and lacked the self-care. The proposed health education programme is primarily intended for R-BGs raising GOTHA in the lowveld.

6.6.1(a) One-to-one basis

CHNs may give health education to R-BGs and/or other rural elderly learners as individuals in a health facility such as a clinic or at home during home visits in the community. Some of the benefits of teaching on a one-to-one basis were highlighted by Rankin and Stallings (2001:265 – 266) as that health education sessions becomes individualized, the learner is able to discuss issues of a confidential nature with the teacher/educator because of privacy that is afforded and there is more intensive interaction between the client and nurse. All the above benefits are also applicable to the CHNs and R-BGs in the lowveld where the study was conducted.

6.6.1(b) Small groups

According to Rankin and Stallings (2001:266), small groups are made up of between 2 to 5 persons. In trying to reach out to R-BGs raising GOTHA, CHNs need to liaise with among others religious and community leaders and ask to meet with the elderly in small groups and teach them. For instance, CHNs may ask the parish priests to give them time during Sunday school classes for the adults in order to give health education to a group of elderly men or women. Though Sunday school is known as children’s classes in some countries, in Swaziland, s number of churches hold Sunday School classes for the various age groups, including the elderly.

The CHN may choose to teach a group of elderly on a topic such as personal hygiene, since cleanliness is next to God.

In the Bible, it is also documented that the human body is the Temple of God. Therefore, this topic would be suitable and relevant as it links well with the teachings in the Bible.

Market women who sell vegetables are yet another small group target audience for this programme. These may be given health talks especially before they start their selling business in the morning. In order to address their needs, the CHN shall first conduct a need assessment and then give health education that is relevant based on the findings of the need assessment and degree of self-care deficit.

As compared with teaching on a one-to-one basis, teaching in small groups is more cost effective and greater cohesion by the group members (Ranking and Stallings, 2001:266). For instance if the CHN used the group discussion strategy to teach about HIV and AIDS and stigma, the participants may end up forming a support group in their own area of residence and give each other morale support. Thus stigmatization is likely to decrease.

6.7 CHARACTERISTICS OF AN EFFECTIVE CHN EDUCATOR

The following are some of the examples of an effective educator (Banks, 2000:online) that CHNs may use to become effective educators of R-BGs raising GOTHA. The effective educator:

- is interested and holds the elderly learners' interest (advocate for the elderly)
- is optimistic, positive and non-threatening.
- presents content that is accurate and current.
- teaches content in small doses.
- provides positive reinforcement.

- employs a variety of teaching strategies.
- utilizes learning objectives to guide her/his health education efforts , and
- uses time and resources wisely.

6.8 CHAPTER SUMMARY

This chapter has presented, described and discussed guidelines for implementing the proposed health education programme to empower with self-care R-BGs raising GOTHA in the lowveld. These were divided into: culture- and education-focused guidelines. While the culture-focused guidelines were concerned with the manner of approach since the consumers of the programme are going to be the elderly, namely, R-BGs raising GOTHA, the education-focused ones concentrated on the teaching-learning process of, especially, the adult learner. It was pointed out that the CHNs would undergo a special workshop that would equip them with the necessary knowledge, appropriate attitudes and relevant skills on how to effectively teach, especially older adults.

Chapter six also marked the end of phase three and also phase three (b) The last phase of the development of the health education programme is discussed in the next chapter.

CHAPTER SEVEN

EVALUATION OF THE PROPOSED HEALTH EDUCATION PROGRAMME TO EMPOWER WITH SELF-CARE RURAL-BASED GRANDPARENTS RAISING GRANDCHILDREN ORPHANED THROUGH HIV/AID IN THE LOWVELD OF THE KINGDOM OF SWAZILAND

Desire is the starting point of all achievement.
"Whatever the mind of man can conceive and believe it can achieve
– Napoleon Hill

7.1 INTRODUCTION

A description of the process of implementing the proposed health education programme was presented in phase three (b) namely, chapter six. The chapter described and discussed culture and education related guidelines are going to be used by CHNs to empower with self-care the R-BGs raising GOTHA in the lowveld. Chapter six marked the end of phase three.

Chapter seven represents phase four and also the last chapter of this thesis. Phase four is concerned with presenting feedback from selected stakeholders who evaluated the developed health education programme. In addition, the following are discussed:

- synopsis of the development process of the study,
- limitations of the study,
- contributions of the study, (
- implications of the study findings
- recommendations,
- minor improvements for the elderly and

- a concluding summary of the entire study.

7.2 SYNOPSIS OF THE STUDY AND PROGRAMME DEVELOPMENT PROCESS

The development process of this research and the proposed health education programme to empower with self-care R-BGs raising GOTHA was carried out in four interrelated phase. The four phases may be likened to the four phases of the nursing process, namely, assessment, planning, implementing and evaluation. The four phases of this research process are briefly outlined next.

Phase one marked the beginning of the development process of the research and focused on exploring the day-to-day personal realities of R-BGs raising GOTHA in the Chiefdom of nkonjwa in Sithobela *Inkhundla* (constituency)in the lowveld of Swaziland. Through this study, the researcher sought to answer the following main research question, "What are the lived experiences of rural-based grandparents raising grandchildren orphaned through AIDS in the lowveld?

Primarily, the purpose of the study during the first phase of its development process was:

- to explore and describe the lived experiences of rural-based grandparents raising grandchildren orphaned through HIV/AIDS in the Chiefdom of *Nkonjwa* within the *Sithobela* constituency in the Kingdom of Swaziland

Therefore, a qualitative, exploratory, descriptive and contextual research design study was selected. The data were collected by the researcher primarily through unstructured aaudio taped face-to-face individual interviews with the R-BGs raising GOTHA in their

homesteads, field notes and also health records. The individual in-depth interviews were guided by the following two open-ended questions that were asked in the local language of *siSwati*:

1. ***"Ngicela ungichazele kabanti kutsi engabe kunjani kunakekela batukulu bako labashiywa batali babo? "***
   ['Kindly describe for me what/how it is like caring for your grandchildren who were orphaned through HIV/AIDS'] and
2. "***Ukhona njani kumelana netidzingo tonke telabatukulu bako? "[**"How do you manage to care for your grandchildren who were orphaned through AIDS"?

Utilizing the method of Tesch (1990:93) to analyze the collected data, six major categories emerged thence. The categories were: NO SUPPORT, COMPROMISED HEALTH, FEELING OVERWHELMED, SACRIFICING, CONCERNS RELATED TO THE FUTURE OF GOTHA AND, RESOURCE AND BASIC NEEDS CONSTRAINTS.

The ultimate purpose of the study was to formulate a strategy for addressing the findings. Since earlier researchers Mabuza (2008) and Mkhonta (2008) had conducted their doctoral research on the elderly and grandparents caring for orphaned and other vulnerable children, respectively, the strategies they developed their major findings were perceived as applicable too in the present study. The challenges of the R-BGs in the present study warranted a collaborative approach that needs to be spearheaded by government.

Since the present study was conducted out of concern for the health and wellbeing of, especially, R-BGs raising GOTHA and no other study had investigated this phenomenon,

the researcher felt that the category COMPROMISED HEALTH was an area that community health nursing could do something about. In view of their many physical health challenges and self-care deficit, developing a health education programme was considered as an appropriate intervention.

Therefore, with the identification of the lived experience of COMPROMISED HEALTH the research process entered phase two. Phase two focused on describing both the structure and process of the conceptual framework of the health education programme. Phases three (a) and three (b) focused on describing the health education structure and process, respectively. These were discussed in chapters five and six, respectively.

7.3 PHASE FOUR: EVALUATION OF THE PROPOSED PROGRAMME

This phase sought to reveal feedback from the evaluation of the health education programme by selected stakeholders. According to Swanepoel (1999:159) once a detailed plan for the health education programmme has been constructed and specific activities delineated, the plan itself should be evaluated. It is for this reason that selected relevant stakeholders (Bryant, Altpeter and Whitelaw, 2006:205) were approached by the researcher to give their input into the developed health education programme.

With reference to the timing of an evaluation programme, Suvedi (2005: online) pointed out that a programme may be evaluated before, during and after its implementation. It all depends on the purpose of its evaluation. This was an evaluation before implementing. Its purpose was generally to determine whther it reflected the health-related needs

of the R-BGs raising GOTHA as revealed in the identified category of COMPROMISED HEALTH.

7.3.1 The development of the evaluation instrument

Phase four seeks to reveal feedback from those selected stakeholders who took part in the programme evaluation was carried out before its implementing. The reason for pre-implementation evaluation was to ensure that the programme content was evidence informed. According to Bryant, Altpeter and Whitelaw (2006198) and Suvedi (2005: online), programme evaluation starts with the designing and development of an evaluation instrument by the programmer developer.

Consequently, the researcher developed the instrument (refer to appendix I) with aid of information obtained from a programme evaluation-related literature control and also from previously acquired knowledge and skills from her undergraduate and graduate study programmes in curriculum design and development.

A summary of the process of the instrument development through to its evaluation is shown in figure 7.1.

1. Determine purpose of programme evaluation
2. Choose instrument design.
3. Design and develop framework of instrument.
4. Send instrument for evaluating..
5. Discussion on instrument evaluation. feedback
6. Instrument modification

Figure 7.1 The steps for evaluation instrument development

Once the evaluation instrument development process was completed, it was submitted for evaluation by the programme evaluators team within the monitoring and evaluation unit of the National Emergency Response Committee on HIV and AIDS, [NERCHA], a local NGO whose main focus is on the HIV and AID epidemic in Swaziland.

A meeting was held between the monitoring and evaluation team and the researcher once the foremer had scrutinized it. Generally, the instrument was found to be measuring all aspects of an educational programme. However, it was observed that the as[ect that relates to the vision, mission and philosophy which components are standard for an educational programme, were missing. The comment was noted and the tool and programme modified. Thereafter, the instrument (refer to appendix I) was considered as ready for use.

7.3.2 Feedback from stakeholders

The categories of stakeholders comprised four R-BGs raising GOTHA and had been interviewed during data collection, a further 13 elderly (12 grandmothers and 1 grandfather) who were not interviewed but asked for their input, 4 nurse educators who are lecturing at the Faculty of Health Sciences within the University of Swaziland and lastly, the chairperson for a pro-elderly NGO. While the R-BGs, elderly group and chair of the NGO were requested to give their inputs on the content of the programme, the 4

nurse educators were requested to assess the content and structure of the programme. These nurse educators held from graduate to doctoral degrees in nursing. The following are their various feedback.

7.3.2.1 Category 1: R-BGs raising GOTHA

This first category of stakeholders comprised selected R-BGs raising GOTHA who had previously been interviewed BY THE RESEARCHER during data collection. The researcher first briefed THESE r-bgS RAISING gotha individually about the findings from the study and the health education that was subsequently developed from the findings. The researcher then requested each of the four R-BGs raising GOTHA to give any input that was relevant to the developed programme. Their evaluation was independent of the instrument. Generelly, they felt the programme sounded good and they looked forward to learning about their own health issues. Comments that were made by this group of peri-urban based grandparents are listed below.

R-BG #1 ***"We would be very grateful to be taught about the disease thathas finished our children"***

R-BG #2 ***"We would be glad to be taught by the nurses as we have so many diseases and we do not know what to do."***

R-BG #3 **"Thank you nurse we are ready to learn but we cannot write."**

R-BG #4 ***"Bonesi abasijabuleli ngoba sinemikhuhlane leminengi."***
["Nurses seem not to be happy with us because we have too many complaints about our health'.

With regards to the comment made by R-BG #1, the content of HIV and AIDS had already been included in the programme. The comment made by R-BG #4 was also noted and added among

the topics to be discussed at the impending workshop so that the attitudes of the nurses toward the elderly could be explored at the pre-implementing phase and something done about it.

7.3.2.2 Category 2: Peri-urban elderly

This second group of stakeholders was nmade up of 14 grandparents (13 grandmothers and one grandfather who were caring for HIV/AIDS-orphaned grandchildren in peri-urban settings. This group of elderly were invited to a half day seminar where the researcher briefed them about the entire study. Thereafter they were requested to give feedback, especially about the programme content. Their evaluation, like that of the first group was independent of the evaluation tool. The group generally thought that programme addressed most of the health problems of older adults. However, they too, like in the first group, had some negative comments about the attitude of the nurses. This is what one of them had to say:

> ***'Bonesi abasijabuleli, siyabbona ebusweni kutsi abasijabuleli, siyabahlupha.*** ["Nurses are not receptive toward us elderly, we see it in their face that they are not happy with us, we give them problems."]

The trend in negative attitudes about the elderly by nurses was observed from one comment in the previous group of stakeholders. The group was reassured that this had been reported by others and the researcher would ensure that this issue is addressed at workshop level.

7.3.2.3 Category 3: Nurse educators

The third group of evaluators were nurses who were nursing lectures /educators at Faculty of Health Sciences at the University of Swaziland. The procedure that was followed for this group was different from the others discussed so far. Each nurse educator was given copies of the entire study and programme development, namely from chapters one through six to read and critique the, in particular the health education programme. An evaluation tool was also given them to guide them in their evaluation. They were also requested to write down any relevant comments at the end of the evaluation form.

As and when each one of the five nurse educators who were given the entire study finished their assignment, the researcher met with each one of then to discuss their findings and comments. The following are some the comments they documented at the end of the evaluation form:

Nurse educator #1. ***"I really do not have anything to add Because I found the programme all inclusive of the components***

Nurse educator #2. ***"Your study is very relevant to the times in which we find ourselves, especially, the lack of attention to our senior citizens I look forward to its implementing."***

Nurse educator #3. ***"Thank you for asking me to evaluate Your proposed health education programme to facilitate self –care among R-BGsraising GOTHA in the lowveld. I read it with the greatest of interest and find nothing to add to it. Good luck."***

Nurse educator #4. ***"My feedback is that I think you have Covered the most important aspects of a health educational programme."***

7.3.2.4 Category 4: Pro-elderly NGO advocate

This official was also approached in this evaluation exercise because of the advocacy role his organization plays in the affairs of the elderly in Swaziland. He too was briefed about the study, its findings and the subsequent development of the health education programme. His input was also requested like with the first and second groups. This is what he had to say:

> ***"First of all, let me thank you for thinking about this generation of our population. They are what I call the forgotten and yet very important people whom we should look after like precious jewelry. Teaching them about elderly abuse is very good because some of them do not know in what forms abuse manifests itself. I am sure they will want to learn and become knowledgeable like all other people."***

With all the afore-mentioned discussion and comments by the stakeholders, the programme had been evaluated and that also marked the end of phase four.

7.4 LIMITATIONS OF THE STUDY

While this predominantly qualitative study offered some important findings to the general nursing literature (Uys and Basson, 2000:19 – 20) through generating rich data from the descriptions of the R-BGs raising GOTHA in the lowveld, limitations were also inevitable (Leedy and Ormrod, 2005:278). Some of the study limitations are outlined next.

The first limitation of the study was attributed to aspects of its design, namely being exploratory. It was exploratory in the sense that it sought to gain insight and understanding about the phenomenon of raising GOTHA by R-BGs in the lowveld of Swaziland. Such studies generally do not have large samples (Brink, 2003:141) and therefore, an implication of this is that, the findings, thereof, may

not be generalized to the entire population of R-BGs in Swaziland (Brink, 2003:134 – 135).

The second limitation of the study was associated with the identification of the R-BGs who were actually raising GOTHA. The R-BGs were identified by Rural health motivator. The mechanism that was used to identify the R-BGs raising GOTHA was not explained. Rural health motivator are home makers and in addition to their normal home duties, they have been assigned the role of extended health workers at community level. They have a lot on their shoulders. Therefore, the rural health motivators may have selected those R-BGs who lived closer to them. Perhaps, the rural health motivators may have chosen their friends and/or relatives.There may have been some bias in the way the R-BGs were recruited.

The third limitation of this study has to do with the researcher's inability to conduct as many follow-up interviews with the R-BGs as had been planned because of lack of accommodation closer to the research setting (Burns and Grove 2005:359 – 360). The researcher lived some 280 km (round trip) away from the research setting. Owing to that factor, 11 out of 14 R-BGs raising GOTHA were interviewed only once, while only 3 R-BGs raising GOTHA were interviewed twice. This has the implication on perhaps missing out some follow-up data.

The fourth and last limitation of this study is being referred to as inadvertent discrimination. As the researcher was eager to hear the R-BGs describe with their own mouths how it was like raising their GOTHA, those R-BGs who have communication challenges such as the deaf and dumb, were automatically excluded.

7.5 CONTRIBUTIONS OF THE STUDY

Though the study was qualitatively designed, the data generated thence were rich and findings thereof lend support to nursing practitioners and policy-makers. A number of positive contributions of this study are outlined, next.

Primarily, the strength of the study was that it focused on a population group that is under researched, particularly in Africa (Gachuhi and Kiemo, 2005:36). Literature abounds with among others, physical health challenges as a function of aging (Fouad, 2005: online). In particular, in this era of the HIV and AIDS epidemic, though not a big number, a few older adults are HIV-infected and because of being constantly overlooked, they fall between the cracks of the aging and HIV services (Emlet and Poindexter, 2004:online). The findings from the present study bear witness to such a phenomenon.

A second strength of this study was its qualitative design whose main technique for data collection was interviewing. The researcher interviewed all the R-BGs raising GOTHA, one by one, herself in person. Such close interactions with the R-BGs afforded them the opportunity to express their inner feelings as unique human beings with special needs. The R-BGs were also able to discuss the socio--economic realities confronting them in view of their mammoth task of raising GOTHA, which responsibility far exceeded their meagre resources.

The third strength of this study was the revelation of the structure of the traditional family and state of art of daily living in a rural area. Rural areas remain home to

many Swazi families (Population and Housing Census, 2005) and yet the structure of the traditional family has changed over the years, owing primarily to urbanization (Smit, 2006: online). With adult children dying from AIDS (Maziya, 2005:59) and/or emigrating related to unavailable job opportunities (Mba, 2006:online) in their communities, the drought stricken condition of the lowveld and lack of most basic needs in life, the study findings revealed that R-BGs in the lowveld were now gatekeepers and also heading the homesteads.

The fourth strength of this study is attributed to the researcher's efforts and ability to develop a health education programme that will help to improve the health of the elderly in Swaziland. The health needs of the elderly in general, are neglected. Through this study, the need to pay more attention to the elderly has been demonstrated.

Last but not least, the fifth strength of the study was that the researcher was familiar with the research setting and also, the researcher was known in the constituency of *Sithobela* because of the annual clinical placements of nursing students among families and in adjacent schools in the various chiefdoms under this constituency. Therefore, because of having such close interactions with the rural health motivators, the researcher was readily accepted and well received by the R-BGs in their homesteads to conduct the study.

7.6 IMPLICATIONS OF THE STUDY FINDINGS

The findings from this study have implications, among others, on policy-makers, nursing practice in general and community health nursing practice in particular. Selected implications are discussed next.

7.6.1 Central Government

The findings from the data have exposed areas of inequality that impinge upon the lives of R-BGs as elderly persons in our community, such as not having access to health care. Also, the findings have exposed the R-BGs as elderly women in distress because of being neglected and marginalized by society in general in Swaziland. According to Fouad (2005:online) older people in most African countries are a vulnerable group as a result of a lifetime of hardship, maltreatment, and poverty and in older age, high susceptibility to chronic diseases. Mabuza (2008:151) revealed that the elderly in the Hhohho region lacked basic needs in life. The findings from the present study have implications for development of elderly pro-active policies.

The Constitution of Swaziland reads thus: "The family is a natural and fundamental unit of society and is entitled to protection by the State" (Swaziland Government Gazette Extraordinary, 2005:S29). The study findings bear witness that the majority of the Swazi elderly have become heads of families as a consequence of the HIV and AIDS epidemic (Swaziland Review, 2006:86) and yet they receive no assistance such as child ais grant from the state. Instead, they have to fend for themselves and their orphaned grandchildren as best as they possibly can. A country's constitution is the most supreme law in that society. Referring to the constitution and system of governance in the United States of America, whose democracy is admired by a number of African countries, Sithole (1988:85) argued that the purpose of a servant government is to serve the people. The constitution is the constant frame of reference for both government and the people. The philosophy of

servant government is real and anchored in the people's constitution. A people's constitution was ratified in 2005 in Swaziland and therefore this document creates a good base to use to serve the people. In a study that was conducted earlier in Swaziland by ULARN (2003:online) the elderly expressed that they felt used by aspiring MPs whose campaign gimmicks promised them improved social welfare as the elderly in the country. Similar campaigning tactics were reported in Uganda (Najjumba-Mulindwa, 2003: online). This has the implication of morality among politicians and a sense of duty to the electors.

7.6.2 Ministry of Health and Social Welfare

The Ministry of Health and Social Welfare adopted the PHC strategy in order to ensure health to all citizens of Swaziland. The philosophy underlying PHC is based on the philosophy of the Human Rights Charter of 1948 that pointed out that health was a birthright for every human being. Therefore, health is a birthright for all Swazi citizen across the life span, from the cradle to older adulthood. Health services ought to be available, accessible and affordable (Hattingh, et al, 2006:60-61) at all times to the Swazi people, including those who cannot afford, such as the elderly and children.

According to the Ministry of Health Policy (1983:1) the object of the Ministry of Health and Social Welfare is to implement and achieve to the World Health Organization goal of HEALTH FOR ALL BY 2000. As the population of Swaziland is largely rural-based (Ministry of Health Policy, 1983:7) it is in those areas of society that the greater part of health promotion activities should be targeted.

Swaziland is a member state of the United Nations and in 2000 a delegation was sent to attend the international conference on population aging in Madrid, Spain. Many government representatives who were present at that historic conference, including Swaziland, pledged to go back to their countries and improve the general social wellbeing of their elderly population (M2 Presswire, 2002:online). It is worth pointing out that it is almost a decade later and the drafted national social welfare policy for Swaziland, that among others includes sections on the elderly, has not yet been tabled in Parliament.

7.6.3 Ministry of Housing and Urban Development

The findings from this study revealed that most elderly lived in traditional structures that according to recommended housing standards are sub human habitation standards. In a study that investigated the housing situation and its effects on family health, one of the recommendations made by Dlamini (2003:40) was that the Ministry of Housing and Urban Development should also pay attention to rural-housing since some of the traditionally built houses had major structural faults and these were detrimental to health and life. This ministry needs to give equal attention to both urban and rural populace with regards to housing related issues such as for instance, construction supervision.

7.6.4 Ministry of Finance and Economic planning

The findings have shown that the elderly complained about the small size of the social grant money, namely, *imbasha yalabadzala*. As the majority of R-BGs in Swaziland care for GOTHA, they need adequate financial assistance in the form

of child aid grants. According to Noumbissi (2004:online) deficiencies and/or absence of social security in many developing countries and the weakening of the traditional role of the extended family due to, among others, urbanization and modernization (Mba, 2006:online) have also had negative consequences on the health and wellbeing of the aged. Najjumba-Mulidwa (2003: online) found that looking after orphaned grandchildren by elderly women in Uganda impoverished them because of resource limitations such as money to purchase the needs for their grandchildren.

7.6.5 Ministry of Agriculture and Co-operatives

According to Skolnik (2007: online) good nutrition is important at every stage of life for maintaining good health and personal productivity, and very important to the elderly because of the physiological changes that occur in their bodies as people age. According to Skolnik (2007:online) though there is relatively little data on the prevalence of under nutrition among the elderly in developing countries, studies have however, revealed that up to 36% of the men and 27% of the women were undernourished. This has implications of agriculture extension officers going around the homesteads to empower rural-based families with relevant knowledge, attitudes and skills on cultivating suitable drought resistant crops that may either be consumed or sold for commercial purposes in order to secure some cash to buy the required basic needs of their families.

The data revealed that most rural-based families received food relief. However, the quantity of food that was distributed to their families was determined by the size of the family. It may be pointed out that there is need for

food donors to work collaboratively with nutritionists who will guide as to the amounts of caloric intakes for the various family members. Certain factors, such as: the developmental stages of the recipients, major activities, body size, likes and dislikes (Skolnik, 2007: online) need to be taken into account when distributing food to the communities.

Nutritional requirements for the various development stages are different and also require various specified food groups. For instance children are still growing and need sufficient daily food intakes of energy, protein, essential fatty acids, minerals, vitamins and trace elements (Kibel and Wagstaff, 2001:100),

Except for the only male R-BG, the remaining 13 female R-BGs in the study were in the post menopausal periods and therefore needed dietary intakes that took into account sustained bone structure because of depleted levels of female gonadtrophins (Mba, 2006:online). Therefore, it is not enough to distribute food basing it merely on the size of family alone.

7.6.6 Ministry of Education

One of the major challenges of raising GOTHA by the R-BGs was not being able to provide their GOTHA with all their education-related needs such as school uniform, exercise books, rubbers, pens and pencils. Some of the GOTHA doing high school needed bus fare money on a daily basis as they were day scholars and commuters. Despite the existence of an educational programme for orphans and vulnerable children that was initiated by government through the Ministry of Education, all R-BGs found themselves having to

make payments for education-related expenses for their GOTHA.

It is worthwhile pointing out that Swaziland endorsed and ratified the Convention of the Right of the Child in 1995 which is approximately 14 years ago. Furthermore, the right to education for every child in the Kingdom was duly recognized and is enshrined in the Constitution of the country (Swaziland Government Gazette Extraordinary, 2005:S30). Therefore, the responsibility of educating these children who are in difficult circumstances does not rest with the R-BGs but with the Government of Swaziland through the Ministry of Education. Matshalaga (2004:71) reported similar findings from a Zimbabwe-based study that investigated grandmothers who were caring for grandchildren orphaned by AIDS.

7.7 IMPLICATIONS ON COMMUNITY HEALTH NURSING

The findings from this study have several implications for all four faculties of nursing, namely, practice, education, management and research. In particular, these implications shall focus on community health nursing practice in Swaziland.

7.7.1 Community health nursing practice

Since community health nursing in Swaziland is largely defined by setting of practice and the study was conducted in a rural community, the following are its implications to community health nursing practice.

The R-BGs reported that no nurses ever paid them any home visits. Such a revelation came as a surprise since home visiting is the epitome in community health nursing practice. Not conducting home visits was also found to be

in contravention of the PHC strategy that the Ministry of Health and Social Welfare of Swaziland adopted in order to ensure health for all her citizens (National Ministry of Health Policy, 1983:7). One of the many benefits of conducting home visits was highlighted by Clark (2003:498) as that the community health nurse is able to see, observe and assess the context within which the client lives.

7.7.2. Community health nursing education

According to Dreyer, Hattingh and Lock (1999:33) health education is the heart of community nursing. Therefore, nursing curricula should reflect this reality. Health education is one of the leading strategies of promoting the health and wellbeing among individuals, groups, families and communities. It is more cost effective to keep the people healthy because health care services are, to a greater extent unaffordable, particularly, in Swazi rural areas and among the Swazi elderly.

Nursing students, especially in their fourth year of a nursing programme, should be encouraged to embark on research problems that are identified from their own communities. Not only would this aid the nursing students in cutting down on costs of traveling to distant communities to collect data, but identifying problems in their own residential communities will also foster in them the habit of researching and thus promote evidence-based practice (Burns and Grove, 2005:634).

7.7.3 Community health Nursing research

Nursing, the world over, is still striving toward better leves of profession. Unless nurses conduct research and develop their own unique body of knowledge (Brink, 2006:27), nursing shall remain undeveloped and/or under-

developed and the status of professionalism shall remain idealistic. Conducting research among the nurses in Swaziland is imperative if quality nursing care is to be discharged to clients.

Since research findings always indicate other areas for further research, based on the findings of the current study, other areas for investigating were identified. There is an increase in the elderly population in general as well as in sub-Saharan Africa (Velkoff and Kowal, 2007:1) and therefore there is a need to engage in research that is elderly focused that will help in improving their various life situations.

The various faculties in the three campuses of UNISWA, namely, *Kwaluseni, Luyengo and Mbabane,* should conduct collaborative research in trying to identify strategies to ameliorate the general welfare of the elderly in Swaziland. Both students and faculty members may engage in such research exercises. Some of the areas for investigating jointly are listed below:

- The level of undernourishment of the elderly in Swaziland.
- The perceptions of the elderly raising children orphaned through AIDS regarding the role of the Swazi Government in the AIDS orphan care in the current HIV and AIDS epidemic. .
- Knowledge, attitude and practice (KAP) of urban and rural-based elderly about standard precautions when caring for chronically sick adult children and other relatives at home.
- The perceptions of rural-based elderly about their own sexuality.

- The extent of human violence among the elderly in Swaziland.
- The lived experiences of elderly men aged 60 and above looking after grandchildren orphaned through AIDS.

Rural area focused scientific inquiry is imperative because:

- it is where the majority of the people live, including the elderly.
- rural areas are underserved with health care services.
- of the increase in the elderly population (Velkoff and Kowal, 2006:1). Their developmental and health requirements need the attention of nurses.

7.7.4 Community health nursing management

The Ministry of Health and Social Welfare in conjunction with the Swaziland Nursing Council need to ensure that the nurse/client ratio is adequate as determined by national and international nursing standards so that quality nursing (Shongwe, 2000:1) care is rendered to clients at all times.

With regards to community health nursing practice, the size of the community served should determine the number of nurses to be deployed. Like nurses posted to wards and give health education by the bedside, CHNs too, have the duty to go around in the various parts of their communities and teach members how to remain healthy and well.

7.8 RECOMMENDATIONS

Based on the afore-gone implications, the following are some brief recommendations. There is need to:

- show greater respect and recognition of the elderly by policy-makers.

- formulate urgent pro-active social welfare policies for the elderly.
- treat all elderly persons aged 60 years and above free of charge in all health care facilities. This also includes children.
- decentralize social welfare operations.
- train social workers and deploy them in rural areas because this where the majority of the people reside.
- pay out child aid grants, especially to those families that have children that are classified as orphaned and/or vulnerable.
- ensure that nursing curricula content are contextual in order to serve the real needs of the population.
- utilize more rural-based clinical laboratories than urban- and peri-urban based ones because the majority of the population resides in rural areas (Population and Housing Census, 2007).
- revive home visiting as part of routine community health nursing practice.
- ensure that members of the families, who receive food rations from Government and NGOs, are given food according to their stipulated daily caloric requirements.

7.9 Concluding summary

Following the exploration of the day-to-day subjective realities of R-BGs raising GOTHA in the Chiefdom of *Nkonjwa* at Sithobela in the Kingdom of Swaziland, the researcher identified six major categories that reflected their lived experiences.

The magnitude of some of the identified categories was beyond the scope of nursing and therefore need a strategy

that is collaborative in order to address them. They need government intervention. Other categories could be classified as consequences of the severe resource constraints experienced by R-BGs raising GOTHA and are likely to be resolved with appropriate remedial measures.

One category, however, was directly to do with the health of the R-BGs, namely, COMPROMISED HEALTH and revealed that the R-BGs raising GOTHA suffered from a number of physical health conditions that needed prompt attention. These R-BGs raising GOTHA lacked self-care. The health-related problems of the R-BGs raising GOTHA, were an area that nursing could do something about.

Consequently, a health education programme to empower with self-care R-BGs raising GGTHA in the lowveld was developed. The programme is a proposed one. Prior to implementing it, a workshop to train the community health nurses in the lowveld will be needed in order for the teaching-learning process of these older adults to proceed effectively.

Therefore, this thesis serves to confirm that both the primary and ultimate purposes of the study have been achieved. The researcher adhered to the standards provided for conducting ethical research.

Chapter seven ended with revealing feedback from the various stakeholders about the developed health education programme. Also discussed in the final chapter were: the limitations of the study, its contributions and implications. Recommendations were suggested.

Since this research was first conceived in the researcher’s mind and through the period of its implementing, some small

positive developments with regards to the elderly in Swaziland have taken place. Some of these are:

- For instance, instead of receiving their social grant for the elderly once every three months, they now can get it on a monthly basis. However, this applicable only to those who have managed to open bank accounts.
- The amount has been increased to E200 - 00 per month.
- The University of Swaziland through the faculty of Health Sciences has linked with the universities of Diak and Turku, both in Finland. A joint research project has been conduct to investigate the wellbeing of the elderly in Swaziland. The data are being currently analyzed. The two universities have offered to train both faculty and nursing students gerontology and geriatric nursing.
- The Lubombo region is about to launch free health services for the elderly.
- The researcher has been asked to present her programme for possible recommendation to use it in training the nurses in the Lubombo region on older adult teaching-learning.

8. REFERENCES

[Referencing compiled in accordance with: HARVARD (author-date) referencing guide January 2007. Viewed 22 January 2008 from, http://www.cqu.edu.au/referencing/ref_style/.harvard_guide.pdf]

ABELDINGER, J, PARSON, C and CASE, A 2004: Orphans in Africa, Parental death, poverty and school enrolment. Viewed 21 July 2008 from, http://www.highbeam.com/doc/1P3-6975879471.html

ABRUZZESE, RC 1992: Nursing staff developmentstrategies for success. St Louis, Mosby.

AGYARKO, RD, MADZINGIRA, N, MUPEDZISWA, R, MUJURU, N, KANYOWA, L. and MATOROKA, J 2002: Impact of AIDS on older people in Africa, Zimbabwe case study Viewed 26 July 2008 from, http://www.un.org

AJALA, AS 2006: The changing perception of ageing in Yoruba culture and its implication on the health of the elderly. *Anthropologist,* 8 (3):181-188.

AMERICAN ASSOCIATION FOR HEALTH EDUCATION 2005: Philosophy of health education, A position statement. Viewed 16 July 2009 from, http://www.aahperd.org/AAHE/pdf_files/pos_pap/Philosophy.pdf

ASHTON-HAY, S 2005: Drama: Engaging all learning styles. In Proceedings 9th International INGED (Turkish English Education Association) Conference, "New Horizons" Economics and Technical University, Ankara Turkey. Viewed 12 May 2008 from, http://eprints.qut.edu.au

ATKINSON, RL, ATKINSON, CL, SMITH, EE, BEM, DJ and HILGARD, ER 1990: Introduction to psychology. Philadelphia: Harcourt brace Jovanich College Publishers.

BABBIE, E and MOUTON, J 2005; The practice of social research South African edition. Cape Town: Oxford University Press.

BACKHOUSE, J 2006: 'Grandparents-as-parent: Social change and its impact on grandparents who are raising their grandchildren.' Social change in the 21st century. 27th October 2006, The Centre for Social Change Research, Queensland University of Technology, pp 1 – 14.

BANKS, T 2000: Teaching learning process, Assess, plan, implement, evaluate, document. Viewed 20 December 2008 from, www.dhhs.state.nc.us/dhsr/hcpr/pdf/principlesofadultlearning.pdf

BBC NEWS 2008: 'More than over 70s 'are enjoying sex'.

Viewed 23 July 2008 from,
http://newsvote.bbc.co.uk/mpapps/pagetools/print/news.bbc.co.uk/2/hi/health/74
4731.stm

BERRY, RD 2004: Community oriented nursing in STANHOPE, M and LANCASTER, J Community and public health nursing 6th edn. St. Louis: Mosby.

BLACKBURN, S 2005: Oxford Dictionary of Philosophy. Oxford: Oxford University Press.

BRATHWAITE, D, DORSEY, S, MAGONGO, R, MATLAKALA, M, MOGOTLANE, S and RODRIQUEZ, H 2002: Elderly citizens' perceptions of their health and care provided in a rural South African community. Viewed 13 December 2007 from, http://www.highbeam.com/doc/1G1-93610978.html

BRESLIN, ET and LUCAS, VA 2003: Women's health nursing, Toward evidence-based practice. St. Louis: Saunders.

BRINK, HI 2006: Fundamentals of research methodology for health care professionals 2nd edn. Cape Town: Juta.

BRINK, HI 2003: Fundamentals of research methodology for health care professionals. Cape Town: Juta and Company LTD.

BRYANT, LL, ALTPETER, M and WHITELAW, NA 2006: Evaluation of health promotion programs for older adults, An introduction. *The Journal of applied Gerontology*, 25 (3):197 - 213.

BUCKLEY, S 1996: Old in Africa: Urbanization and AIDS tear away status, privileges once accorded grandparents. The Washington Post. Viewed on 12 November 2007 from,http://www.com/doc1P2-785714.html

BULLOCK, K 2005: Grandfathers and the impact of raising grandchildren *Journal of Sociology and Social Welfare [online*]. Viewed 23 May 2008 from, http://www.highbeam.com/doc/1G1-131124720.html

BURNS, N and GROVE, SK 2005: The practice of nursing research, Conduct, critique and utilization. 5th edn. St Louis: ELSEVIER Saunders.

BWEMBYA, C THWALA, JM and OTIENO, DA (n.d.) Nutritional analysis of some major micronutrients in the indigenous Swazi vegetables. Department of Chemistry, University of Swaziland.

CALDWELL, R 2005: Food aid and chronic illness, Insight from the community and household surveillance surveys. International Conference on HIV/AIDS and Food and Nutrition Security. International Food Policy Research Institute (IFPRJ], Durban, South Africa, 14 – 16 April 2005.

CENTER FOR DISEASE CONTROL AND PREVENTION 2003: Prostate cancer screening, A decision guide for African American men. Washington: Department of health and human services.

CHADWICK, A 2008: The abandonment of elderly parents and cultural values. Viewed 23 August 2008 from, http://elder-abuse-spotlight.blogspot.com

CHAMBERS, E 2007 – 2008: Helping students to become active learners. Viewed 4 August 2009 from, http://www.turkey.usembassy.gov/up/pads/images/ZbaUSsGav99x5BCBjYKntQ/lLearner_Centred_Teaching

CHILDREN IN DISTRESS [CINDI] 2007: Elderly caregivers consultation report. Viewed 20 October 2008 from, www.cindi.org.za

CHIPETA, DP 1997: Classroom productivity, A first curriculum sourcebook. Gaborone: African Publishing Services.

CLARK, MJ 2003: Community health nursing, Caring for populations 4th edn. New Jersey: Prentice Hall.

COHEN, BJ and WOOD DL 1990: The Memmler's structure and function of the human body 7th edn. Philadelphia: Lippincott, Williams and Wilkins.

CONWAY, MA 2004: Rural grandparents raising grandchildren: Predictors of parental stress. Unpublished Graduate Thesis. Montana State University.

CORNETT, S 2004: Teaching the elderly. Viewed 10 April 2008 from, http://MEDICALCENTER.OSU.EDY/PATIENTED/MATERIALS/PDFDOC/EMPLOYEE/elderly.Pdf

COREY, L and ADAMSON, SM 2004: HIV/AIDS in sub-Saharan Africa. Croatian Medical journal **45**(4):402 – 414.

COX, CB 2003: Designing interventions for grandparents caregivers: the need for an ecological perspective for practice (Support for grandparent caregivers). Viewed 17 October 2004 from, http://www.highbeam.com/library/doc3.asp?ctrlnfo=Round9%3AP

CRAWFORD, D 2004: The role of aging in adult learning, Implications for instructors in higher education. Viewed 19 February 2009 from, http://www.newhorizons.org

CRESWELL, JW 1998: Qualitative inquiry and research design, Choosing among the five traditions. London: Sage Publicans.

D'CRUZ, P 2003: Moments of the truth, The experiences of wives in HIV/AIDS affected nuclear households in Mumba. Viewed 3 November 2006 from, http://www.highbeam.com/reg/reg1.1asp?full=yes&refig=f2af_hbr

DELAUNE, SC and LADNER, PK 2006: Fundamentals of nursing, Standards and practice 3rd edn. Australia: Thomson Delmar Learning.

DENNILL, K 1999 International views on primary health care in DENNILL, K, KING, L and SWANEPOEL, T: Aspects of primary health care: Community health care in South Africa 2nd edn. Oxford: Oxford University Press.

DENNILL, K, KING, L and SWANEPOEL, T 1999: Aspects of primary health care: Community health care in South Africa 2nd edn. Oxford: Oxford University Press.

de TORNYAY, R and THOMPSON, MA 1987: Strategies for teaching nursing 3rd edn. New York: Wiley Medical Publication.

DEVEREUX, S 2006: Social protection mechanisms in Southern Africa. Viewed 11 March 2008 from, http://www.wahenga.net

de VOS AS 2002: Qualitative data analysis and interpretation in De VOS, AS, STRYDOM, H, FOUCHE, CB and DELPORT, CBS: Research at grassroot: For social sciences and human service professions 2nd edn. Pretoria: van Schaik.

de VOS, AS, STRYDOM, H, FOUCHE, CB and DELPORT, CBS 2002: Research at grassroot: For social sciences and human service professions 2nd edn. Pretoria: van Schaik.

DHILLON, A 2007: Indians dump elderly on the flaming scrap heap. The Sunday Telegraph, London. Voewed 26 July 2008 from, http://elder-abuse-spotlight.blogspot.com

DICKOFF, J JAMES, P and WIEDENBACH, E 1968: Theory in a practice discipline. Part 1 Practice oriented theory. Nursing Research. September-October, 17 (1):415 – 435.

DK ILLUSTRATIVE OXFORD DICTIONARY 1998. New York: Oxford University Press

DLAMINI D 2007: Fertility preferences in Swaziland Demographic and Health Survey. Mbabane: Central Statistics Office.

DLAMINI, N 2009a: Ministry blames former government for free education mess. Swazi Observer, 21st July, Page 8.

DLAMINI N 2009b:Mkhuluza feels elderly are neglected … MPs tp lobby for grants to be disbursed monthly. Weekend Observer, 3rd – 4th October, Page 10.

DLAMINI, T 2007: Adolescent perceptions of sexuality and sex and its effects in the prevalence of teenage pregnancy in Swaziland. Unpublished Undergraduate Thesis. Faculty of Health Sciences, University of Swaziland.

DLAMINI, MN 2003: Household conditions and environmental health problems in rural settlements in Swaziland, The case of The Lubombo Region. Unpublished Undergraduate Thesis. Faculty of Health Sciences, University of Swaziland.

DLAMINI, SG 2003: Impact of diabetes mellitus on everyday life. Unpublished Undergraduate Thesis. Faculty of Health Sciences, University of Swaziland.

DLAMINI, SR 2003: Poverty, Scarcity and hardships: The realities of life in the lowveld region of Swaziland in KANDUZA AM and DUPONT MKHONZA, S (Eds) Poverty in Swaziland: Historical and contemporary forms. Matsapha: Blue Moon Printing.

DLAMINI, CM 2001: Experiences of the elderly residing in the Mbabane peri-urban settings. Unpublished Undergraduate Thesis. Faculty of Health Sciences, University of Swaziland.

DREYER, M 1999: Philosopical views on community nursing and community health care in DREYER, M, HATTING, HS and LOCK, M: Fundamental aspects of community nursing 2nd edn. Oxford: Oxford University Press.

DREYER, M, HATTING, HS and LOCK, M 1999: Fundamental aspects of community nursing 2nd edn. Oxford: Oxford University Press.

DUDEK, S 2006: Nutrition essentials for nursing practice 5th edn. Philadelphia: Lippincott, Williams and Wilkins.

du TOIT, DA and van STADEN, SJ 2005: Nursing Sociology 3rd edn. Pretoria: Van Schaik Publishers.

EAGLE, W 2007 VOA News: Urbanization weakens traditional family care for elderly in Ghana. Viewed 26 July 2008 from, http://www.highbeam.com/doc/1P3-1219774871.html

EMLET CA and POINDEXTER, CC 2004: Unserved, unseen and unheard, Integrating programs for HIV-infected and HIV-affected older adults. Viewed 27 July 2008 from, http://www.highbeam.com/doc/1G1-116341961.html

FAWDETT, J 1989: Abalysis and evaluation of conceptual models of nursing 2nd edn. Philadelphia, F.A. Davis Company.

FACIONE, PA 2009: Critical thinking:What is it and why it counts. Viewed 19.08.2009 from http://www.insightassessment.com

FAJEMILEHIN, B 2000: Old age in a changing society, Elderly experiences of caregiving in Osun State, Nigeria. African *Journal of Nursing and Midwifery* 2 (1):23-27.

FATAH, S 2008: Shunting aside the elderly, Special to The Star. Viewed 23 August 2008 from, http://elder-abuse-spotlight.blogspot.com

FLETCHER, KR 2008: Health of older adults in STANHOPE, M and LANCASTER, J Community and public health nursing 6th edn. St. Louis: Mosby.

FOSTER, PC and BENNETT, AM 2002: Self-care deficit nursing theory Dorothea E. Orem in GEORGE, JB (Ed) Nursing theories: Base for professional nursing practice 5th edn. New Jersey: Prentice-Hall.

FOSTER, PC and JANSSEN, NP 1990: Dorothea E. Orem in GEORGE, JB (Ed) Nursing theories: The base for professional practice 3rd edn. New Jersey: Prentice Hall.

FOUAD D 2005: Role of elderly people in the era of HIV/AIDS in Africa. Viewed 23 November 2007 from, http://globalaging.org/armedconflict/countryreports/general/old%20hiv.Pdf

FOUCHE CB 2002: Research strategies in De VOS, AS, STRYDOM, H, FOUCHE, CB and DELPORT, CBS: Research at grassroot: For social sciences and human service professions 2nd edn. Pretoria: van Schaik

FRANCIS-CHIZORORO, M 2007: Orphan hood, childhood and identity dilemma
of child headed households in rural Zimbabwe in the context of HIV/AIDS pandemic Viewed 23 July 2008 from, http://uaps2007.princetown.edu/download.aspx?submission=70431

FRIEDMAN, MM, BOWDEN, VR and JONES, EG 2003: Family nursing, Research, theory and practice 5th edn. New Jersey: Prentice Hall.

FULLER-THOMSON, E 2005: Grandparents raising grandchildren in Canada, A profile of skipped generation families. Viewed 7 April 2007 from, . http://socserv2.mcmaster.ca/sedap

FURUKAWA, CY and HOWE, JS 2002: Definition and components of nursing:Virginia Henderson in GEORGE, JB Nursing theories: The base for professional practice 5th edn. New Jersey: Prentice-Hall.

GACHUHI, JM and KIEMO, K 2005: Research capacity on aging in Africa, Limitations and ways forward. Generations Review. 15 (2):36 - 38.

GALLAGHER, C 2006: Abandoned by their own children, The Star (South African) Viewed 11th November Viewed 26 July 2008 from, **http://www.highbeam.com/doc/1G1154300397.html**

GELDENHUYS, C 2003: Smart sleep , Get a life. Cape Town: ABC Printers.
GIDDENS, A 2005: Sociology 5rd edn. Cambridge: Polity Press.

GIDDENS, A 1997: Sociology 4rd edn. Cambridge: Polity Press.

GILLIES, CL, HIGHLER, BL, ROBERTS, BM and MARTINSON, IM 1989: Toward a science of family nursing. New York, Addison-Wesley Publishers Company

GININDZA, H and MASUKU, R 2007: Introduction in Swaziland Demographic and Health Survey. Mbabane: Central Statistics Office.

GLICK DF and STANHOPE, M 2004: Programme management in STANHOPE, M and LANCASTER, J Community and public health nursing 6th edn. St. Louis: Mosby.

GOERING, L 2007: Indians abandoned by younger generation, The Chicago Tribunal: 15th April. Viewed 26 July 2008 from, http://www.highbeam.com/doc/1G1-161974396.html

GRAY, DE 2004: Doing research in the real world. London: Sage Publications.
GROBLER, F 2003: Contraception, Theory and practice 4th edn. Pretoria: Van Schaik Publications.

GWEBU LD 2002: Factors contributing to cataract blindness in Swaziland. Undergraduate Thesis. Faculty of Health Sciences, University of Swaziland.

HAGGAR, K and BROCOPP, D 2009: The use of a chronic diary in older people. *British Journal of Nursing*, 18 (8): 490 – 497.

HAGLUND, K 2000: Parenting a second time around, An ethnography of African American grandmothers parenting grandchildren due to parental cocaine abuse. *Journal of Family Nursing*, 6 (2): 120-135.

HAJJAR, R, KAMEL, HK and DENSON, K 2004: Malnutrition in aging. Viewed 5 December 2008 from, http://www.ispub.com/ostia/index.php?mx1filepath=journals/jgg/vol1n1malbutrition.xml

HALL J 2008 HIV/AIDS and the elderly Swazi Observer, 7th May, Page 14.

HALL, J 2005 Rights, Help on the way for elderly Swazis raising AIDS survivors. Viewed 1 April 2006 from, http://www.highbeam.com/library/doc3.asp?ctrllnfo=Round91%3AP
HANSEN, K, HEATH. M, LAWRENCE, L. LEAVY, D RYAN, K and SONNTAG, AG. 2008: Coping with grief, guidelines and resources for assisting children. Viewed 5 March 2008, http://www.com/doc/coping%2%2?

HARALAMBOS M and HOLBORN, M 2004: Sociology, Themes and perspectives 6thedn. London: HarperCollins Publishing Limited,

HARKER, L 2006: Chance of a lifetime, The impact bad housing on children's lives. Viewed 26 October 2008 from, http://www.shelter.org.uk

HARRIS, R and VEINOT, T 2004: The empowerment model and using e-health to distribute information. Viewed 18 January 2009 from, www.sfu.ca/act4hlth/

HATTINGH, SP, DREYER, M and ROOS, S 2006: Aspects of community health 3rd edn. Cape Town: Oxford University Press.

HELPAGE INTERNATIONAL 2008 New survey highlights poverty of older Jamaicans. Viewed 22 March 2008 from, http://www.helpage.org/News/Latestnews/QZop

HERLIHY, B 2007: The human body in health and illness 3rd edn. St Louis: Saunders Elsevier.

HOWARD, BH PHILLIPS, CV MATINHURE, N, GOODMAN, KJ McCURDY, SA and JOHNSON, CA 2006: Barriers and incentives to orphan care in a time of AIDS and economic crisis A cross-sectional survey of caregivers in rural Zimbabwe. Viewed 10 November 2008 from, http://www.biomedcentral.com/1471-2458/6/27/prepub

INWOOD, S 2002: Grandparents raising grandchildren: when grandparents are raising their children's children, family dynamics change considerably. Nurses can be instrumental in assessing these clients in their health needs, and providing education and support. Viewed 28 July 2008 from, http://www.highbeam.com/doc/1P3-588011191.html

JELE, M 2007: The level of knowledge of rural-based pregnant women about breastfeeding as a means of transmitting HIV infection from mother to her infant. Unpublished Undergraduate Thesis. Faculty of Health Sciences, University of Swaziland.

JOEL, LA. 2003: Kelley's dimension of professional nursing 9th edn. New York: McGraw-Hill.

JOSLIN D and HARRISON R 2002: Self-reported physical health among older surrogate parents to children orphaned and affected by HIV disease. *AIDS Care* 1 (5): 619 - 624.

KAMAL, MA 2008: Barriers to adherence to highly active antiretroviral therapy among HIV-infected adult individuals in Swaziland. Unpublished Graduate Thesis Trinity College, University of Dublin.

KHAN, M 2007: Today's research on aging: How does HIV/AIDS affect the elderly in developing countries? Viewed 12 May 2008 from, www.prb.org/pdf07/TodaysResearchAging8.pdf

KAISER, L.M, HATTON, DC and ANDERSON, DG 2004: Women's health in Stanhope, M and Lancaster, J Community and public health nursing 6th edn. St. Louis: Mosby.

KAISER NEWS, 2007: Liberia: Fake orphans to attract donor funds. Viewed 16 June 2008 from, http://medilinkz.org/news/news2.asp?NewslD=20435

KATAOKA-YAHIRO, MR, CERIA, C, and YODER, M Fall 2004: Grandparent caregiving role in Filipino American families. *Journal of Cultural Diversity [online]* . Accessed 15 October 2008 from, http://finderarticles.com/p/articles/mi_m0MU/is_3_11/ai/_n8585218/pg.1?tag-artBody;col1

KAVUMA, E 2001: Grandmothers called out of retirement, The challenges of African women facing AIDS today. *Canadian Woman Studies (online)* Viewed 2004 from, http://highbeam.com

KAWEWE, S 2006: Reclaiming civil society and the plight of AIDS orphaned children and elderly women caregivers in sub-Saharan Africa, A global human rights dilemma for international social workers. Viewed 12 May 2007 from, http://www.highbeam.com/doc/1G1-165971631.html

KIBEL, M, SELOOJEE, H and WESTWOOD, T 2007: Child health for all 4th edn. Cape Town: Oxford University Press.
KIBEL, MA and WAGSTAFF, LA 2001: Child health for all, A manual for Southern Africa 3rd Cape Town: Oxford University Press.

KNODEL, J and VANLANTINGHAM, M 2002: The impact of the AIDS epidemic on older Persons (Epidemiology, social, cultural and political). Viewed 4 January 2008 from, http://www.un.org/ageing/coverage/index.html

KNOWLES, M. 1990: The adult learner, A neglected species 4th edn. Houston: Gulf Publishers.

KOBAYASHI, KM 2000: The nature of support from adult sansei (third generation) children to older Nisei (second generation parents in Japanese-Canadian families. Journal of Cross Cultural Gerontology 15:185 - 200.

KULBOK, PA, LAFFREY, SC And GOERPPINGER, J 2004: Integrating multi-level approaches to promoting community health in STANHOPE, M and LANCASTER, J Community and public health nursing 6th edn. St. Louis: Mosby.

KUMAR, R 2005: Research methodology, A step by step guide for beginners 2nd edn.
London: Sage Publications.

KVALE, S 1996: Interviews: An introduction to qualitative research interviewing. London: Sage Publications.

LANDENBERG, KM AND CAMPBELL, JC 2008: Violence and Human abuse in STANHOPE, M and LANCASTER, J Community and public health nursing 6th edn. St. Louis: Mosby.

LANG, SS 2006: Seniors raising children a second time around. getting support from expanding corporative extension programmes. Viewed 7 July 2008 from, http://www.news.cornell.edu.stories/Feb06/grandparents.parenting.ssl.html

LAWTON, S, CANTRELL, J and HARRIS, J (Eds) 2000: District Nursing, Providing care in a supportive context. Edinburgh: Churchill Livingstone.

LEEDY, PD and ORMROD, JE 2005: Practical research, Planning and design 8th edn. New Jersey: Pearson Merill Prentice Hall.

LEININGER, M 1995: Transcultural nursing, Concepts, theories, research and practices 2nd edn. New York:: McGraw-Hill.

LINCOLN and GUBA 1985: Naturalistic inquiry in POLIT, DE and BECK, CT 2004: Nursing research, Principles and methods 7th edn. Philadelphia: Lippincott Williams & Wilkinson.

LINSK, NL and MASON, S 2004: Stresses on grandparents and other relatives caring for children affected by HIV/AIDS. Viewed 29 July 2008 from, http://www.highbeam.com/doc/1G1-116341966.html

LIU, R QIAO, X and LIU, Y 2007: A paradigm shift of learner-centred teaching style, Reality or illusion? Viewed 6 August 2009 from, http://www.W3.coh.arizona/awo/AWP13%BL.iu%5D.pdf

LONGMAN DICTIONARY OF CONTEMPORARY ENGLISH 1995. Essex: Longman Group Ltd.

LUKHELE, BB 2009: The elderly people's perceptions on the social grants in meeting their financial needs. Unpublished Undergraduate Thesis. Faculty of Health Sciences, University of Swaziland.

LUKHELE, S 2008: Boy (19) arrested for raping his own grandmother. The Times of Swaziland, 16th July, Page 1.

LYSYCIA, J 2008: Superstretch. London: hamlyn.

M2 Presswire, 2004: Caring for vulnerable children impossess heavy costs on families and nations. Viewed 20 March 2008 from, http://www.highbeam.com/doc/1G1/126167806.html

M2 Presswire, 2002: Difficult situation of Africa and countries in conflict in support of older people highlights at ageing assembly in Madrid Part 1 of 2. Viewed 20 March 2008 from, http://www.highbeam.com/doc/presswire.%20.web.achive

M2 Presswire, 1999: UN - Elderly should not be seen as depreciating asset, General told. Viewed 20 March 2008 from, http://www.scienceblog.com/community/older/archives/L/1999/B/un991463.html

MABUZA, EM, 2008: A strategy for facilitating the mobilization of resources to meet the basic needs of the elderly in the Hhohho region in Swaziland. Unpublished Doctoral Thesis, University of Johannesburg,

MABUZA, F 2008: 14-year-old girl in forced marriage … drops out of school, marries a 64-year old traditional healer. Weekend Observer, 23 – 24 October, page 6.

MABUZA F 2005: Tears of an old woman …old lady single handedly raises her grandchildren after demise of their parents. Weekend Observer, 18th-19th July, Page 7.

MABUZA F 2002: No more tears to shed! Weekend Observer, 16th – 17th February,
Page 7.

MACTONIS, JJ 2008: Sociology 5TH edn. London, Pearson Prentice Hall.

MAGAGULA, T 2002: Situation analysis of the elderly people in Malindza community. Unpublished Undergraduate thesis. Faculty of Agriculture: University of Swaziland.

MAGONGO, M 2008: Subsidize bus fares – Minister Hlo'bsile. Weeked Observer, 8th-9th November, Page 2.

MAKIWANE, M SCHNEIDER, M and GOPANE, M 2004: Experiences and needs of older persons in Mpumalanga. A study conducted for the Department of Health and Social Services. Unpublished research report. Mpumalanga: Department of Health.

MAKIWANE, M and KWIZERA, SA 2004: An investigation of quality of the elderly in South Africa with specific reference to Mpumalanga Province. Viewed 10 March 2008 from, http://www.hrsc.ac.za/research_publication-6660.phtml

MAMBA, GP 2002: A situational analysis of selected organizations providing services to elderly people in Mayiseni community. Unpublished Undergraduate Thesis. Faculty of Agriculture, University of Swaziland.

MASILELA, N 2008: Canadian couple adopt a Swazi boy. Swazi Observer, 29th October, Page 13.

MASILELA, BH, NAMAGANDA, R and SITHOLE, SI 1994: Childbearing and childrearing in Africa, Implications on mental health. A paper presented at the 6th International Conference on Women's Health Issues at The Gaborone Sun, Botswana.

MASON, S 2004: Stresses on grandparents and other relatives caring for Children affected by HIV/AIDS. Viewed 1 January 2004 from, http://www.highbeam.com/library/doc3.asp?ctrlInfo=Round6%3AP

MASON-MVUSI, TR 2003: The poverty of females and blackness in Swaziland in
KANDUZA, AM and DUPONT-MKHONZA, S (Eds) Poverty in Swaziland: Historical and contemporary forms. Matsapha: Blue Moon Printing.

MATSHALAGA, N 2004: Grandmothers and orphan care in Zimbabwe. Harare: SAfAIDS.

MATHUNJWa, N 2008: The elderly grants mean nothing to these poor people … elderly pin hopes on aspiring MPs. Times of Swaziland, 16th September, Page 14.

MATHUNJWa, N 2009: Elderly want grant package increased. Times of Swaziland, 16th June, Page 13.

MAUDENT, A. 2008: Only 24% have tested for HIV. Times of Swaziland 10th March, Page 4.

MAVUSO, M 2007: Family planning in Swaziland in Swaziland Demographic and Health Survey. Mbabane: Central Statistics Office.

MAVUSO, S 2008: King tells *BoGogo* to vote for one another. Swazi News, 26th July, Page 11.

MAYA, FG 2003: The lived experiences of rural Swazi families caring for the elderly at home. Unpublished Undergraduate Thesis. Faculty of Health Sciences: University of Swaziland.

MAZIYA, EM 2005: The effects of an adult child care and death due to AIDS on older people in Swaziland. Unpublished Graduate Thesis. Department of Social Work. University of Botswana.

MBA C 2006: The health condition of older women in Ghana: a case study of Accra City. Viewed 7 February 2008 from, http://www.highbeam.com/doc/1P312197871.html

MBUGUA, T 2004: Responding to the special needs of children: educating HIV/AIDS orphans in Kenya. Viewed 26 July 2008 from, http://www.highbeam.com/doc/1G1-121646363.html

McEWEN, M 2002: Community-based Nursing: An introduction 2nd edn. St. Louis: Saunders,

McKENZIE, JF, PINGER, RR and KOTECKI, JE 1999: An introduction to community health 3rd edn. Boston: Jones and Bartlett Publishers.

McNEIL, JD 1990 Curriculum: A comprehensive introduction 4th edn. California: HarperCollins Publishers.

MEGAN I JVOTI, S and ADAM, D 2004: Antecedants of intergenerational
Support: Family in context and families as context. Viewed 27 July 2008 from,
http://www.highbeam.com/doc/1P3-842877671.html

MEYER, S, NAUDE, M and SE van NIEKERK 2004: The nursing unit manager, a comprehensive guide 2nd edn. Sandton: Heinemann Higher and further education (Pty) Ptd.

MEYERHOFF, MK 2004: A look into adolescent mind. (Perspective on parenting). Viewed 22 July 2008 from, http://www.highbeam.com/doc/1G1-128708722.html

MHLONGO, N 2008: Father of 40 has lost 8 kids to AIDS: Ten of his children Died between 2002 and 2006, eight of them through HIV/AIDS-related diseases. Times of Swaziland, 6th January, Page 10.

Minkler, M 2000: African American grandmothers raising grandchildren: A national profile of demographic characteristics. Viewed 1 January 2004 from

http://www.highbeam.com/library/doc3.asp.crtl1info=Roundk%3AP

MINISTRY OF HEALTH AND SOCIAL WELFARE 2007: National Health Policy, Mbabane Government Printer.

MINISTRY OF HEALTH AND SOCIAL WELFARE 2006: 10th round of national HIV sero---surveillance in women attending antenatal care, sexually transmitted infections clients and tuberculosis patients at health facilities in Swaziland, Survey report January 2006. Mbabane: Government Printer.

MINISTRY OF HEALTH AND SOCIAL WELFARE 2002: 8th HIV sentinel surveillance report. Mbabane: Government Printer.

MINISTRY OF HEALTH National Policy 1993: Mbabane, Government Printer.

MKHONTA RN 2008: Guidelines for support of orphaned and vulnerable children being cared for by their grandparents in the informal etting of Mbabane, Swaziland. Unpublished Doctoral Thesis, University of South Africa.

MORLAND, V 2003: How to teach adult learners. Viewed 12 May 2009 from, http://www.ro1.learning.com/guides/teaching_adults.pdf

MOTSA, SM 1999: Professional support available to caregivers of people living with HIV/AIDS. The case for Molepolole. Unpublished Graduate Thesis. Department of Nursing, Faculty of Education, University of Botswana.

MURRAY, RB and ZENTNER, JP 2001: Health promotion strategies through the life span. New Jersey: Prentice Hall.

MUSI, P 2006: Knowledge review and analysis: hunger and vulnerability in Swaziland. Viewed 11 January 2007 from, http://www.wahenga.net

NAJJUMBA-MULINDWA, I 2003: Chronic poverty among the elderly in Uganda: Perceptions, experiences and policy issues. Viewed 11 March 2007 from, http://www.chronicpoverty.org/pdfs/mulindwa

NATIONAL SOCIAL WELFARE POLICY OF SWAZILAND 1995. Mbabane: Government Printer.

NDLANGAMANDLA, N 2009a: *BoGogo* used in political campaigns. Swazi Observer, 17th July, Page 9.

NDLANGAMANDLA N 2009b: "We have no new cases of cholera so far". Swazi-Observer 6th July, Page 6.

NDLELA, M 2008: E6.2m armed robbery. Times of Swaziland, 15th October, Page 2.
NDLOVU, H 2009: Granny (65) stabbed to death. Swazi Observer, 6th July, Page 2.

NDLOVU, SSB 2008: The impact of HIV/AIDS in the economy of Swaziland. Unpublished Undergraduate Thesis. Faculty of Agriculture: University of Swaziland.

NDLOVU, FJ 1999: Street children in selected urban areas of Swaziland, Manzini and Mbabane. Unpublished Undergraduate Thesis. Faculty of Agriculture: University of Swaziland.

NGOTIAMA, Z 2003: Adult education and poverty alleviation in Swaziland in KANDUZA AM and DUPONT-MKHONZA S (Eds) Poverty in Swaziland: Historical and Contemporary forms. Matsapha: Blue Moon.

NGWISHA JK 2003: The concept of poverty: Its analysis and application to Swaziland in KANDUZA AM and DUPONT-MKHONZA S (Eds) Poverty in Swaziland: Historical and Contemporary forms. Matsapha: Blue Moon.

NHLABATSI, VS 2004: The impact of health education on diabetic patients, A case of the Mankayane Government Hospital. Unpublished Undergraduate Thesis. Faculty of Health Sciences: University of Swaziland.

NHLEKO, M 2009: Elderly people demand social grants increase. Times of Swaziland, 19th February, Page 12.

NHLEKO, M 2007: Man beats own mother to death. The Times of Swaziland, 20th April, Page 4.

NKAMBULE, R 2007: HIV/AIDS-related knowledge, attitudes and behaviour in Swaziland Demographic and Health Survey. Mbabane: Central Statistics Office.

NORUSHE, TF 2005: A programme to care for children orphaned by AIDS. Unpublished PhD Thesis. Faculty of Health Sciences: Nelson Mandela Metropolitan University.

NUNN, PE 2002: Health perceptions and parenting stressors of parenting
African-American grandparents. Viewed 21 July 2008 from, http://www.highbeam.com/doc/1G193610981.html

NOUMBISSI, A 2004: Poverty among the elderly in South Africa. African Conference on aging. 18th – 20 August 2004, Johannesburg Organized by UAPS, Department of Social Development and HSRCC.

NTOZI, PJM 2002 Impact of HIV and AIDS on fertility in Sub-Saharan Africa. Fourth meeting of the follow-up committee on the implementation of the DND and the ICPD PA YAONDE, Cameroon 28 – 31 January 2002. Viewed 13.10.2008 from, http://www.uneca.org/eca_resiurces/major_eca_website/icpd/fourth/fc4-05.%20doc%20impact%20hiv%20%fertility.html.%20Introduction

OREM, DE 2001: Nursing, Concepts of practice 6th edn. St. Louis: Mosby.

ORNSTEIN, AC and HUNKINS, F 1993: Curriculum foundations, principles and theories 2nd edn. Boston: Allyn Bacon.

OXFORD LEARNER'S DICTIONARY 2000 6TH edn London, Oxford University Press

PERA, SA and Van TONDER S (Eds) 2004: Ethics in nursing practice. Cape Town: Juta.

POINDEXTER, C 2001: "I'm still blessed, The assets and needs of HIV-affected caregivers over 50. Viewed 14 May 2007. http://www.highbeam.com/library/doc3/asp?ctrllinfo=Round7%3AP

POEDJASTOETI, S 2007: Other proximate determinants of fertility in Swaziland Demographic and Health Survey. Mbabane: Central Statistics Office.

POLIT, DF and BECK, CT 2004: Nursing research, Principles and methods 7th edn. Philadelphia: Lippincott, Williams and Wilkins.

POPULATION and HOUSING CENSUS BROCHURE 2007. Mbabane: Central Statistics Office.
POPULATION COUNCIL, 2006: Aging Surviving catastrophe, The elderly in Cambodia. Viewed 13 June 2008 from, http://www.popcouncil.org/publications/popbriefs/pb12(1)_3.html

POTTER P and PERRY, AG 2003: Basic nursing, Essentials for practice **5**h edn. St. Louis, CV Mosby.

RANDOM HOUSE WEBSTERS DICTIONARY 1993. New YorkRandom House Inc.

RANKIN, SH and STALLINGS, KD 2001: Patient education: Principles and practice 4th edn. Philadelphia: Lippincott.

RICHARDS, L 2006: Handling qualitative data, A practical guide. London, Sage publications.

RITCHTIE, J and LEWIS, J (Eds) 2003: Qualitative research practice, A guide for social science students and researchers. London: Sage Publications.

ROE KM and MINKLER, M 1998/99: Grandparents raising grandchildren: Challenges and responses. *Generations (online)* Viewed 26 June 2003 from, http://search.globalepnet.com/direct.asp?tb=1&_ug=dbs+0%2C8%2C9%210+1n_en%2Dus+AS13DE82%2D398%

ROSENDAHL CB 1999: Textbook of basic nursing 7th edn. St. Louis: Lippincott.

RUBIN, HJ and RUBIN, IS 2005: Qualitative interviews, The art of hearing data 2nd edn. London: Sage Publications.

SCHAFERSMAN, SD 1991 An introduction to critical thinking. Viewed 23.08.2009 from http://www.freeinquiry.com/critical-thinking.html

SCHENK, K and ESU-WILLIAMS, E 2005: The elderly as HIV/AIDS caregivers, An assessment of the burden of HIV/AIDS caregivers on the elderly in the Eastern Cape Province of South Africa. Viewed 16 June 2008 from, http://www.popcouncil.org/Horisons/projects/SouthAfrica_ElderlyCaregivers.htm

SEBASTIAN, JG 2008: Violence and human abuse in STANHOPE, M and LANCASTER, J Community and public health nursing 6th edn. St. Louis: Mosby.

SHONGWE, NT 2000: Quality assurance, An evaluation of the quality of nursing in Swaziland. Unpublished Doctoral Thesis, University of South Africa.

SIHLONGONYANE, P 2003: Late Majahebutimba's family broke. Swazi News, 12th July, Page1.

SILVERMAN D 2001: Interpreting qualitative data, Methods for analyzing, talk, text and interaction 2nd edn. London: Sage Publications.

SILVERMAN D 2000: Doing qualitative research: a practical

handbook. London: Sage Publications.

SIMELANE, T 2008a: Grief as *boGogo* grant gets stolen, The elderly demand to government, "We want our money say *boGogo*". Swazi Observer, 15th October, Page 9.

SIMELANE, T 2008b: Bizarre armed robbery inside police station. Swazi Observer, 15th October, Page 3.

SIMELANE. PS 2004: Child-headed households, Experiences of the children. Unpublished Undergraduate Thesis. Faculty of Health Sciences, University of Swaziland.

SIMELANE HS, MAGONGO, SC and KUNENE, T 2003: HIV/AIDS in the Umbutfo Swaziland Defence force in RUPLYA, M. (Ed) 2004 Battle within HIV and AIDS. Pretorai: Institute for Security studies.

SINGH, V 2008: Elderly abandoned near bus stand. Hindustan Times, 22nd March. Viewed 23 August 2008 from, http://elder-abuse-spotlight.blogspot.com

SITHOLE, SI 2003: Poverty and raising a child with mental retardation, Experiences of the family in KANDUZA AM and DUPONT-MKONZA, S (Eds) Poverty in Swaziland: Historical and contemporary forms, Matsapha: Blue Moon Printing.

SITHOLE, SI 2000: The lived experiences of first year nursing students while on placement in the clinical laboratory. Unpublished independent research. Faculty of Health Sciences, University of Swaziland.

SITHOLE, SI 1998: The lived experiences of families raising children with Mental retardation. Unpublished Graduate Thesis. Faculty of Education: University of Botswana.

SITHOLE, SI 1993: The perceptions of psychiatric patients about their treatment during and after seclusion. Unpublished undergraduate thesis. Faculty of Education. University of Botswana.

SITHOLE, N 1988: The secret of American success, Africa's greatest hope. Washington DC: Classic Press.

SKOLNIK, R 2007: Today's research on aging, Underweight, undernutrition, and the aging. Viewed 12 May 2008 from, www.prb.org/pdf07/TodaysResearchAging8.pdf

SMELTZER, SC and BARE,B 2004: Brunner and Sudarth's textbook of medical-surgical nursing 10th edn. New York: Lippincott, Williams and Wilkins

SMIT, R 2006: The impact of labor migration on African families in South Africa, Yesterday and today. Viewed 30 January 2008 from, http://www.highbeam.com/doc/1G1-12164627
SPEZIALE, SHJ and CARPENTER, DR 2003: Qualitative research in nursing 2nd edn. Philadelphia: Lippincott, Williams and Wilkins.

STANHOPE, M and LANCASTER, J 2004: Community and public health nursing 6th edn. St. Louis: Mosby.

STRAUSS, A and CORBIN, J 1990: Basics of qualitative research, Grounded theory procedure and techniques. London: Sage Publications.
STUMPF, SE 1993: Socrates to Satre, A history of philosophy. New York: McGeaw-Hill, Inc.

SUKATI, Z 2009: *Gogo* (65) hacked to death for E80. Times of Swaziland, 6th July, Page 4.

SUKATI SS 2008: All for a 'lousy' E100. The Times of Swaziland. 2nd December, Page 2.

SUKATI, CWS, VILAKATI, DL and SITHOLE SI 2002 Factors contributing to poor attendance of classes by the students of the institute of distance education at the University of Swaziland. *BOLESWA Educational Research Journal.* Volume 19, pages 44 - 58.

SUSSILO, MV 2005: Beyond the grave: adolescent parental loss, Letting go and holding on. Viewed 13 May 2008 from, http://ww.highbeam.com./doc/

SUVEDI, M 2005: Introduction to program evaluation. Viewed 16. July 2009 from, . www.ag.ohio_state.edu/-brick/suvedi/2.html

SWANEPOEL, T 1999: Communication in health care delivery in Dennill, K, KING, L and SWANEPOEL, T Aspects of primary health care: Community health care in Southern Africa 2nd edn. Oxford: Oxford University Press.

SWAZILAND BUSINESS YEAR BOOK, 2005: 14th edn. Mbabane: Government Printer.

SWAZILAND GOVERNMENT GAZETTE EXTRAORDINARY 2005. Government Printer.

SWAZILAND REVIEW 2006 Manzini: Swazi Review of Commerce and Industries (Pty) Ltd.

SWAZILAND RURAL, HEALTH INITIATIVE (SRHI) 2000: Community home based care and HIV/AIDS risk reduction program. Matsapha: Jubilee Printing and Publishing.

SWEDISH INSTITUTE 2007: Elderly care in Sweden. Viewed 23 November 2007 from, www.sweden.se

TESCH, R 1990: Qualitative Research: Analysis types and software tools. New York: The Falmer Press.

THE GOVERNMENT OF SWAZILAND and UNCEF CORPORATION 2001 - 2005: Mid-term review 2004. Mbabane: Webster Printers.

THE NATION 2007: An unraveling disaster. Corporate Social Investment Supplement, December Pages 4 - 6.

THE LITTLE OXFORD DICTIONARY 1998. REVISED 7TH edn. Oxford: Oxford University Press.

THE OXFORD ADVANCED LEARNER'S DICTIONARY 2000: Oxford, Oxford University Press.

THE SATURDAY STAR (SOUTH AFRICA) 2007: Abandoned by their own children. Viewed 23 August 2008. http://elder-abuse-spotlight.blogspot.com

THE SUNDAY TELEGRAPH 2007: Indians dump elderly on the flaming scrap heap. Viewed 26 July 2008 from, http://www.highbeam.com/doc/1P2-8957567.html

THOMAS, EA 2007: Rural place experience and women's health in grandmother-mothering. Unpublished Doctoral Thesis. University of Arizona.

THWALA, SBP 2009 Understanding the values and beliefs of rural Swazi women regarding their birth practices in the northern Hhohho region of Swaziland. Unpublished Graduate Thesis. Health Sciences, RMIT University, Australia.

THWALA, SBP 2004: The experiences of orphans whose parents have died due to HIV and AIDS-related conditions in the Msunduza peri-urban area. Unpublished Undergraduate Thesis. Faculty of Health Sciences: University of Swaziland.

TIMES OF INDIA 2008: Elderly neglect and abandonment: Senior citizens suffer in silence in Goa. Viewed 23 August 2008 from, http://elder-abuse-spotlight.blogspot.com

TSABEDZE, L 2008: *Madala* weds sweet little thing as 3rd wife. Swazi News, 1st November, Page 7.

UMCHUMANISIS LINK ACTION RESEARCH NETWORK(ULARN) 2003: Social protection of The Elderly In Swaziland. Viewed 10 October 2007 from, http://www.sarpn.org.za/documents/dooo1193/P1325CANGO_elderly-report_oct2003.pdf

UNAIDS SWAZILAND and NERCHA 2008: Monitoring the declaration of Commitment on HIV/AIDS (UNGASS), Swaziland Report January.

UNAIDS 2004: Report on the global AIDS epidemic.

UNDP SWAZILAND 2008: Swaziland human development report: HIV & AIDS and culture. Mbabane: Webster Printers.

UNICEF SWAZILAND 2006: Annual report.

UNICEF SWAZILAND 2006 – 2010: National Plan of Action for Orphans. And Vulnerable children. Swaziland. Mbabane: Government Printer.

UNIVERSAL DECLARATION OF HUMAN RIGHTS 1948 – 1998. Viewed 07 April 2008 from, http://www.un.org/Overview/rights.html

UYS, L and CAMERON, S 2003: Home-based HIV/AIDS care.Cape Town, Oxford University Press.

UYS, HHM and BASSON, AA 2000: Research methodology for nursing. Cape Town: Kagiso Tertiary.

Van DYK, A 2005 HIV/AIDS care and counseling, a multidisciplinary approach 3rd edn. Cape Town: Pearson Education.

VELKOFF, VA. and KOWAL, PR 2007: Population Aging in sub-Saharan Africa Demographic dimensions. Washington: US Government Printing Office.

VENTER I 2004: A screening instrument for mental illness in black patients in primary health care settings. Unpublished Doctoral Thesis. Faculty of Health Sciences: University of the Free State.

VILAKATI, F 2009: Elderly grant money spent on cops, transport. Swazi Observer 19th February Page 9.

VILAKATI, F 2008: Starving *Gogo* does not want to live anymore. Swazi Observer. 27th November. Page 5.

VILAKATI, JN 2003: Revisiting divine providence in a monetary economy KANDUZA AM and DUPONT MKHONZA, S (Eds)

Poverty in Swaziland: Historical and contemporary forms, Matsapha, Blue Moon Printing.

VOA NEWS 2007: Urbanization weakens traditional family care for elderly in Ghana Viewed 26 July 2008 from, http://www.highbeam.com/doc/1P3-1219774871.html

WEBER, JA 2001 From grandparent to caregiver: The stress and satisfaction of raising grandchildren. Familiesin Society: Journal of Contemporary Human Service{online]. Viewed on 17 October 2004 from http://highbeam.comlibrary/doc3.3asp?ctrlinfo=Round9%3AP

WESTER'S DICTIONARY

WILLIAMS, WH 2005: Nutrition for health, fitness and sport. New York: McGraw-Hill.

WHITESIDE, A, NGCOBO, N, TOMLINSON, J and HICKEY, A 2003: What is driving the HIV/AIDS epidemic in Swaziland? And what more can we do about it? Unpublished Research report at National Emergency Response Committee on HIV/AIDS (NERCHA), Mbabane.

WHITLEY, D. KELLY, S. J. and SIPE, T. A. 2001: Grandparents raising grandchildren: Are they at Increased health risks? Accessed on 05.05.2006. http://highbeam.com/doc/IgI-75453649.html

WOMEN AND LAW IN SOUTHERN AFRICA 1998: Family in transition, The experiences of Swaziland. Manzini: Ruswanda Publishing Bureau.

WOMEN IN DEVELOPMENT SOUTHERN AFRICA AWARENESS, 2000: Beyond inequalities Women in Southern Africa. Harare: Cannon Press.

WORLD BANK, 2000: Global poverty trends: Populations living on less than one US$1 a day and less than US$2 a day. New York, World Bank.

WORLD HEALTH ORGANIZATION, 1988: The challenges of implementation. District health services for primary health care. Geneva: WHO.

WRIGHT, LM and LEAHEY, M 2000: Nurses and families, A guide for family assessment and intervention 3 rd edn. Philadelphia: FA Davis Company.

ZIMMERMAN, B 2005: Orphan living situations in Malawi: A comparison of orphanages and foster homes. Viewed 20 April

2007 from, http://www.highbeam.com/DocPrint.aspx?Dolcd=1G1:140305

ZWANE A 2007: Orphans and vulnerable children in Swaziland Demographic and Health Survey. Mbabane: Central Statistics Office.

ZWANE, TM 2003: Poverty and food shortage in Swaziland in KANDUZA AM and DUPONT-MKHONZA S (Eds). Poverty in Swaziland: Historical and Contemporary forms. Matsapha: Blue Moon.

9. APPENDICES

9.1 APPENDIX A

Approval To Conduct Study By The Ethics Committee

(Faculty Of Health Sciences, University Of The Free State)

UNIVERSITEIT VAN DIE VRYSTAAT
UNIVERSITY OF THE FREE STATE
YUNIVESITHI YA FREISTATA

Direkteur: Fakulteitsadministrasie / Director: Faculty Administration
Fakulteit Gesondheidswetenskappe / Faculty of Health Sciences

Research Division
Internal Post Box G40
☎(051) 4052812
Fax nr (051) 4444359

E-mail address: gndkhs.md@mail.uovs.ac.za

Ms H Strauss

2006-07-26

MS SI SITHOLE-BARROW
P O BOX 2736
MBABANE
SWAZILAND

Dear Ms Sithole-Barrow

ETOVS NR 112/06
RESEARCHER: MS SI SITHOLE-BARROW
PROJECT TITLE: THE LIVED EXPERIENCES OF RAISING AIDS-ORPHANED GRANDCHILDREN BY RURAL-BASED SWAZI GRAND-PARENTS.

You are hereby kindly informed that the Ethics Committee approved the above-mentioned study at their meeting held on 25 July 2006.

Your attention is kindly drawn to the following:

- A progress/final report have to be submitted after completion of the study or within a year after approval of the project
- That all extentions, amendments, serious adverse events, termination of a study etc have to be reported to the Ethics Committee

Will you please quote the Etovs number as indicated above in subsequent correspondence to the secretariat.

Yours faithfully

DIRECTOR: FACULTY ADMINISTRATION

339, Bloemfontein 9300, ☎ (051) 405 3013, 401 2847, (051) 444 3103, gndklt.md@mail.uovs.ac.za
Republiek van Suid-Afrika, Republic of South Africa

9.2 APPENDIX B

Researcher's Letter Of Request To The Ministry Of Health And Social Welfare In The Kingdom of In Swaziland

To Conduct The Study

Faculty of Health Sciences
PO Box 369
Mbabane

6th June 2006

Research Unit
C/o Ministry of Health & Social Welfare
PO Box 5
Mbabane

Dear Sir/Madam,

RE: REQUEST FOR PERMISSION TO CONDUCT RESEARCH

TITLE: **THE LIVED EXPERIENCES' OF RURAL-BASED GRANDPARENTS RAISING GRANDCHILDREN ORPHANED THROUGH HIV/AIDS IN THE KINGDOM OF SWAZILAND**

I am a part time doctoral student in nursing and enrolled with the University of the Free State in Bloemfontein (RSA). In fulfillment of the Degree DOCTOR OF PHILOSOPHY, I am expected to conduct research. Thereforthe, the purpose of this letter is to request permission to conduct a study in the Chiefdom of Nkonjwa within the Sithobela inkhundla in the Lubombo region.

As the HIV/AIDS epidemic continues to kill the adult population, it has been observed that the children they leave behind come under the care of grandparents. Studies on the elderly in general, have revealed that older adults have many health challenges because of aging. As yet in Swaziland, no research has investigated the lived experiences of, in particular rural-based grandparents raising orphaned grandchildren, especially in light of their being elderly persons caring for minors. The state of health of the elderly in Swaziland is an area of concern to the researcher.

Primarily, the study seeks to explore and describe the lived experiences of rural-based grandparent raising grandchildren orphaned through HIV/AIDS. Thereafter and based on the central finding, the ultimate purpose is to

formulate a strategy that shall be used to address that central finding from the analyzed data.

The study shall be qualitative, exploratory, descriptive and contextual in design. The data are going to be collected through unstructured individual face-to-face audio-taped in-depth nterviews that shall be conducted in the homesteads of the rural-based grandparents by the researcher herself. All necessary ethical considerations have been taken into account, for example: informed consent, privacy and confidentiality and anonymity. Data collection shall commence as soon as permission is given.

I am enclosing a copy of the proposal that was also submitted and approved by the Ethics Committee at the Faculty of Health Sciences at the University of The Free State in Bloemfontein, Republic of South Africa.

I will be glad to provide you with any additional or missing information, as deemed.

Looking forward to hearing from you at your earliest convenience.

Yours sincerely,

Sifiso I. Sithole-Barrow (Mrs.)
Student Number 2003077852

9.3 APPENDIX C

Permission From Ministry Of Health And Social Welfare

To Conduct The Study

Telegrams:
Telex:
Telephone: (+268 404 2431)
Fax: (+268 404 2092

MINISTRY OF HEALTH
P.O. BOX 5
MBABANE
SWAZILAND

THE KINGDOM OF SWAZILAND

July 9, 2006

Ms. Sifiso Ivalinda Sithole
Faculty of Health Sciences
P.O.Box 369
MBABANE

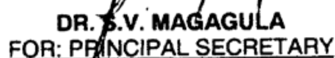
RE: PERMISSION TO CONDUCT A STUDY

Permission is granted to **Ms. SIFISO IVALINDA SITHOLE** to conduct research on the Title: The LIVID EXPERIENCES OF RURAL BASED GRANDPARENTS RAISING HIV/AIDS ORPHANED GRAND CHILDREN IN THE KINGDOM OF SWAZILAND: a Proposed Self-care Health Education Programme.

The direct benefit of the study is that community health nurses shall be able to integrate this programme empowering these grand parents with self-care.

We look forward to a copy of the report.

Yours faithfully,



DR. S.V. MAGAGULA
FOR: PRINCIPAL SECRETARY

9.4 APPENDIX D

Informed Consent

THE 'LIVED EXPERIENCES' OF RURAL-BASED GRANDPARENTS RAISING GRANDCHILDREN ORPHANED THROUGH HIV/AIDS IN THE KINGDOM OF SWAZILAND.

INFORMED CONSENT

Dear Participant,

RE: PARTICIPATING IN THE STUDY

I am Mrs Sifiso Sithole-Barrow and am a nurse educator at the Mbabane Campus. I am currently studying for my doctoral degree with the University of the Free State in South Africa and am required to carry out research.

I have chosen to investigate the day-to-day life experiences of people like you who are looking after grandchildren whose parents have passed on because of AIDS-related illnesses. I wish to understand more from you what/how it is like to care for such children from your own perspective. After analyzing what you will have tolld me and also what I will have observed, the intention of this study is to come up with a waty that shall help to address that central finding.

Thank you very much for showing willingness to take part in the study. At this point, I wish to share with you the following information:

- Your choice to take part in this study is purely voluntary. You are not forced at all.

- Should you initially decide to take part in this study and then change your mind, during the process and want to withdraw, your decision shall be respected by the researcher and you will not be made to suffer in any way.

- You will not receive any money for taking part in the study. Your participation is being done on voluntary basis. This research shall contribute in other ways that may not yield direct benefits to you yet.

- I will come to your home on the agreed day and time, sit down with you and ask you two questions for which you are expected to provide answers according to how those experiences shall have been lived by you. The duration of our conversation will depend on how much information you shall be sharing with me. It is only you and I that shall be having this conversation and no one else listening. We shall be speaking in siSwati. Since what you will be sharing with me is going to be a lot for me to remember and also I shall be listening to other grandparents; stories, I shall not remember what you said. Therefore, with your permission I shall request to use a tape recorder to collect all what you say. I can only use this machine if you give me permission to do so. I will first demonstrate to you how it works and then you shall also do what I will have done. Once the purpose of the study is achieved, I will destroy all the recorded tapes and tear the manuscripts.

- I am afraid that the information you are going to share with me, will need to be shared with others through writing about in my final research report, presenting at nursing conferences and writing articles in journals. However, I will make sure that your name does not appear alongside the information. I will not use your real name. No one will ever know that it was you who said that.

- You might find the study a bit uncomfortable because as you talk to me you might have memories of your deceased children. Should you feel very affected by this after I have gone, please just inform your Rural Health Motivator who will put you in touch with the nurses at Sithobela. It is not intentional to hurt you.

Thank you very much for listening to me. At this point in time, I shall welcome any questions you might have about what I have said.

May you please then indicate your willingness and intention to take part in this study by signing in the space given below.

I have understood the information the researcher has explained to me about this study. I wish to take part in the study.

(i) Name of Rural-based Grandparent:

____

Signature: ____________________

Date: ____________________

(i) Name of Rural Health Motivator:

____

Signature: ____________________

Date: ____________________

(i) Name of Researcher ____________________

Signature: ____________________

Date: ____________________

9.5 APPENDIX E

The Unstructured Data Collection Instrument

THE LIVED EXPERIENCES OF RURAL-BASED GRANDPARENTS RAISING GRANDCHILDREN ORPHANED THROUGH HIV/AIDS IN THE KINGDOM OF SWAZILAND.

DEMOGRAPHIC INFORMATION

Name:

Age:

Marital status:

Source of income:

No of children:

No. of children who died from HIV and AIDS:

No. of people who live in the homestead:

No. of adults:

No of children:

No. of GOTA being looked after:

THE LIVED EXPERIENCES OF THE R-BGs RAISING GOTHA IN THE LOWVELD

Question 1:

"Ngicela ungichazele kabanti kutsi engabe kunjani kunakekela batukulu bako labashiywa batali babo" ['Kindly describe for me what/how it is like caring for your AIDS-orphaned grandchildren?"] and

Question 2:

"Ukhona njani kumelana netidzingo tonke telabatukulu bako?" ["How do you manage to look after your AIDS-orphaned grandchildren?")

9.6 APPENDIX F

Specimen Of Main Study Interview With Grandmother G – Participant #7

MAIN STUDY INTERVIEW

THE 'LIVED EXPERIENCES' OF RURAL-BASED GRANDPARENTS RAISING GRANDCHILDREN ORPHANED THROUGH HIV/AIDS IN THE KINGDOM OF SWAZILAND.

RURAL-BASED GRANDMOTHER G – PARTICIPANT No. #7

Demographic information

Name: Grandmother G (G-G)

Age: 76 years

Marital status: widow

Source of income: *imbasha yalabadzala* (E240 – 00 every three months)

No of children:

No. of children who died from HIV and AIDS: all 4 sons

No. of people who live in the homestead: 10

No. of adults: 2

No of children: 8

No. of GOTA being looked after: 7 (3 through 17 years)

Key: Researcher = R; Grandmother G = G-G

R: Thank you very much Grandmother G for accepting to be interviewed. There are two questions and I am going to ask you, I will start with the first question now. It reads thus: "***Ngicela ungichazele kabanti kutsi engabe kunjani kunakelela batuku bako labashiywa batali babo."*** ("Kindly describe for me how/what it is like caring for your grandchild whose parents passed on.")

G-G: Oh my child, I do have grandchildren, my girl, here at home, as you see me the way I am [using a walking stick because of a nasty bout of arthritis]. I have grandchildren who were left behind by three sons I lost. They left me with their small children. Providing their food is a challenge for me. Usually when the fields had been ploughed, I would walk around with a hoe in order to weed in other people's fields and then return home with some bit of grains of maize that I ground, prepared and offered to my [grandchildren. This year, however my child, this year, since people have not ploughed or done anything to their fields, I just don't know what I am going to do with them, what will I give them to eat since no ploughing has taken

place this year. Everything is at a standstill! This is what is worrying me a lot because I used to feed them by going to work for people in the community. This year, where will I go? This year, my child, people are saying that we must prepare the ***maganu*** fruit and then go and sell it. As you can see my girl as you came, I was busy preparing the fruit. I am doing it in order to feed us so that the good people out there can give me a few coins so that I can then in turn go and buy some food for the orphans with whom I live and feed. That is it my child, I am doing it for them as you can see me doing this.

G-G: (continues) God is very kind, as He, my child, has given me healthy grandchildren who do not suffer from any illnesses. There is no illness that has bothered me with the orphans as you can see for yourself they are running around the homestead. I have not even needed to take them to the hospital for any reason. The only person who has given me problems is their mother. I have had to escort her to the hospital a few times. The children are healthy, my child.

G-G: (continues) … Oh yeah, my child, that is how I survive here at home. I survive through picking leaves from the trees and then prepare them and let them [grandchildren] eat and before I know they move away from me and start to play around in the yard. That is basically how I feed them. There is no other way I look after them. I look after them through doing small jobs in other people's homes and in return some good persons give me whatever they can afford to give me and I go back and cook for them. ***Uhm uhm*** my child, that is how I feed them.

R: … nods

G-G: (continues) I have many problems and it looks like it is these problems that will kill me sooner than later…and leave these children of mine alone… I keep thinking that for how long will I keep on living like this? Oh, you see my girl, this will cause me suffer from what they call stroke and leave these orphans alone. I don't know how God can assist me to persevere and not think too much … and yet again one cannot help thinking. Thinking stems from the problems and then I think a lot … in my heart I cry tears and wonder why God left me with all these children. Their grandfather left me with these children. We saw our sons passing on with the grandfather (Grandmother G's husband). We used to feed them together. He used to go and produce fibres from sisal and make ropes out of it and I would get out too and go to people's homesteads and weed their fields. We made joint efforts in feeding them. Then their grandfather passed away, I am left alone. That is what is in my heart my child. But then I really don't know who will help me feed these children of mine. And even if this person exists, she/he will ask from where do they know me? Oh my Lord. I always pray and say "Jesus my Saviour for as long as other people are still eating I will not die. Maybe God will provide someone to feed me. That is how I live my child. That is what is in my heart as you see me here. (Grandmother … looking quite low in spirit and voice becoming smaller).
(then long silence)

R: How many are at school?
G-G Children who are schooling?

R: Yes, Grandmother.
G-G: They are four, ***uhm uhm*** they are four.

R: Who pays their school fees?
G-G: For these children?

R: Yes, Grandmother.
G-G: These two (illustrating with her fingers using both hands) … these three have been enrolled in the school programme [for orphans and other vulnerable children (OOVC)] … the teachers have enrolled them in this programme. This other one (pointing at the thumb of the left hand) has stopped. He chose to stop attending school because he was schooling down there at Lavundlamanti. He said that "Grandmother, I am stopping school as there is no one to pay for me since at Lavundlamanti school they want all fees to be paid upfront." I tried to convince him to wait and see and he said "There is no money." He is around and he visits me sometime, he is there I just watch him. He is the only one who is out and yet he was schooling down there. Then remained little _____ (name withheld) who kept weeping on me saying "Grandmother, I like going to school." "I said to her what can I do as you can see that the other one is out of school" "Grandmother, you mean to say I will leave school just like that and come and sit around here at home? I do like school." She also left and went to Lavudlamanti where they had gone to receive food donations and upon returning home, I asked "What will I do with you guys?" I asked the mother to go and ask for assistance in one school near here and found out that they were only giving food rations. Otherwise five children were at school and the sixth one finished and is now looking for a job.

G-G: (continues) I am praying that my children get education so that when it is time for me to pass on, they will be matured and can fend for themselves so that they do not get beaten by people when they walk from one homestead

to another because of hunger. Well, when there is no one to fend for them they will beat them up. What will they eat because I know how to get to people's homesteads and ask for food? Also I select and pick up leaves from trees and bring them home and prepare for them to eat. That is what I am crying for, my child, that I leave behind as much as one who is matured or even has secured a job and feeding the other. Then I die. For sure if I were to die now and leave them like this, my ghost will return because I will not be able to see anything no matter how much of a Christian I am. When I die, I will have a strong urge to look behind as if I can still see them and yet that will lead me astray. ***Eeh,*** …

G-G: (continues) Otherwise, I am still quite well. I am still in reasonable health, though what will soon be painful is that my eyes do not see very well. They are somewhat dusty. I do not understand what they are up to. When I look at things, those things are not clear. This one [pointing at right eye] is cloudy, in the morning. The objects seem very dark and then they improve gradually as the day passes. They are like that my eyes. It is painful not having any money at all because I missed the opportunity of being seen and treated in Mbabane by foreign eye doctors who were operating on people for free. I was very hurt. Only if I had the money, maybe I would also be feeling better and then be in a better position to look after my children. I can see that these eyes will play havoc on me. How will these children be able to look after and feed me? ***Uhm,*** I had to forget about it [missing the opportunity to have eyes seen by doctors] my child.
(some brief silence)

G-G: (continues) And these knees of mine, my child, they are also problematic.
(Grandmother pauses a few seconds)

R: They are giving you problems ….?
G-G: **Uhm**. They have been giving me problems. This one (pointing at the right knee) is slightly better. This one (pointing at the left one) does not want to get better, ***uhm uhm***.

R: How are they giving you problems? Please elaborate.
G-G: It feels like the structures behind here (pointing to back of both knees) are being pulled on. I don't know … this one when I stretch my legs for a long period of time, the structure does not firm up and when I bend it, I feel some pain … I can feel that it is progressing. But this one (right knee) has recovered. It is the left one that is still problematic.

R: Let me continue and ask you the second question, grandmother: ***"Ukhona njani kumelana netidzingo tonke tabo batu bako labashiywa batali babo?"*** ("How do you manage to cope with looking after your grandchildren who have been orphaned trhooough AIDS?")
G-G: It is like I do manage to cope my child, and yet again I cannot manage to cope. Well, I can somewhat manage because these orphaned children, when you have them in your home what else do you do with them my child because caring for them entails providing food for them to eat.
When it comes to clothing, they are going to be affected since the cold is coming … ***haa*** they are really going to suffer because I cannot provide clothes for them. With regards to food, I go searching for it everywhere and that is how they manage to eat. But when it comes to clothing,

there is nothing they can put on to cover their bodies. That is what bothers me that my children will be white from the cold winds.
(Long pause)

R: Is there anything else that has been left out, grandmother?
G-G: Something I can talk about?
(Grandmother's non-verbal cues hinting that she wants to talk)

R: Yes it looks like there is.
G-G: (continues) It is the issue of food, my child. The issue of food, as you can see the state of the country [meaning the drought], I don't know, my mind is all boggled up since I do not know how I am going to survive with my children. That is what is giving me the greatest challenge. (emphasizing) Feeding them, feeding them, my Lord what will I do for them? As I sit here right now, whatever edibles I have managed to secure, I cook it in the mornings and they also eat the same food in the evening while I apply an abdominal binder (***kubopha sisu***) to myself. It pleases me to see them eat. However, in the meantime, I am starving to death. That is all, (***indlala, indlala)*** hunger, hunger that I don't know what I will do with it.

Children of my mother (***bantfwana ba make***), I just don't know toward what direction I should turn to [in search for food]. That is what is giving me the hardest of times. Even when I am well in my heart, and I think and look at them, oh today they are running around like this because I went out to the homestead of so and so and they donated what they too could. Tomorrow they need to run around again, what will I give them tomorrow? The good people around here

are also tired of me, my child, (they say) ***ha ha*** we wonder how they survive because you know people talk nicely in front of you [in your presence] and then behind your back, they say we have had enough of this woman, even when they know I have nothing else. Is there one homestead with a son who is still alive to whom I can say that we are hungry? There is no such!!! We are sitting alone here as you see us here. We are complete. There is nowhere I can go to [to ask for assistance]. Even in my [natal] home, the situation is equally bad. I often wonder when people around say I should seek assistance from home and yet there is nothing there. My home of birth has ceased to be. My brother died, my sister-in-law died, my mother died, and that was the end, Oh yes, that was the end! Oh yes that was the end! The little ones, the children who were left behind and the young sister-in-laws, they just look upon me as an elderly auntie in the family. I ask them, "My brother's children, what are you feeding on?" They say that they too are hungry. What really can I do for them as the sisters-in-law are widows just like me. There is nothing I can do for them. Usually, one should be able to ask for assistance from one's mother or the natal home or one's sister-in-law. My Lord, not someone like me, ***mntsch***! There is **n-o-t-h-i-n-g!** Whenever I see anyone who can make me happy (assist through providing food) I feel like that person has taken the place of my mother and father since when that person gives me something, I cook for the orphans. I am only requesting that I be able to well enough to go around the people begging for food even though they say (as a widow in mourning) you cannot tie up food donations using mourning garments, I then ask for a piece of paper and they give me and I am able to carry food back to my children, my child. I have no past, I have no future I am complete as you see me here! Also, as you are here you could have seen me

sitting with others who are visiting, you will always find me here, together with my daughter-in-law who is not very well and nearly died on me. She says that I am holding her back because people would be very surprised if she now left [and returned to her natal home] because of the death of her husband (grandmother's son). What excuse will I give for leaving the homestead? I am the reason why she has remained behind, otherwise, she would long have taken her children and gone away. She said she will not go anywhere but will remain and die here. Oh I thank the Lord for giving me this child (daughter-in-law), people [daughters-in-law] run away. She does not want another husband. She does not want anyone. She is used to being poverty-stricken. She reported to me that a good Samaritan at church had given her a dress for which I am grateful for her sake.
(sudden pause)

R: Thank you Grandmother.
G-G: (continues) Hey, hunger, this our hunger, this our hunger, ***hah*** … and the state of being poverty stricken with my children who will suffer in the coming cold weather until they turn white and the people will laugh at them. Those who still have husbands to buy them clothes … they will laugh … they will laugh their lungs out when they see my children putting on … ***eeh*** … With what [money] will I dress them? They will turn white from sitting around the fire in order to keep warm. I cannot even afford a candle, I cannot afford even matches, ***haa yee***!!! To be so needy!! I cannot afford even a simple candle … (a big sigh). I try to crash the ***maganu*** fruit so that when the buyers buy from me I can also buy a candle and also matches. When they buy and I get 50 Emalangeni (Rand), Oh where else would I get it from?

(Silence again)

R: Grandmother, is there still anything more you wish to say concerning caring for your GOTA or how you are managing to cope with providing them with their needs.

G-G: That is basically what I encounter, my child. It is not having enough food, It is not having clothes and it is their not attending school … I really don't know what I am going to do since I was counting on [financial] assistance that was there at school. They were learning. With help from good people of the community who donated food to me, I knew that my children who were in school, they will come back in the evening and find that there was ready prepared food. But now, it pains me a lot that my children will not be attending school like other children. They will be side tracked and start stealing from within the community. That really makes me feel sad, my girl. And hunger too is making me miserable because I wonder how I am going to feed such a big family. As you can see for yourself, right now they are playing because they have full stomachs. A child does not play when he/she is hungry, my child. He/she sits close to you and when you command him/her "Go and play". He/She replies "I am hungry granny." Oh right now, they are like Kings, they are playing away, their bellies are full. That is what is in my heart and troubling me very much. And also,, this good person (meaning the sickly daughter-in-law) whom I don't know how she is health wise. I really don't know what to do with her. If only I had the [financial] means I would send her to hospital so that they can examine her and see how she really is.

R: Is there anything in particular that you think might be causing her to be unwell?

G-G: I am just aware of/worried about her coughing … because these days they give us through radios a lot of health-related education that malaria does not fully show its manifestations if the blood is hot. I think she needs to go and have a check up even if I cannot see anything with my naked eye. It is her first time to fall sick ever since her husband died so I said "Go and be examined my child, and see what has entered your body because all along you have been well." That is what is worrying me,because they say once the body gets hot, the immune system is re-activated. "Go to hospital as they will attend to you and you can be around to see the young ones grow up. When the time comes for Satan to do his tricks [kill you], you will know that the orphans have grown.

G-G: Thank you very much, my child, for visiting me and don't get tired, please, of coming to check on me, the orphan that I am. When their grandfather was still alive, we never went hungry, my child, Their grandfather used to occupy himself with removing fibres from sisal and make rope that he sold and then bought all the needs that I have already mentioned. He would bring home food and we ate. He never slept [he was a hard worker]. He used to cut down trees for people who requested him to do so and he brought home money. We were never hungry. He worked hard for his family and unfortunately he passed on and we remained like this, ***uhm*** We never went hungry. He also tilled land using people's livestock and they would then pay him whatever little they could, but now, there is nothing … ***haa uhm***

G-G: (continues) And these grandchildren, I started looking after them when they were very small. ***Eeh*** … this double orphan (no mother, no father), was so small that she hardly noticed that her mother had passed on. These others, I also

took them on when they were still small but now they have grown and it is because of my land tilling efforts in order to feed them. (With a smile on her face) Oh My God, my children are growing. I am pleased, ***uhm uhm*** my child. They make me happy, particularly, with regards to their health. They are not sickly children. Occasionally, when they have slightly elevated body temperature, I usually administer them water and soap enema, and they recover fast. None of all the orphans have given me any serious health problems. Here comes the double orphan (pointing at the oldest A-OG). The clothes he is wearing, were given to him by another child. I just saw him coming home wearing it. "Who gave you the shirt?" "I have been given by Mfana." That is how we survive. That is what is in my heart [to tell you], my child. I was happy when she (the rural health motivator) informed me that there is sister [nurse] who will be coming here. I asked her [rural health motivator] how she thought you could be of help to us here.(suddenly remembering something)

G-G: Another thing I have not mentioned that also helps in addition to weeding people's fields is the old age grant that we receive. When I receive it, my child, I go and buy food to add to what I get from my own fields and I feel good. But for now, it has delayed and we are so hungry (it started drizzling and we moved into grandmothers sleeping room). We don't know when we are going to receive it next time. That is it my child. I do receive old age grant for the elderly. They made us old people take PIN (personal identity number) so that we could get it. Even if it is ten cents only, for a person like me who does not work, where was I going to get it? Can that money be picked up from the ground? I thank God for what government is giving us. ***Eeh***, even though I hear others complaining, I am not because

from where was I going to get it. What the children [social welfare personnel] of God are giving me is a lot … I don't buy clothes but I buy for the orphans.

R: When you say you buy for the orphans, what do you buy?

G-G: I buy packets of mealie-meal … and from another good person I buy a bucketful of maize and it costs 50 Emalangeni (equivalent of Rands) and I come back and eat with my children, ***uhm uhm***. There is no business I run, I am just seated.

R: How about relish?
G-G: Relish! What type of relish do you mean? Don't talk about relish. There is no such thing since the sun has been very hot. There is nothing. Before, we were like kings and walked on people's fields picking up ***ligusha*** (Corchorius olitorus) leaves that we used as relish. Do you think you can afford real relish here? ***Mntsch***! There is no such, they just eat with ***ligusha*** unless I go to someone and buy tomatoes from those who grow them and then my children get relish. That is how I feed them. When I get mealie-meal I also buy tomatoes in the stores, cook for them and they eat and sleep on full stomachs. That is my battle in looking after the double orphans with whom I live. When they have eaten ***palish*** and tomatoes, they go to bed very contented such that they become so talkative and narrate too many stories to me such that I have to instruct them to stop talking and go to sleep, as we will be tired. In my heart, I question myself because when they are hungry I am deeply troubled, especially as I am in mourning like this, ***ha***a.
(At this point G-G was looking uneasy as if troubled)
Researcher then decided to end the interview.
R: Thank you so much grandmother G-G. Thank you

END OF INTERVIEW

9.7 APPENDIX G

Teaching-learning Workshop Programme

Schedule For

Community Health Nurses In The Lowveld

WORKSHOP OVERVIEW

In order to effectively implement the proposed health education programme to empower with self-care R-BGs raising GOTHA in the lowveld, there is need for all CHNs who are deployed in health facilities in that region to undergo a workshop that shall equip them with the necessary and relevant knowledge, attitudes and skills for teaching the rural-based grandparents. .

Workshop particulars and sponsorship

Organizers of workshop: : Ministry of Health and Social Welfare in collaboration with

the Unversity of Swaziland, UNISWA

Co-ordinators : Ms SI Sithole and Dr. EM Mabuza

Facilitators : Invited Specialists in Gerontology and Geriatrics.

: Nursing lecturesr at the Faculty of Health Sciences,

University of Swaziland.

: Nursing lecturers at the Nazarene College of Nursing

Special Guest Speakers : Swaziland Action Group against abuse (SWAGAA),

: UmtfuntiwemaSwati, Women and the Law Southern Africa

Participants : Community health nurses in the lowveld.

No. of workshops : 2 (August and September 2010)

Duration : 9 days for each workshop

Type of workshop :Residential

Venue : UNISWA at Sithobela Rural Health Centre

Workshop shall cover both theoretical and clinical objectives.

At the end of the workshop successful candidates shall receive crtifictes of erit.

THEORETICAL COMPONENT

DAY 1 Monday

Early morning session: 07.30hrs – 10.00hrs

Presenter	Events
Opening	
Ms SKS Masuku	Registration
Reverend M. Zwane	Opening Prayer
Ms SI Sithole	Self-introduction
Ms SI Sithole	Workshop objectives
Chief Nursing Officer	Opening ceremony

Mid Morning Session: 10.30hrs – 13.00hrs

Presenter	Topics
Invited Specialist team in Gerontology/Geriatrics	• Adulthood • Population Aging • The Place Of Gerontology and Geriatrics • Attitudes towards the e;derly

Afternoon Sessions: 14. 00hrs - 16.00 hrs

Presenter	*Topics*

Invited Specialist team in Gerontology/Geriatrics	• Conceptualization About Adulthood • Myths About Aging

DAY 2 Tuesday

Early Morning Session: 08.00hrs – 10.00hrs

Presenter	Events
Invited Specialist team in Gerontology/Geriatrics	• Theories About Aging • Role Of The CHN In Older Adult Health Promotion • Ethics In Old Adult Nursing

Mid Morning Session: 10.30hrs – 13.00hrs

Presenter	*Topics*
Invited Local Physician Dr. MD Mathunjwa	• Changes In Adulthood (Part 1) • Changes In Adulthood Part (11) • Common Illnesses In Old Adulthood (Part 1)

Afternoon Session: 14.00 – 16.00

Presenter	*Topics*
Local Invited Physician Dr MD Mathunjwa	• Common illness in old adulthood (Part 11) • Implications of old adulthood on learning

DAY 3 Wednesday

Early Morning Session: 08.00hrs – 10.00

Presenter	*Topics*
Mrs. MS Motsa and Dr.. EM Maabuza	• Communication models • Effective communication in old adulthood • Barriers to communication in old adulthood

Mid Morning Afternoon Sessions: 10.30hrs – 13.00hrs

Presenter	*Topics*
Dr EM Mabuza Dr MD Mathunjwa Ms SI Sithole	• Theories and principles of adult learning • Group dynamics • Conducive learning environment for the adult

Afternoon Session: 14.00 – 17.00

Presenter	*Topics*
Ms Motsa Mrs. CZ Vilakati Ms SI Sithole	• Target of adult learning • Culture sensitive approach • Instructional strategies (Part 1)

	• Instructional strategies (Part (11) •

DAY 4 Thursday

Afternoon Session: 14.00 – 17.00

Presenter	*Topics*
Humaras NGO Swagaa Umtfunti wemaSwati	• Rights of the elderly • Elderly abuse • Experiences of elderly abuse

Morning sessions

Presenter	*Topics*
Professor NA Sukati	• Mental Health & the Elderly

Afternoon sessions

Presenter	*Topics*
Ms SI Sithole	• Teaching plan

DAY 5 Friday

Morning and afternoon sessions

Presenter	*Topics*
Participants 1 -16	• Microteaching sessions Class dismiss for weekend break

CLINICAL PRACTICE AT SITHOBELA INKHUNDLA

Days 6,7 and 8 Monday, Tuesday and Wednesday

		Supervisors
<u>Monday AM</u> <u>Group teaching</u> - Participant #1 - Participant #2 - Participant #3 - Participant #4 - Participant #5 - Participant #6	<u>Monday PM</u> <u>Individual teaching</u> - Participant #9 - Participant #10 - Participant #11 - Participant #12 - Participant #13 - Participant #14	Ms SISithole-Barrow Dr EM Mabuza Mrs MS Motsa Ms SKS Masuku

. Participant #7 . Participant # 8	. Participant #15 . Participant #11	
Tuesday AM Group teaching - Participant #1 - Participant #2 - Participant #3 - Participant #4 - Participant #5 . Participant #6	Tuesday PM Individual teaching - Participant # - Participant #8 - Participant #9 - Participant #10 - Participant #11	Ms SISithole-Barrow Dr EM Mabuza Mrs MS Motsa Ms SKS Masuku
Wednesday AM Group teaching - Participant #12 - Participant #13 - Participant #14 - Participant #15 - Participant #16	Wednesday PM Individual teaching - Participant #12 - Participant #13 - Participant #14 - Participant #15 - Participant #16	Ms SISithole-Barrow Dr EM Mabuza Mrs MS Motsa Ms SKS Masuku

Day 9

Presenter	*Topic*
Mrs.MS Motsa Ms SI Sithole Dr EM Mabuza Ms SI Sithole	- Feedback on clinical practice - Post test - Way forward - Post test results feedback
Chief Nursing Officer Registrar Swaziland Nursing Council	*Closing ceremony* - Certification - Official closing Closing Prayer

9.8 APPENDIX H

Specimen of A Teaching Plan

A TEACHING PLAN

This hypothetical teaching plan has been planed for a group of elderly women who attend one Zionist church in Nkonjwa. The CHN approached the parish priest and was allocated time to come and teach elderly women who attend Sundat school at that church. Therefore, the CHN shall be guided by this teaching plan in order to facilitate self care among these rural elderly women.

Title of the teaching	Appropriate diet for someone

plan	with elevated blood pressure (EBP)
Date of lesson	12th November 2009
Time	10.00 - 10.30 AM
Venue	Church of Zion, Nkonjwa, Sithobela
Teaching method	Lecture-discussion
Group details	Sunday school for elderly women aged 60 years and above
Number of learners	10 elderly women
Subject	Elevated blood pressure
Level of education	Mixed (no education – primary school)
Room arrangement	Semi circle sitting arrangement with teacher/CHN in front
Instructional aids	Posters, video-cassette, models, real food items such as vegetables, pictures of various food types.
Evaluation format	Prepared questions • during the lecture-discussion and • at the end of lecture-discussion
Aims of the lesson	The aim of this lesson is to enable the old adult with EBP to plan own healthful meals.
Intended learning objectives	At the end of this session, the old adult learner shall be able to: 1. define EBP. 2. mention 5 contributory factors of EBP.

	3. Identify the 4 food groups that form part of our daily diet. 4. Plan a meal for someone with EBP

TEACHING PLAN, continued - Actual implementing of the lesson

Time	Content & sequence	Teacher activity	Learner activity
3/60 mins	*Define* EBP	• Ask learners. • Say out prepared definition. • Show poster with heart pumping and relaxing.	• Give answer. • Listen to prepared definition. • Look at poster.
7/60 mins	*State* 5 contributory factors toward EBP.	• Show a poster with these factors and ask what they are seeing. • Acknowledge learner efforts by thanking, clapping hands and smiling	• Look and listen to question. Answer question.
7/60 mins	*Identify* the 4 food groups	• Display the various real food specimens, pictures of food and ask learners to identify to which food group they belong.	• Look attentively at the display of food and food pictures. Answer by identifying to which food groups these belong.
9/60 mins	*Plan* a meal suitable for someone with EBP	• Put together a meal containing all 4 food groups by asking the group which foods to combine.	• Listen attentively to the CHN and inform her/him which foods to put into

			plate.
4/60 mins		Evaluate lesson • Ask for summary of lesson from the group	• Listen to questions and answer as deemed.

Appendix I

A Specimen of the Programme Evaluation Instrument

STUDY TITLE: THE LIVED EXPERIENCES OF RURAL-BASED GRANDPARENTS RAISING GRANDCHILDREN ORPHANED THROUGH HIV/AIDS IN THE KINGDOM OF SWAZILAND: A PROPOSED SELF-CARE HEALTH EDUCCATION PROGRAMME

PROGRAMME EVALUATION INSTRUMENT

KEY:

Strongly disagree Disagree No opinion Agree

1 2 3 4

Strongly agree

5

The proposed self-care health education programme rural-based grandparents raising grandchildren orphaned through HIV/AIDS in the lowveld:

1. has an explicit Vision statement.

   1 2 3 4 5

2. has an explicit Mission statement 1

   2 3 4 5

3. has an explicit philosophy. 1

   2 3 4 5

4. identifies the learners. 1

   2 3 4 5

5. is evidence-informed. 1 2 3 4 5

6. identifies the programme implementers. 1 2 3 4 5

7. makes provision for the orientation of the implementers. 1 2 3 4 5

8. takes into account other necessary resources. 1 1 2 3 4 5

9. specifies the goal of the programme. 1 2 3 4 5

10. makes provision for learning objectives. 1 2 3 4 5

11. takes into the three domains of learning. 1 2 3 4 5

12. has made provision for formative evaluation. 1 2 3 4 5

13. has made provision for process evaluation. 1 2 3 4 5

14. has made provision for summative evaluation. 1 2 3 4 5

15. reflects content that is organized from simple to complex. 1 2 3 4 5

16. suggests the venues for teaching. 1 2 3 4 5

17. suggests appropriate teaching strategies. 1 2 3 4 5

18. offers tips on conducive teaching-learning environment. 1 2 3 4 5

19. takes into account gender sensitiveness.

1 2 3 4 5

20. takes into account adult learning principles.

1 2 3 4 5

21. considers the culture of the learners.

1 2 3 4 5

Phase/purpose	**Population: Sampling**	**Sample type**	**Data Collection**	**Data analysis**	**Reasoning strategies**	**Trustworthiness**
Phase One: Sought to explore and describe the lived experiences of R-BGs raising GOTHA in the lowveld in the Kingdom of Swaziland	R-BGs raising GOTHA: Non probability sampling	Purposive sample	*Individual face-to-face unstructured interviews. *Field notes - Descriptive - Personal - Theoretical - methodological *Photographs *Health cards	Coding of data utilizing the method of Tesch (1990:90)	*Phenomenological bracketing *Critical thinking - analysis - synthesis *Reflexiviity * Intuiting	Strategies of: *Credibility *Confirmability *Transferability *Dependability
Phase Two: Was concerned with developing the conceptual framework that guided the health education programme	Findings from R-BGs raising GOTHA in Phase One	N/A	Findings from identified category COMPROMISED HEALTH in phase one	Description of structure and components of conceptual framework	Critical thinking - interpretation - -synthesis - Inductive & deductive reasoning	Use of well established procedures, principles, logical reasoning,
Phase Three (a): Focused on describing the	Based on identified category COMPROMISED	N/A	The physical challenges of R-BGs raising GOTHA. AS	Critical thinking of the physical conditions of	Inductive & deductive reasoning	Literature review on programme planning and development

structure and content of the health education programme	HEALTH from data analysis in Phase One		IDENTIFIED FROM THE DATA analysis in Phase One	R-BGs & observational notes. - analysis - synthesis		
Phase Three (b): Sought to describe the guidelines for implementing the health education programme	Based on the analysis of the demographic data of R-BGs raising GOTHA in Phase One	N/A	Findings from demographic aspect of R-BGs in Phase One	Critical thinking - inferring -	Inductive & deductive reasoning	
Phase Four: Sought to evaluate the programme	* R-BGs raising GOTHA in *Nkonjwa* * Peri-urban elderly raising GOTHA * Pro-elderly NGO representative * Nurse educators: non probability sampling	Purposive Accidental/purposive Purposive Accidental/purposive	Face-to-face meetings with: R-BGs raising GOTHA, & Pro-elderly chairperson.. Seminar with peri-urban elderly persons raising GOTHA. Formal evaluation by nurse educator.	Analysis of the data from all stakeholders, Analysis the data in phase On	Critical thinking - analysis - interpreting - evaluating	*Instrument for evaluating *Checking of instrument at NERCHA by monitoring and evaluation unit *Description of steps of development of evaluation instrument