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# **DEVELOPMENT OF GUIDELINES FOR THE PRIMARY HEALTH CARE SERVICES TO SUPPORT WIDOWS IN TSHWANE, GAUTENG PROVINCE, SOUTH AFRICA**

By

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Degree

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In

**Nursing Science**

In the

**Faculty of Health Sciences**

At the

**University of Pretoria**

**Supervisor: Prof. M.D. Peu**

**Co-supervisor: Dr. A.E. van der Wath**

**2018**



## DECLARATION

Student No. 20253967

I, Gopolang Lenah Sekgobela declare that the thesis **DEVELOPMENT OF GUIDELINES FOR THE PRIMARY HEALTH CARE SERVICES TO SUPPORT WIDOWS IN TSHWANE, GAUTENG PROVINCE, SOUTH AFRICA** is my own work and it has not been submitted before for any degree or examination at other institutions. All the sources that have been quoted have been indicated and acknowledged by means of complete references in the text and bibliography.

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GOPOLANG LENA SEKGOBELA

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DATE



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## DEDICATION

This study is dedicated to **Amos Malegodi Sekgobela** for making me the woman I am today. Thank you my angel for paving a way for me and encouraging me to always believe in myself. I remember clearly how you always looked at me...and that was enough to help me face life courageously no matter how many times I fell. We laughed and cried together to the end of it all.

Through life and death...You will always be my guardian angel!

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## ABSTRACT

### DEVELOPMENT OF GUIDELINES FOR THE PRIMARY HEALTH CARE SERVICES TO SUPPORT WIDOWS IN TSHWANE, GAUTENG PROVINCE, SOUTH AFRICA

**STUDENT:** GOPOLANG LENA SEKGOBELA  
**DEGREE:** PhD (Nursing Science - University of Pretoria)  
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**CO-SUPERVISOR:** Dr. A.E. van der Wath

Widowhood is a stressful life event demanding practical support such as giving assistance and encouragement on physical, psychological, social and spiritual levels. The intent of this study was to explore and describe the experiences widows have of primary health care services. The usefulness of this study lies in primary health care nurses gaining understanding of the health support needs of widows. The findings of this study enabled the researcher to develop guidelines for primary health care nurses to support widows in Tshwane, Gauteng Province.

The study was conducted in two phases—Phase 1 and Phase 2. In Phase 1 of the study, a qualitative, descriptive phenomenological approach grounded in Husserl's philosophy (1859-1938) was followed to explore the experiences of widows in terms of primary health care services delivered to them. The study enabled the health support needs of widows to be identified. The study population for Phase 1 was made up of widows residing in Tshwane Metropolitan Municipality. Participants were purposively selected. They were 12 widows aged between 25-65 years. Data were collected by means of unstructured individual phenomenological interviews aimed at describing the essence of the widow's experiences. The phenomenological reductions and reflexivity were applied during data collection and data analysis. The descriptive phenomenological method of data analysis was used, as it is in line

with the reflective life-world research. The essence of the widow's experiences, as well as the constituents related to widowhood, support needs and health support required by widows from the primary healthcare services were deduced from the transcribed interviews.

The essence of the experiences identified was verified by means of a literature synthesis. The findings were presented and summarised in tables and the illustrative quotations from participant's concrete descriptions of the research phenomenon. The essence of the experience was described under the eight constituents that emerged from the data analysis: widowhood as an embodied experience; widowhood as an intense emotional experience; cognitive impact related to the effects of widowhood; widowhood experienced on an existential level; widowhood as a socially disruptive experience; widow's need to feel in control; widow's need to accept what happened and the widow's need to resume a meaningful or normal life. Going through the painful mourning period, women attempted to find help from other people including the primary health care services. Participants recommended person-centred care, appropriate referrals and establishment of peer support groups for widows. This approach had the capacity to provide the basis for the evidence of all knowledge claims in this study. The development of the guidelines was based on the empirical data obtained in Phase 1.

Phase 2 of this study entailed the development and validation of guidelines for the primary health care services to support widows in Tshwane, Gauteng Province. The development and validation of the guidelines was guided by the framework developed by the researcher based on the AGREE II (2010) instrument: advancing guideline development, reporting and evaluation in healthcare and AGREE II (2003-2013) instrument: appraisal of guidelines for research and evaluation, incorporating the Delphi technique. Delphi technique is a method for consensus building by using a series of rounds to collect data from a panel of experts to ensure reliable guidelines.

The findings of this study led to the primary health care nurses and the researcher gaining deeper understanding of the health support needs of widows, and to the development of guidelines for providing primary health care services that support widows. This study meets the ethical requirements namely beneficence, respect for human dignity and justice, and might benefit widows making use of primary health care services.

**Key concepts:** Widowhood, widows, health support system, primary health care services, health support, guideline development.



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## CHAPTER 1

### BACKGROUND TO THE STUDY AND PROBLEM STATEMENT

#### 1.1 INTRODUCTION

Chapter 1 introduces the concept of widowhood, the background and rationale to the problem, the problem statement, and the significance of the study. Research questions, the purpose of the study, the research objectives, and a brief paradigmatic perspective of the study are presented. The chapter also defines key concepts, gives a brief overview of the research methodology, the ethical considerations guiding the study and the outline of this thesis.

Widowhood is among the most distressing of all life events that may result in both physical and mental health declines such as depression (Utz, Caserta & Lund 2012, p.460). However, as a result of different variables it remains unclear why some widows experience a more difficult adjustment process than others. Every widow needs to be treated as unique based on her gradual improvement towards resolution of the grief process and the identified needs (Townsend 2015, p.831; Taylor, Kuchibhatla, Østbye, Plassman & Clipp 2008, p.104; Pinquart & Sörensen 2003, p.117; Scannell-Desch 2003, p.30).

Generally, women usually survive their spouses and some live many years after the loss of their spouses. Often, women do not remarry or take longer to remarry than men who are likely to remarry after the loss of their spouses (Choi & Vasunilashorn 2014, p.127; United Nations 2010, 2009, n.p.; Abel & Kruger 2009, p.331). This tendency is supported by statistics on widowhood (Federal Interagency Forum on Aging-Related Statistics 2012; Administration on Aging 2011; Swiss Statistics 2009). The United Nations (2010) report on widowhood indicates that about 245 million women around the world were widowed from the year 2005 to 2010 and more than 115 million of them lived in devastating poverty with their dependants. According to the year 2011 census by Statistics South Africa (processed during 2011/2013), 5.7% of South Africans aged 20 or older were widowed.

Families and communities are the primary contexts within which bereavement occurs and coping with widowhood is facilitated (Bennett 2009, pp.5-9; Schaefer & Moos 2001, p.161).

Various cultural beliefs and customs determine how widows and widowers should behave. Societal and religious expectations play a role in reinforcing the cultural norms and influencing people's attitudes towards widowhood dynamics. For example, in the South African context, and mostly among Zulu, Tswana, Sotho and Pedi cultural groups, widows are expected to mourn for the loss of the spouse for a period of at least one year by wearing black while the same cultural norms are less rigid to widowers (Ramukumba 2011, p.158; Rosenblatt & Nkosi 2007, pp.77-80; Manyedi, Koen & Greeff 2003, p.69).

Widowhood has profound effects on the surviving spouse's well-being in all aspects of life, including the state of health (Choi & Vasunilashorn 2014, p.130; Pruchno, Cartwright & Wilson-Genderson, 2009, p.808). Widows are in need of appropriate social, psychological, spiritual and health support to assist them through widowhood and to reconstruct their lives to normality (Townsend 2015, p.835; Sutherland 2009, p.423). The most compassionate self-action is to find a caring, nurturing support system and find balance in moving forward and adapting to the devastating circumstances (Holtslander, Bally & Steeves 2011, pp.256-259).

## **1.2 BACKGROUND AND RATIONALE TO THE PROBLEM**

Widowhood is a reality and is often a lifelong struggle rather than an acute crisis that is simply resolved over a circumscribed period of time (Townsend 2015, p.835; Das 2013, pp.221, 228; Shih, Turale, Shih & Tsai 2010, p.857; Sadock & Sadock 2007, p.64). All over the world, widows face many challenges in almost all spheres of their lives; they struggle to cope on their own and are in need of support that will help them to move forward. A widow who is not properly supported and adjusted could pose a problem to herself, her family and the society as a whole (Nnodim, Ike & Ekumankama 2013, p.49; Rosenblatt & Nkosi 2007, pp.77-78). Moreover, widowhood could affect immediate dependants and future generations (Widows' Rights International 2011, n.p.; Sheykhi 2006, p.253). The incidence of widowhood and response to widowhood are discussed in Section 1.2.1 and Section 1.2.2 respectively. This is followed by Section 1.2.3 on health and other consequences of widowhood, Section 1.2.4 on bereavement support and Section 1.2.5 on widowhood in the South African context.

### **1.2.1 Incidence of widowhood**

According to Statistics South Africa (2013, p.13) the number of reported deaths in the country between 1997 and 2010 (processed during 2011/2013) was 6 563 959. The leading cause of deaths among African people was tuberculosis (Statistics South Africa 2014, p.31). The same

statistics show that there were slightly more male (51.5%) than female deaths (48.5%) in 2010 and this is also similar to trends in previous years; about 5.7% of South Africans aged 20 or older were widowed (Statistics South Africa 2013, p.23). The United Nations (2010) report reveals that between the year 2005 and 2010, the following countries were having high numbers of widows: China 43 million widows from a total population of 1.338 billion, India 42.4 million widows from a total population of 1.206 billion and United States 13.6 million widows from a total population of 309.3 million.

The World Health Organization (2007a, 2007b) and Statistics South Africa (2013, p.15) emphasise that accurate information on numbers of deaths and causes of death are critical to guide decision making in public health. Based on the available statistics on death and widowhood, the researcher believes that the higher the health risks in a particular country, the higher the probability of increased death rates and the likelihood of widowhood. As a result, the researcher agrees with the World Health Organization (2007a, 2007b) and Statistics South Africa (2013) that available statistics on the causes of deaths should guide decision making in public health and the planning of effective interventions with the aim of promoting health outcomes in a country to reduce the death rates and, therefore, the likelihood of widowhood.

### **1.2.2 Response to widowhood**

There is evidence of association between kinship and the person's adaptation to widowhood. A relationship that is perceived to be of high value is more likely to accelerate attachment functions (Townsend 2015, p.835; Lalive d'Epinay, Cavalli & Guillet 2010, pp.316-317; Mancini, Robinaugh, Shear & Bonanno 2009, p.1133; Schaefer & Moos 2001, p.156). The intensity of grief due to widowhood may be related to how one felt about the person who passed away and how sudden or predictable the loss was (Townsend 2015, p.835; Pruchno et al. 2009, p.809). The loss of a close, caring and a nurturing relationship is more devastating than the loss of a less valued relationship. The process of grieving takes time and healing usually happens gradually (Townsend 2015, p.835; Stroebe, Abakoumkin & Stroebe 2010, p.93). The loss that is sudden or unexpected is associated with higher levels of grief-related distress and may require more time and effort for the widowed spouse to make sense of what happened (Townsend 2015, p.835; McKiernan, Spreadbury, Carr & Waller 2013, p.15; Rodger, Sherwood, O' Connor & Leslie 2006, p.120).

Even though loss is universal, the form and course of bereavement are individualised variables (Townsend 2015, p.835; Schaal, Elbert & Neuner 2009, p.204). Prigerson (2004, pp.38-40)

indicated that approximately 80%-90% of bereaved people experience normal or uncomplicated grief. Although uncomplicated grief can be very painful and disruptive, most bereaved survivors overcome the initial sense of disbelief and gradually come to accept the loss as a reality. Working through the circumstances of the loss, the secondary losses and health changes that accompany bereavement is part of a healing process (Glazer, Clark, Thomas & Haxton 2010, p.532). As a result, every widowed person should be treated as unique based on the identified needs (Townsend 2012, p.939). Uncomplicated and complicated bereavement will be discussed as responses to widowhood.

### **1.2.2.1 Uncomplicated bereavement**

Adaptation to grief and bereavement occurs when the person's physical, physiological and behavioural response to changes in the body and external circumstances results in the person's timely return to normality (Townsend 2015, p.5). Different theorists described the phases of grief in an attempt to understand this complicated process (Kübler-Ross 1969; Engel 1964; Bowlby 1961). Even though most bereaved people do not grief in subsequent phases, these phases of grief have been proven valuable by most individuals (Stroebe, Schut & Boerner 2017, p.456).

Kübler-Ross (1969), well-known pioneer of near death studies, described the five phases of the grieving process. Initially, the person experiences mental-health-related issues such as denial, which is manifested by feelings of shock and disbelief where the reality of the loss is not yet acknowledged. This phase is followed by anger, which might be directed to self or others including God. Depending on different religious beliefs or orientation, the person might bargain with God in an attempt to reverse or postpone the loss. However, as the reality of the loss sinks deeper, feelings of sadness and depression become effective and the person focuses on the reality and its meaning. The feeling of peace regarding the loss enables the person to gradually accept the loss (Townsend 2015, pp.831-833).

Engel (1964, pp.64, 93) described five phases of the grief process. Initially, the person experiences shock and disbelief to protect the self against the overpowering effects of stress. As the person recognises the loss, anger might be directed towards self and others in the immediate environment that is blamed for the loss. During the final phase of grieving, various culture-specific rituals associated with the loss are performed. Preoccupation with the loss gradually subsides over time and the person begins to attend to daily activities and interact with others (Townsend 2015, pp.833-836). Bowlby (1961, pp.22, 42) described four phases in the grief process. Initially, the person experiences feelings of shock and disbelief and has a

profound desire to recover what has been lost and return to the state of normality. The individual realises that the loss is real and presents with feelings of despair, after which the person accepts the loss; then new goals and meaningful patterns of living are established. Worden (2009, pp.42-77) described four tasks of mourning. The person accepts the reality of the loss, processes the pain of grief, learns to adjust to life circumstances without the lost entity and let go of the lost entity in the midst of embarking on a new life.

Widowhood entails a process of adaptation to changed circumstances. According to Roy's (1976) model of adaptation, "a person, a family or a community are considered as a holistic adaptive system that is in constant interaction with the environment, exchanging information, matter and energy". The adaptation process could have a positive (adaptive) response or a negative (maladaptive) response depending on the person's past experiences, level of knowledge and understanding, strengths or limitations. An adaptive response to the circumstances maintains the integrity of the person (Townsend 2015, pp.2-3; George 2011, pp.291-323). Selye (1976, 1974, 1956) describes the general adaptation reaction in three distinct phases. First, the person goes through the alarm reaction state when his or her physiological response of the "fight or flight" syndrome is activated. Second, the person goes through the state of resistance using the physiological responses of the first phase as a defense to help him or her to adjust to the stressor. The third phase could either be prevented, delayed or becomes worse depending on the individual's ability to adapt to the circumstances. The state of adaptation is manifested by the physiological symptoms (Townsend 2015, pp.3, 22-23). However, it should always be emphasised that people are unique and it is possible for a person to accomplish some of the phases and not others depending on the available coping mechanisms and resources (Townsend 2015, pp.833-836).

#### **1.2.2.2 Complicated or prolonged bereavement**

A complicated or prolonged response to loss occurs when the person is not able to satisfactorily progress through the phases of grieving to return to normality. The repercussions of bereavement can lead to psychosomatic illnesses such as pathological depression (Townsend 2015, pp.23, 477; Uys & Middleton 2014, p.676). Complicated bereavement may lead to a prolonged experience of grief which cannot be narrowed to a particular condition (Rando, Doka, Fleming, Franco, Lobb, Parkes et al. 2012, p.253). Prolonged experience of grief is often described as a maladaptive grief response, especially when the person's level of functioning deteriorates to an extent that the person is unable to do activities of daily living for a long time. Most commonly, the person might have feelings of worthlessness (Townsend 2015, p.837).

According to Selye (1974, 1956), the third phase of exhaustion may occur when the person is exposed to stress for a long time and the body can no longer tolerate the stressor. The person no longer has the capacity to utilise his or her immediate resources and begins to present with symptoms such as headaches, mental problems, and ulcers. At this stage, clinical interventions are necessary to promote adaptive responses; otherwise the person might face other consequences of bereavement, even death (Townsend 2015, p.4).

### **1.2.3 Health and other consequences of widowhood**

Widowhood experiences are unique (Lund, Caserta, Utz & De Vries 2010, p.291). The extent to which bereavement affects the physical and the mental well-being of the surviving spouse may vary by gender. Although studies comparing gender differences in bereavement yield contradictory results (Chatterjee 2016, pp.10378-10382; Perkins, Lee, James, Oh, Krishna, Heo et.al 2016, pp.5-10; Lalive d'Epinay et al. 2010, pp.305-306), men and women experience bereavement in different ways based on the patterns of communication, expression of emotions and resources available for coping with the loss (Lee & Carr 2007, p.462; Daggett 2002, p.625). Moreover, widowhood is regarded as one of life's greatest stresses and a highly traumatic experience and the majority of families are affected by it (United Nations 2010, n.p.). Researchers attest that bereavement due to widowhood is a painful state for most people and their families, and might trigger long-term psychological morbidity (Nnodim et al. 2013; Rosenblatt & Nkosi 2007; Manyedi et al. 2003). A study by Ha (2009, pp.471-480) and an earlier study by Porcino (1985, p.119) agree that the lack of an appropriate support system could lead to the widow's failure to adjust to widowhood, manifesting in serious health risks such as an emotional crisis, possible mortality and risks that could affect immediate dependants, inclusive of future generations.

### **1.2.4 Bereavement support**

A social support system can help the widow to address the challenges of stressful circumstances and learn to appreciate the help she receives from others especially if the support is perceived as effective. Appropriate support allows people the opportunity to talk about their thoughts and feelings, and obtain feedback from others as they come to terms with their transformed reality (Worden 2009, p.77; Riley, LaMontagne, Hepworth & Murphy 2007, p.281).

On 22 December 2010 the United Nations General Assembly recognised 23 June as International Widows Day (established by the Loomba Foundation). On 23 June Shrimati Puhpa

Wati Loomba, the inspiration for the foundation, became a widow. International Widows Day is a global day to raise awareness and help widows and their dependants who are suffering through poverty, illiteracy, HIV/AIDS, conflict and social injustice. The establishment of the International Widows Day sheds light on widowhood, a humanitarian crisis that has gone unnoticed for far too long. The purpose of the day is to empower widows and give them a reason to be hopeful and realise their rights (United Nations 2010, n.p.). A coalition of international non-governmental organisation's (NGO's) such as Widows Rights International launched a campaign for a United Nations resolution on widowhood. The resolution called for a Commission of a United Nations Report on Widowhood and the appointment of a United Nations Special Representative on widowhood (Widows' Rights International 2011, n.p.). A fund was created to enable widows' organisations to mobilise relevant resources, ensure that the voices of widows are heard and include widows as a specific category in national action plans (United Nations 2010, n.p.).

Support for action on widows' rights has increased; for example, the promotion of education about rights such as inheritance and property rights, custody of children and eradication of harmful cultural practices in many countries. The Womens' Rights Charter was ratified in 2005 and it marked a milestone in the promotion and protection of widows' rights in Africa (Article 20 & 21) (United Nations 2009, n.p.). The researcher agrees with the beliefs of organisations such as Widows' Rights International (WRI) that widows need to voice their rights and needs, and those promoting widows' rights will instill a sense of hope for women in similar situations. Moreover, government- and non-governmental organisations need to mobilise support for the ratification of the Widows' Rights Protocol by all African states (Widows' Rights International 2011, n.p.).

### **1.2.5 Widowhood in the South African context**

All cultures have unique beliefs and practices regarding death that should be observed, be adequately understood and respected by the nurse. Notably, the field of nursing is interwoven into multiple cultures and understanding different cultures enables nurses to render appropriate intervention measures (Ellis & Hartley 2012, p.3; Ramukumba 2011, p.156). In the South African context, particularly within the Zulu, Tswana, Sotho and Pedi culture, widows are restricted from participating in public events such as weddings or campaigns during the mourning period. Moreover, engaging with a widow is taboo especially during the first year of mourning (Ramukumba 2011, p.158; Rosenblatt & Nkosi 2007, p.78). In the researcher's experience, the practice is still relevant. Other aspects of widowhood in the South African context are unique and may have an effect on how widows experience and cope with



widowhood. For instance, the rising violence that is reported daily in the media threatens families in South Africa as a factor beyond their control (Holcomb 2014, p.643). According to Statistics South Africa (2013, p.23) life expectancy at birth is estimated at 57.7 years for males and 61.4 years for females. In the year 2010 alone, 5 208 men and 1 497 women died due to unnatural causes such as violence. This dire situation poses a big challenge for women who are likely to become widows and live through the difficulties of widowhood.

As already indicated, widowhood is a lifelong struggle and widows face many challenges in almost all spheres of their lives (Nnodim et al. 2013, p.49). As a result, there is a continuous need for research on this situation. The researcher acknowledges that research similar to the proposed study has been done before in South Africa; for example, in Limpopo Province, North West Province, (Maselesele 2005; Manyedi et al. 2003) and other countries such as Sweden, Nigeria, and Canada (Nnodim et al. 2013; Möller, Björkenstam, Ljung & Yngwe 2011; Lowe & McClement 2010). However, the studies used a qualitative, explorative and descriptive approach and open coding as a method of qualitative data analysis. In this study, the researcher is highly concerned with the way the phenomenon of widowhood plays itself out in the unique multi-cultural South African life-world: How is widowhood spontaneously experienced and what are the actual conscious experiences as lived by widows? What is the essence, the deeper meaning of widowhood? The researcher envisioned that a phenomenological descriptive study would lay bare the psychological essences of the experience: the structures of meaning immanent in (Wertz 2005, p.170) the deep human experience of widowhood in a society where culture still dictates the experience of widowhood in many ways.

### **1.3 PROBLEM STATEMENT**

The death of a spouse is ranked as the number one stressor by the United Nations (2010). In a study by Schaal et al. (2009, pp.209-211), the majority of widows (70%) indicated that the death of their husbands was the most painful loss in their lives compared to the death of a parent, child or sibling. The loss is likely to result in disorganisation of one's life and to health-related risks such as depression. Moreover, it was concluded that unresolved grief would endure over time in the absence of clinical interventions.

The researcher has observed various scenarios for the past three years during widows' events in Soshanguve, a township in the City of Tshwane, Gauteng Province in South Africa: Every year during the month of August (women's month), widows from Soshanguve township and

nearby areas around the City of Tshwane are invited by one of the churches in the area in celebration of Widows' Day. During the event, widows interact with each other and are given the opportunity to share their challenges and receive professional guidance from the invited professionals such as nurses and social workers. It was during two of the events in the years 2012 and 2013, during personal conversation with some of the widows, that the researcher (a professional nurse) realised that many of these widows had lost their spouses more than five to ten years before but still appeared to be sad, exhibited low morale and verbalised that life was tough following the loss of their spouses.

The literature confirms that in the long term, bereaved spouses do not simply "return to baseline" following the loss, since most grief does not fully resolve or permanently disappear (Townsend 2015, p.835; 2012, p.943; Stroebe, Stroebe, Hansson, Stroebe & Schut 2001, p.746). The consequences of prolonged grief not being addressed affect the general well-being of people resulting in, for example, loss of productivity and increased health costs. Moreover, the lack of appropriate support from the health care system could indirectly affect widows' health and the health of the people around them (Möller et al. 2011, p.261; Finlay 2009, p.475). Similarly, some of the widows who attended the event in Soshanguve complained of health problems, but indicated that they were reluctant to visit the local clinics since they were not receiving the appropriate help that they needed.

There is a need for adequate and appropriate interventions from the health care system such as primary health care services to support widows and enable them to cope with and adjust to widowhood (Asai, Fujimori, Akizuki, Inagaki, Matsui & Uchitomi 2010, p.39; Stroebe et al. 2010, p.87; Kim 2009, pp.39-41). Notably, health care professionals can help; only if they understand the process of grief and signs of successful mourning (Shear 2012, pp.119-121). Stroebe et al. (2010, p.86) assert that health care professionals such as primary health care nurses are part of the support system and it is important that they identify widows who are at risk and determine vulnerability and protective factors likely to modify the health impact of widowhood. Elwert and Christakis (2008, p.2092) suggested that future research should examine specific effects of widowhood and identify opportunities for health interventions. However, in the researcher's experience as a professional nurse, there are no accessible health care support systems for widows within different communities, be the support from government or non-governmental systems. As a result, the researcher wished to (1) explore the experiences of widows regarding the support provided by the primary health care services; (2) describe the health-support needs of widows and (3) develop guidelines for the primary health care nurses to support widows. The

concept “widows” as used in the study context refers to widows residing in the City of Tshwane, Gauteng Province in South Africa.

## **1.4 SIGNIFICANCE OF THE STUDY**

The significance of this study was revealed in the experiences of widows regarding the support provided by the primary health care services. During the interviews with widows, the phenomenological descriptions of the widow’s experiences gave the widows a voice. The support for widows may be strengthened by incorporating widows’ suggestions on how they preferred to be supported by primary health care services. This strengthening might promote provision of care from primary health care nurses, as well as self-care, as it would assist the widows to recognise their potential or presenting health problems. Widows who are more aware of their health status are more likely to use the available primary health care services. The significance of this study is outlined in the following dimensions: nursing research, nursing practice and policy development.

### **1.4.1 Nursing research**

The findings of this study assisted the researcher in identifying the gaps in available research on widowhood and contributed towards the knowledge and deeper understanding of the health-support needs of widows (Phase 1). Opportunities for further research into the topic were identified (see Chapter 6, 6.6.2).

### **1.4.2 Nursing practice**

The guidelines developed from the study findings, with incorporation of existing research and literature related to the study phenomenon assisted the researcher in recommending nursing practice guidelines for continued excellence in the primary health care setting to promote health support for widows (see Chapter 6, 6.6.1).

### **1.4.3 Policy development**

According to Widows’ Rights International (2011) a need exists for policies to create an enabling environment for widows and their dependants. The findings of this study could assist government and non-government organisations in developing policies for primary health care services to render appropriate health support for widows. The development of such policies would be in line with the human rights and patients’ rights charter having set out “the right to

receive appropriate health care services” (Constitution of RSA 1996, 2003, Chapter 2, Section 7 & 27).

## **1.5 RESEARCH QUESTIONS**

From the problem statement set out above, the following research questions according to the two study phases were formulated:

### **Phase 1**

- What are widows’ experiences of widowhood in the City of Tshwane, Gauteng Province?
- What are the experiences of widows regarding the health support given by primary health care services in the City of Tshwane, Gauteng Province?
- What health support is required by widows from the primary health care services?

### **Phase 2**

- What guidelines for the primary health care services to promote health support for widows in Gauteng Province in the City of Tshwane could be developed?

## **1.6 PURPOSE OF THE STUDY**

The purpose of this study was to develop guidelines for the primary health care services to promote health support for widows in the City of Tshwane, Gauteng Province.

## **1.7 RESEARCH OBJECTIVES**

The specific objectives that formed the basis of this study were the following, according to the two study phases:

### **Phase 1**

- To explore and describe widows’ experiences of widowhood in the City of Tshwane, Gauteng Province.
- To explore and describe the experiences of widows in relation to the health support given by the primary health care services in the City of Tshwane, Gauteng Province.
- To explore and describe the health-support needs of widows that can be addressed by the primary health care services in the City of Tshwane, Gauteng Province.

## **Phase 2**

- To develop guidelines for the primary health care services that will promote health support for widows in the City of Tshwane, Gauteng Province.

### **1.8 PARADIGMATIC PERSPECTIVE**

A paradigm is a world view that comprises of sets of philosophical premises that directs the researcher's means of investigation inclusive of the design for collecting and analysing data (Polit & Beck 2014, pp.6, 387; De Vos & Strydom 2011, p.40). The researcher's paradigmatic perspective for this study was reflected in the philosophical and methodological assumptions. The researcher adopted descriptive phenomenology as a philosophical framework in conducting this study, as it is a suitable qualitative research approach that focuses on the lived experiences of participants (Polit & Beck 2014, p.270; Wojnar & Swanson 2007, p.174). This approach requires the researcher to explore the phenomenon through a close and direct interaction with the participants in a natural setting. The point of view of phenomenology is that the person is interwoven into the environment and the fundamental realities about a person are easily obtained in the life experiences of the person. The world and the self shape and influence one another (Grove, Gray & Burns 2015, p.69; Polit & Beck 2014, p.270; Burns & Grove 2011, p.76; Flood 2010, p.7). A detailed description of the researcher's paradigmatic perspectives is given in Chapter 2.

### **1.9 DEFINITIONS OF KEY CONCEPTS**

The specific key concepts that formed the basis of this study were the following: widowhood, widow, health care system, primary health care services, health support and guideline development.

#### **1.9.1 Widowhood**

Widowhood is the period of being a widow that is manifested in a state of grieving for the loss of the spouse and is often influenced by culture, spiritual beliefs and customs (Attig 2004, p.343). In this study, widowhood was seen as a critical life-world experience during which widows are adjusting to their changed circumstances. During this period, some of the widows might have physical, psychological, social and spiritual experiences evidenced by health problems.

### **1.9.2 Widow**

A widow is a woman who survived her husband and has not remarried (Olukayode 2015, p.67). For the purpose of this study, a widow is a woman who lost her husband (from a heterosexual marriage) to death at least a year before but less than five years before and has not remarried. The concept “widows” as used in the study context refers to widows residing in the City of Tshwane, Gauteng Province in South Africa.

### **1.9.3 Health care system**

A health care system is an institution of health care or department rendering health services to promote, protect or restore the health of individuals and populations (Van Rensburg 2012, pp.1-2). A professional health care system is run by a team of health care providers who are formally educated and trained for their relevant duties (Wilkinson & Treats 2011, p.230). In this study, a “health care system” pertains to a set of primary health care services run by trained health care providers promoting the well-being of widows.

### **1.9.4 Primary health care services**

In the South African context, primary health care pertains to the first level of care in a continuing health care process and is commonly rendered by nurses at a clinic (Engelbrecht & Van Rensburg 2012, p.485). Most importantly, the care is provided at the community level and is easily accessible and acceptable to the community and inviting of community involvement (Clark 2015, p.16; Hattingh, Dreyer & Roos 2012, p.10; United Nations 2009, n.p.). The emphasis is on prevention and the means of providing the care is based on feasible, scientifically sound and culturally appropriate methods that are accepted by the society (Clark 2015, p.17; Jerome-D’Emilia 2014, p.53). In this study, “primary health care services” refers to the local clinics within the community in the City of Tshwane that deliver primary health care to widows and support widows to move towards a state of optimal health.

### **1.9.5 Health support**

Health support refers to all efforts that are organised by the health care system, such as primary health care services, to work together to promote the health of people towards optimal wellness (Rector 2014, p.17). In this study, “health support” refers to the rendering of adequate and appropriate health support to widows in order to move towards a holistic state (physical, psychological, social, and spiritual) of optimal health. The effectiveness of the health support given was determined by the widows’ experiences in this study.

### **1.9.6 Guideline development**

Guidelines are systematically developed standards of practice that are recommended by a team of experts, with an aim to help practitioners and clients in making appropriate decisions pertaining the health care suitable for particular situations. These standards are directed towards a significant improvement in the quality of health care and health outcomes (Mahtani 2015, n.p.; Stanhope 2014, p.295; Polit & Beck 2012, p.31; Burns & Grove 2011, pp.495-496; Parahoo 2006, p.427). In this study, "guidelines" are regarded as principles and recommendations for health support programmes and services within the primary health care services. The developed guidelines are intended to lead to the rendering of adequate and appropriate health support for widows to move towards a holistic state (physical, psychological, social and spiritual) of optimal health.

## **1.10 OVERVIEW OF THE RESEARCH METHODOLOGY**

The methodology of this study is dealt with in detail in Chapter 2 (phase 1) and Chapter 5 (phase 2). The following is the brief overview of the methodology:

This study was conducted in two phases, which were Phase 1 and Phase 2.

### **1.10.1 Phase 1**

A qualitative, descriptive phenomenological, contextual design was employed in Phase 1 of this study to explore the health-support needs of widows (see Chapter 2, 2.6). The use of descriptive phenomenology in this study was aimed at describing the actual conscious experiences as lived by the study participants, with no manipulation of the natural situation. This "telling" of experiences gave the researcher an opportunity to explore and describe the meaning of the complex experiences of widows with regard to the health support given by the primary health care services (Grove et al. 2015, pp.33, 67; Polit & Beck 2014, p.270; Burns & Grove 2011, p.76).

The study population in Phase 1 was widows residing in the following areas of the City of Tshwane Metropolitan Municipality: townships such as Atteridgeville, Mamelodi, Soshanguve and suburbs such as Pretoria North, Pretoria East (Lynwood, Menlopark, Meyerspark, Pretoria West (Danville, Phillip Nel) and Centurion. Study participants were purposively selected from the available lists from the widows' forum and from the lists of widows who attended widows' day

events in one of the churches in Soshanguve Township. The setting for this study was at a place chosen by the participants, a place which was comfortable and familiar to them.

Data were gathered by means of unstructured individual phenomenological interviews, as the researcher was seeking to understand the experiences of the participants. Most of these face-to-face interviews took round 30-55 minutes and gave the researcher an opportunity to be in contact with the participants in a naturally occurring situation. An audio-recorder was used to capture all the data (Greeff 2011, p.359). Various communication techniques such as paraphrasing, clarification, probing, exploration and reflecting were used as needed to facilitate the interview (Townsend 2015, pp.140-147; Burger 2013, pp.320-325; Greeff 2011, pp.345-346). Furthermore, the researcher made observational notes of verbal and non-verbal cues such as facial expressions and other gestures displayed by the participants (Polit & Beck 2014, pp.294-295; Burns & Grove 2011, pp.85-89; Greeff 2011, pp.350-351; Starks & Trinidad 2007, p.1375). Interviews continued until data saturation had occurred.

Descriptive phenomenological data analysis was used. The researcher attempted to understand the meaning of widows' experiences on the sole basis of the data collected. The emphasis was on the openness of and sensitivity towards the life-world description, the phenomenon and its meaning (Dahlberg, Dahlberg & Nyström 2008, p.231). This emphasis was chosen to describe the essence of the phenomenon as accurately as possible (Giorgi 2009, p.91). Thus, the researcher stayed with empirical original data that were given by the participants (Giorgi 2009, p.1; Dahlberg et al. 2008, p.241). Giorgi's (2009, 2012) descriptive phenomenological method of data analysis was used as it is in line with reflective life-world research (see Chapter 2, 2.6.2.4). The researcher and an independent coder analysed the transcribed interviews. The findings were described in terms of the available literature (see Chapter 4). The essential meanings identified from the empirical data in Phase 1 (see Chapter 3, 3.2) were used by the researcher to draft the preliminary guidelines before proceeding to Phase 2 of the study.

### **1.10.2 Phase 2**

Phase 2 of this study was used to develop and refine the guidelines to promote adequate and appropriate health support for widows from the primary health care services. The drafting of the five preliminary guidelines by the researcher was based on the empirical data collected in Phase 1 and was supported by the relevant literature (see Chapter 5, 5.4). A literature search of relevant sources was conducted to confirm the formulated statements if they collated with what had been published (Creswell 2014, pp.27-29). During the process of the formulation of



preliminary guidelines, the researcher observed various attributes related to the development of the guidelines. These attributes included clarity, validity, relevance, comprehensiveness, applicability, effectiveness and acceptability (see Chapter 5, 5.3.1) (Mahtani 2015; Agree Collaboration 2010; 2003-2013; Parahoo 2006; Thompson & Dowding 2002).

The development and validation of guidelines was directed by the framework developed by the researcher based on the AGREE II (2010) instrument: advancing guideline development, reporting and evaluation in healthcare, and AGREE II (2003-2013) instrument: appraisal of guidelines for research and evaluation. The framework incorporated the Delphi technique to ensure that the guidelines were in line with the above-mentioned attributes (see Chapter 5, 5.3.2.3). The Delphi technique is a method for obtaining judgments and views from an expert panel about a topic of interest, with the purpose of seeking agreement on the issue without direct confrontation (Green & Thorogood 2014, p.128; Botma, Greeff, Mulaudzi & Wright 2010, p.253; Bowker, Lakhanpaul, Atkinson, Armon, MacFaul & Stephenson 2008, pp.85-95; Okoli & Pawlowski 2004, pp.16-18).

In this study, 16 experts participated in the development and the validation of the drafted guidelines. The panel consisted of qualified experts, national and international, from academic, private, government and non-government organisations in the area of qualitative research, policy and or guideline development, healthcare, bereavement counseling, or human behavior (see Chapter 5, Table 5.2). The experts were purposively selected based on their expertise. The data collection from the Delphi experts was conducted in subsequent rounds until consensus was reached (see Chapter 2, 2.8.4) (Polit & Beck 2012, p.267; Botma et al. 2010, pp.253-254; Parahoo 2006, p.199). The final guidelines are intended to provide a framework for rendering adequate and appropriate health support to widows. The development of guidelines is dealt with in Chapter 5.

### **1.10.3 Ethical considerations**

Research involving people must deal with ethical matters to ensure that participants' rights are protected and participants are free from unnecessary harm (Marshall & Rossman 2016, pp.51-52; Polit & Beck 2014, p.80). Ethics refer to the standards of practice of a particular group of individuals. Notably, ethics entails a set of principles or moral values in human conduct. Ethics protect human rights especially those most vulnerable to maltreatment (Ecker 2013, p. 287; Ellis & Hartley 2012, pp.245, 289; Pera & Van Tonder 2011, pp.5-6). The Bill of Rights affirms the democratic values of human dignity, equality and freedom (Constitution of RSA 1996, 2003,

Chapter 2, Section 7). Ethics and human rights should be taken into account in every phase and aspect of research from the beginning to the end (Botma et al. 2010, p.4). According to the Belmont Report issued in 1979 (cited in Haber & LoBiondo-Wood 2014, p.256; Polit & Beck 2014, pp.83-91), the three fundamental ethical principles on which standards of ethical conduct in research should be based are: beneficence, respect for human dignity and justice. These ethical principles that guided the researcher are described in the paragraphs immediately below.

#### **1.10.3.1 Permission to conduct the study**

Research involving people requires the researcher to submit the research plans to the Institutional Review Board. The Institutional Review Board assess the research plans to confirm that the rights and welfare of the participants in the study are protected from harm. Confirmation is also needed that the appropriate methods will be used to secure informed consent and that the potential benefits of the study are greater than the risks (Grove et al. 2015, pp.117-118; Haber & LoBiondo-Wood 2014, pp.263-264; Burns & Grove 2011, p.130; Strydom 2011, pp.126-129). In this study, the researcher obtained permission from the Research Ethics Committee of the Faculty of Health Sciences, University of Pretoria to conduct the study (Protocol 107/2015). Refer to Annexure A.

#### **1.10.3.2 Beneficence**

The principle of beneficence determines that researchers should secure the safety and well-being of participants by minimising anticipated risks and maximising potential benefits. This principle includes the right to freedom from harm and discomfort and the right to protection from exploitation (Grove et al. 2015, pp.119-120; Haber & LoBiondo-Wood 2014, pp.256-260; Polit & Beck 2014, p.83).

##### **a) The right to freedom from harm and discomfort**

Researchers are compelled to avoid, prevent or minimise harm. Participants must not be exposed to unnecessary risks of harm or discomfort. Research should be conducted by qualified people. Importantly, ethical researchers must be prepared to terminate the study if they suspect that continuation could in anyway harm the participant (Grove et al. 2015, pp.108-109; Haber & LoBiondo-Wood 2014, p.260; Polit & Beck 2014, p.83).

In this study, there was no anticipated physical or physiological harm. However, the researcher anticipated emotional discomfort because some people find it difficult to talk about their sorrows and disappointments in life. Prior to the interviews, participants were made aware that they

would be reminded about the death of their spouses and might relive the traumatic experiences. The researcher made it clear that the participants' rights to retire from the study at any given moment would be respected. Moreover, as an advanced psychiatric nurse, the researcher held a debriefing session (Polit & Beck 2014, p.90) with each participant, during which she provided debriefing and emotional support as needed after the interview. However, the researcher undertook to refer the participant to a therapist or health care practitioner of her choice when needed. In this study, all participants continued with the interview until data saturation. Moreover, following the interviews, all participants verbalised that they were in a comfortable emotional state and further counselling or referral to the therapist was not necessary.

#### **b) The right to protection from exploitation**

Involvement in the study should not place participants at unfavorable conditions that expose them to damages. Participants need to be reassured that their involvement in the study or any information they might provide will not be used against them. The participants should know the extent to which their responses and records will be kept private and confidential (Polit & Beck 2014, p.83). Data such as audiotapes should be locked securely in a safe place at all times to be protected from unauthorised individuals (Sumner & Cannon 2014, p.101).

In this study, participants were ensured that any personal characteristic related to them would be withheld in reports and publication of the study. Moreover, the data collected would not be used against them and would be used solely for the purpose of this study. All personal information gathered are kept in a safely locked place at the Department of Nursing Science at the University of Pretoria. The researcher signed a declaration for the storage of research data and/or documents.

#### **1.10.3.3 Respect for human dignity**

This principle includes the right to self-determination and the right to full disclosure (Polit & Beck 2014, p.84).

#### **a) The right to self-determination**

Self-determination means that potential participants can voluntarily decide whether to take part in the study without risks of prejudicial treatment. Participants have a right to ask questions, to refuse to give information and to withdraw from the study (Grove et al. 2015, p.101; Haber & LoBiondo-Wood 2014, p.260; Polit & Beck 2014, p.84). In this study, participants were not coerced to participate and were informed that their participation was entirely voluntary. Three

potential participants refused to participate in the interview process and were not required to give reasons. Widows who agreed to participate were informed that they had an option to withdraw, discontinue at any time or even withhold any specific information. It was also made clear that failure to participate in or withdrawal from the study would not result in any penalty or loss of benefits such as debriefing or emotional support by the researcher. In this study, participation was entirely voluntary and no one of the 12 participants withdrew from the study.

#### **b) The right to full disclosure**

Ethical researchers should willingly describe the nature of the study, the person's right to refuse participation, the researcher's responsibility and likely risks and benefits. Prospective participants were given information leaflets regarding the study (Annexure B: PICD 1). The researcher did not deceive the participants by deliberately withholding information. The researcher made the participants aware that participation might remind them of their deceased spouses and that the participant might relive the traumatic experience of losing a partner. Prospective participants were given around one to two weeks to comprehend the information and ask questions before making a decision whether to participate or not to participate (Grove et al. 2015, pp.111-112; Polit & Beck 2014, p.84).

#### **1.10.3.4 Justice**

The principle of justice entails the participant's right to fair treatment, the right to privacy, the right to confidentiality and anonymity, and the right to informed decision making (Grove et al. 2015, pp.105-107; Haber & LoBiondo-Wood 2014, p.256; Polit & Beck 2014, p.85).

#### **a) The right to fair treatment**

The right to fair treatment demands that researchers should select participants based on the study requirements and not on the person's vulnerability. Researchers must treat people who decline to participate or who withdraw from the study in a non-prejudicial manner (Grove et al. 2015, p.107; Polit & Beck 2014, p.85). In this study, prospective participants were chosen on the basis of the inclusion criteria and not on the person's "weaknesses". Widows who chose not to participate in the study were not judged in any way and were not required to give any reason for the decision made.

#### **b) The right to privacy**

The right to privacy demands that the research questions should not be more intrusive than it needs to be and that the participant's privacy is maintained continuously (Grove et al. 2015,

pp.105-106; Polit & Beck 2014, pp.85-86; Strydom 2011, p.123). In this study, each participant was made aware of her right to choose to what extent she would like to share the information. The study only included widows who indicated that they were “emotionally ready” to participate in the study. The researcher started by asking less emotional and less intrusive questions, which were answered by all participants.

### **c) Confidentiality and anonymity**

Research participants have the right to anonymity and the right to assume that their personal information will be kept confidential. Complete anonymity exists if the participant’s identity cannot be linked to his or her individual responses, not even by the researcher (Haber & LoBiondo-Wood 2014, p.259; Polit & Beck 2014, pp.88-89). In this study, each participant was assigned a code number. The research report was written in such a way that the participant’s personal information could not be linked to her individual responses.

### **d) Informed decision making**

Obtaining informed consent from participants is essential for conducting ethical research. The participants should be fully informed about the study by the researcher and all essential information should be explained thoroughly (Grove et al. 2015, pp.111-114; Haber & LoBiondo-Wood 2014, p.261; Polit & Beck 2014, pp.87-88; Burns & Grove 2011, p.122). In this study, participants were given adequate information about the process of this study and were given enough time to comprehend the information. Each participant was given an opportunity to ask questions about the study and the researcher answered all questions with honesty. Participants were given around one to two weeks to comprehend the information and the researcher then asked each participant if all the information given was clear. The researcher documented the informed consent process by having participants sign a consent form. Each participant was given a copy of the consent form (Annexure B: PICD 1).

## **1.11. OUTLINE OF THE THESIS**

This thesis is outlined as follows:

- Chapter 1: Background to the study and problem statement
- Chapter 2: The paradigmatic perspective and methodology of the study
- Chapter 3: Discussion of research findings from Phase

- Chapter 4: Literature synthesis
- Chapter 5: Development and the description of the guidelines in Phase 2
- Chapter 6: Conclusion of the findings, validation and description of the guidelines with recommendations, limitations, implications and conclusions.

## **1.12. SUMMARY**

Chapter 1 introduced the concept of widowhood, background and rationale to the problem, the problem statement, and the significance of the study. Research questions, the purpose of the study, the research objectives, and a brief paradigmatic perspective of the study were presented. The introduction also defined key concepts, gave a brief overview of the research methodology, the ethical considerations guiding the study and the outline of the thesis. A detailed discussion of the researcher's paradigmatic perspective together with the methodology of this research is dealt with in Chapter 2.

## CHAPTER 2

# PARADIGMATIC PERSPECTIVE AND METHODOLOGY OF THE STUDY

### 2.1 INTRODUCTION

Chapter 2 discusses the researcher's paradigmatic perspective together with the methodology of this study. This study was conducted with the aim of exploring and describing the health-support needs of widows that could be addressed by the primary health care services.

### 2.2 PARADIGMATIC PERSPECTIVE

The paradigmatic perspective will be discussed in terms of phenomenology within a constructivist paradigm followed by the historical overview of phenomenology and the specific philosophical assumptions of phenomenology.

#### 2.2.1 Phenomenology within a constructivist paradigm

Finlay (2009, pp.6-7) highlights that researchers agree that phenomenological research methods are recommended when the research question requires responsiveness to the issue under study and the subjective experiences proceeding within the mind of the researcher and the participants. Phenomenological knowledge reveals meaningful reality and reforms ways of understanding to a more thoughtful action through constructivism. The constructivist paradigm assumes that the discovery of a particular information or experience is at a higher level when the distance between the researcher and those under study is minimised through a close and direct interaction (Polit & Beck 2014, p.8; Flood 2010, pp.7-8). Thus, constructivists choose a more direct, physical mode of data collection (Mertens 2010, p.19). Constructivist researchers often address the process of interaction among people. The researcher's intention is to comprehend different point of views individuals have put to the world. It is believed that humans have the mind and are able to construct their own experiences of reality (Creswell 2014, p.8; Polit & Beck 2014, p.9). In deliberating upon constructivism, Crotty (1998, pp.8-9, 42-65) highlights that there is no meaning without a mind to construct a meaningful reality. Human beings do not discover meaning but construct their meaningful realities as they closely come

into contact with the universe and its inhabitants which they are viewing and analysing. Thus, constructivists prefer using broad and less rigid questions to enable participants to freely share their views and give richer content of their experiences. Furthermore, people engage with their world and make sense of it based on the realities of the world of meaning brought upon them by culture. Notably, without culture there is no significant action that directs human behavior and structured experience. Thus, constructivist researchers seek to understand the context or setting of the participants through visiting this context and gathering firsthand information in a naturally occurring situation (Creswell 2014, p.9).

The researcher visited the participants at a place chosen by them such as their home, a place which was comfortable and familiar to them. The researcher was able to collect data in a context in which participants felt free. Face-to-face unstructured phenomenological interviews were used to gather information. An initial broad open-ended question was asked for facilitating the start of the discussion. Interviews enabled the researcher to be in close contact with the participants in a naturally occurring situation to gain from participants, a first-person description of their lived experiences of the health support provided by the primary health care services. The researcher presented herself as the listener and asked participants to give accounts of their experiences.

The ontological, epistemological and methodological assumptions guiding descriptive phenomenology within a constructivist paradigm will be discussed in the paragraphs immediately below.

### **2.2.1.1 Ontological assumptions**

Ontology involves the philosophy of “how one sees reality”. It is believed that each person is unique and experiences reality from his or her own point of view. Therefore, each person experiences a different reality. As the result, the phenomenon of “multiple realities” exists and needs to be considered by qualitative researchers (Polit & Beck 2012, p.12; Delport, Fouché & Schurink 2011, pp.309-311; Mertens 2010, p.18; Dahlberg et al. 2008, p.23; Krauss 2005, pp.758-760).

“The lived world” is a central theme of phenomenology that reveals itself as a highly organised whole that is socially shared. “The lived world” is understood by people through their own perspectives since the world is not the same for everyone. Furthermore, language pervades the meanings of people’s surroundings and forms part of what makes the life-world more a



collective place than the product of an individual isolated subjectivity (Fouché & Schurink 2011, pp.309-311; Dahlberg et al. 2008, p.35; Krauss 2005, p.760; Husserl 1970, pp.173-174). Thus, philosophical truth is embodied in language. Notably, language mediates “being and truth” by giving voice to the experience to communicate meaning to the world (Munhall 2012, pp.25, 33; Kwant 1966, p.173). In descriptive phenomenology, the phenomenon is the meaningful reality that reveals an essence that can be discovered and be described. The truth of an essence of the phenomenon can be only revealed by “setting aside” the researcher’s experiences and personal beliefs or assumptions of the phenomenon (Converse 2012, p.30).

In this study the researcher assumed that widows’ experiences of widowhood could never be understood without being considered as a living whole encompassing widows’ subjective experiences from their lived viewpoint of body, health, knowledge and existence (Dahlberg et al. 2008, pp.32-42). The researcher took into consideration how losing the spouse to death was spontaneously lived in the widows’ life-worlds, precisely as widowhood is encountered in everyday affairs (Giorgi 2009, p.61; Wertz 2005, p.168). Unstructured phenomenological interviews were conducted with widows to gain in-depth and detailed descriptions of life-world experiences of their health needs. The researcher set aside her own values and beliefs, and through empathetic understanding allowed the multiple realities of the widows’ life-world experiences to emerge.

#### **2.2.1.2 Epistemological assumptions**

Epistemology is the study of knowledge and attempts to answer the basic questions: “what can be known, who can know, how we know what we know?” “what distinguishes true (adequate) knowledge from false (inadequate) knowledge?” (Krauss 2005, pp.759-761). It is believed that knowledge is subjective and context bound as there are different views and understandings of the world (Green & Thorogood, p.11; Polit & Beck 2012, p.13; Fouché & Schurink 2011, p.309; Mertens 2010, p.19). The various forms of language that are used bring human experience of knowledge into emergence. Language and meaning assist us in understanding the actual meaning of our various experiences (Munhall 2012, p.38).

The epistemology of descriptive phenomenology focuses on the meaning of the perceptions of lived experiences rather than on arguing a point or developing a theory. In descriptive phenomenology, the researchers bracket their preconceptions. The goal is to discover the essence of the phenomenon and come to a new understanding of it (Flood 2010, p.7, Kleiman 2004, pp.13-16). The researcher’s role is to look deeper into experiences of consciousness to

process how a phenomenon is constructed and understood to arrive at its essence. The focus is on what people consciously know (Giorgi, 2012, p.6; Giorgi 2009, pp.4-5; Lopez & Willis 2004, pp.726-731). Thus, people are viewed as conscious beings; having minds with which they perceive the world and reflect upon it to make meaning of their everyday experiences (Wartenberg 2008, p.19).

In this study, the researcher bracketed her prior knowledge of the widows' health support provided by the primary health care services within the City of Tshwane. The researcher believed that the experiences of widows could only be explored through in-depth interaction. This interaction enabled the researcher to explore the meaning of the phenomenon as lived through by widows and gained in-depth knowledge and a richer description of the health-support needs of widows. As a result, the findings of this study were the sole creation of the interactive process between the researcher and the participants.

### **2.2.1.3 Methodological assumptions**

Methodology outlines the specific principles or practices used to generate new knowledge about the phenomenon under study (Krauss 2005, p.759). The mode of research is determined by what one is attempting to achieve rather than adhering to a particular theory or paradigm. Thus, the methodology must be related to the phenomenon under study and should be employed correctly. The strengths of the methodology are considered of importance while the weaknesses are accepted as method-related limitations of the research. Importantly, the "strengths" of the methodology should outweigh the "weaknesses" for the research to be valid (Munhall 2012, p.113; Krauss 2005, p.761; Cavaye 1996, pp.227-239).

A constructivist assumes that reality is the results of human processes that cannot be separated from its constituents (Green & Thorogood 2014, p.18). It is assumed that the more open-ended the questioning is, the better the researcher can listen carefully to what participants say about their life-world. The researcher searches for the multiple meanings of the views of participants instead of reducing meanings by classifying them into thoughts or images (Creswell 2014, p.8). Furthermore, constructivist researchers explore meaning and focus on the specific contexts in which people live to understand their actual conscious experiences as lived by them in their natural setting. Notably, rather than focusing on a particular theory, constructivism derives a pattern of insightful meanings from the general facts or instances. This pattern of meaning culminates in this study to the essence of the experiences for several participants who have all lived through the phenomenon of widowhood (Creswell 2014, pp.8, 14).

Nursing phenomenological researchers gained insight into the fundamental principles and methodological keywords related to phenomenology. Thus, nursing phenomenological researchers most commonly base their study design on either Husserl's (1962) or Heidegger's (1962) philosophy whose point of views of the person and the world in which that person exists differ. Husserl's philosophy supports descriptive phenomenological research, whose purpose is to describe experiences as they are lived. Heidegger's view is that the researcher interprets the data, creating a strong insightful text that "brings to mind the phenomenon described" and giving insight into the meaning of the phenomenon (Flood 2010, pp.8-10; Dahlberg et al. 2008, p.24; Kleiman 2004, pp.7-12; Sadala & Adorno 2002, pp.282-286; Johnson 2000, pp.134-143).

In this study, a descriptive phenomenological inquiry grounded in the philosophy as founded by Edmund Husserl (1859-1938) was used as it focused on the description and analysis of lived experiences of widows to understand how they created meaning. In descriptive phenomenological research, reality is comprehended through embodied experience, and the constructivist phenomenologist explores, analyses and captures the meaning and essences of an experience (Flood 2010, pp.8-9; Holloway & Wheeler 2010, p.219; Giorgi 2009, pp.77-78, Starks & Trinidad 2007, p.1374). The "given" needs to be described precisely as it appears, in a straightforward description of an experience without any form of modification (Giorgi 2012, p.6; Giorgi 2009, p.78).

The researcher positions him-or herself by assuming the attitude of phenomenological reduction (bracketing). The researcher still considers what is given but handles it as something that is only present to his or her consciousness and resists saying that it actually is the way it appears. Most importantly, the researcher seeks for the richer descriptions of a phenomenon as is perceived and concretely lived by the participants prior to and independent of all personal knowledge or the scientific knowledge (Creswell 2014, pp.14, 18; Giorgi 2012, p.4; Giorgi 2009, pp.87-88; Moran 2000, p.78). The researcher suspends (brackets) scientific explanations such as theories, hypothesis and conceptualisations of the subject matter and shows special sensitivity toward the phenomenon being investigated (Giorgi 2012, p.5; Wertz 2005, pp.167-168; Moran 2000, p.11). The researcher strives to leave his or her own world behind, collaborates with the participants and empathetically joins the participant, and focuses only on the meaning of the situation as it is given in the participant's experience (Creswell 2014, p.18; Wertz 2005, p.172; Moran 2000, p.11). A phenomenological approach to research is based on the belief that the meaning of lived experiences might be only clarified through one-to-one interaction between the researcher and the participants. These interactions must involve direct contact, observation and

attentive listening to create a more complex way of understanding the meaning of the situation (Kumar 2012, p.792; Polit & Beck 2012, p.495; Husserl 1970, p.112).

In this study, unstructured in-depth phenomenological interviews were conducted to explore the human experience of widowhood as provided by the widows. The descriptions of the phenomenon were obtained from the widows by the researcher to decant the essence of the experiences of widows who have all experienced the health support by the primary health care services. During this process, the researcher adopted an attitude of phenomenological reduction, setting aside prior thoughts, conceptions or judgments and was open to the descriptions precisely as provided by the participants. The intention of analysing the collected data was to search for the essence of widowhood. The researcher empathetically engaged with participants to understand the meaning of their situations.

### **2.2.2 Historical overview of phenomenology**

Converse (2012, p.28) asserts that to produce phenomenological research findings that matches the philosophy of phenomenology, researchers should know the history and fundamental principles related to phenomenology. First and foremost, phenomenology is a philosophical approach rooted on philosophical propositions rather than theoretical concepts. Phenomenology is the study of events and trends from the viewpoint of the lived experiences of the participants seeking to develop a deeper understanding of everyday experiences. Importantly, the meaning one creates in the world is determined by the actual experiences of the person with his or her immediate environment (Tilley & Long 2014, p.233; Converse 2012, p.28; Munhall 2012, p.113).

Phenomenology originated from the views of Brentano (1838-1917) who was Husserl's teacher. Brentano's intention was to differentiate between mental and physical phenomena (Crane 2009, p.31; Moran 2005, pp.3, 18). Descriptive phenomenology as initially described by Husserl in the first edition of the Logical Investigations (Husserl 1970), has its origins in the views of Brentano. The philosophy of phenomenology in the modern sense was intended to be a philosophical method. The method was later adopted by almost all subsequent phenomenological philosophers (Converse 2012, p.29; Crane 2009, p.31, Wartenberg 2008, p.25; Dahlberg et al. 2008, pp.30-31; Moran 2005, pp.3, 18; Moran 2000, p.7).

Converse (2012, pp.28-29) outlines that prior to Husserl, the ancient Platonic allegory of the cave presented the idea that what people comprehend to be reality is only a reflection of the

phenomenon of the reality. In the 18<sup>th</sup> and 19<sup>th</sup> centuries the concept of phenomenon began to transform in a philosophical manner that viewed phenomena as things that were imagined rather than actual existence of realities. The German philosopher, Kant (2003), viewed a phenomenon as something that presented itself in the human mind in the state of "consciousness" (Converse 2012, p.29; Husserl 1970, pp.91-100). The content of consciousness describes the nature of the intentional acts of consciousness and asks how objects of consciousness present themselves (Delius, Gatzemeier, Sertcan & Wünschler 2007, p.114; Solomon 1972, p.251). Brentano's "principle of intentionality of mental phenomena" states that "every mental act is related to some object and implies that all perceptions have meaning" (Crane 2009, p.31; Moran 2005, pp.3, 18). This statement became the central theme in descriptive phenomenology (Converse 2012, p.29).

Husserl (1910-1911) was not satisfied with the progress of philosophy, as he wished that philosophy could be precisely accurate as the scientific methods of research (Crane 2009, p.31; Giorgi 2008, p.2; Moran 2005, p.35; Husserl 1970, pp.3-7). As a result, Husserl took over the conviction of Brentano that philosophy was a rigorous science as well as the view that philosophy consists of description and not of causal explanation. Moreover, descriptive phenomenology proposed a method for analysing conscious phenomena and methodological procedures that needed to be followed. For example, in the beginning of the year 1913, Husserl's philosophical method highlighted that one should assume the phenomenological attitude, come upon the "being" of the phenomenon that one is interested in studying and use the process of free imaginative variation to, first, determine the essence of the phenomenon, and, second, describe the essence that was discovered (Giorgi 2012, pp.4-5; Giorgi 2008, p.2; Giorgi 1997, p.238; Moran 2000, p.7; Husserl 1962, p.39). In descriptive phenomenology, transcendence as "going beyond" is inherent to a deeper experience of selfhood or "self-experience". The original transcendence is the living ego itself, in that it is directly experienced and is temporally constituted, and never completely able to be captured in a total view of "the self" as the self is essentially "self-transcending" (Moran 2008, p.267; Wartenberg 2008, p.27). Descriptive phenomenology emphasises a way of coming to know through the actual experience of a phenomenon with the intention of describing the experience of the phenomenon. The approach attempts to restore "reality" of humans in their "life-worlds" to capture the "meaning" of the experience (Converse 2012, p.29; Munhall 2012, p.127).

### **2.2.3 Philosophical assumptions of descriptive phenomenology**

The researcher adopted descriptive phenomenology as a philosophical framework in conducting this study as it focuses on the experiences of participants. Phenomenology is best understood as a radical style of philosophising that emphasises the attempt to get to the truth of matters, to describe the phenomenon in a manner in which it appears to the consciousness of the experiencer. Phenomenology is interested in the activities of consciousness and the objects that present themselves to consciousness (Giorgi 2009, pp.4-9; Dahlberg et al. 2008, p.29; Wertz 2005, p.167; Moran 2000, p.60).

Consciousness is the medium between a person and the world, which is designed to deal with any type of object and its manner of appearance (Patton 2015, p.115; Giorgi 2009, pp.4, 68-69). Moreover, every "outside" is what it is only as understood from the inside and the central insight was that consciousness is the condition of all human experience (Giorgi 2009, pp.4-5; Moran 2000, p.61). In addition, anything that had to be dealt with in the world had to come through consciousness and without consciousness there is nothing to be said or done (Giorgi 2009, pp. 4-9; Dahlberg et al. 2008, p.29; Wertz 2005, p.167; Moran 2000, p.60). Notably, through consciousness humans are aware of their being in the world. The body offers humans opportunities to gain access to the world and gain fuller understanding of what it means being human (Munhall 2012, p.128). Moreover, to overcome personal biases that stand in the way of achieving the state of pure consciousness, explanations should not be given before the phenomenon has been clearly comprehended and understood from within searching for the essence of lived experiences (Patton 2015, pp.115-117; Giorgi 2008, pp.67-68; Giorgi 2007, p.73; Moran 2000, p.4).

In this study, the focus was the widow's conscious awareness of her own experiences of the support given by the primary health care services. The study dealt with the widows' critical awareness of the essence of their health needs as felt and thought by them in their own existence as it manifested itself through consciousness. During the interviews, through consciousness of own experiences, the participants were able to access their experiences and described their health needs and the health support from the primary health care services in a pure "consciousness given state" as lived by them (Giorgi 2007, p.73).

## **2.3 PHENOMENOLOGY AS RESEARCH METHODOLOGY**

The philosophy of phenomenological research evolved through a strong objection of the positivist paradigm. It was brought to light that basic principles of a positivist paradigm assumed that researchers could study reality, as reality was ordered, rational and logical. The countermovement of a positivist paradigm, "the naturalistic paradigm" presumed that reality was not rigid but based on subjective realities. In this sense, the philosophy of phenomenology allied closely with the naturalistic paradigm (Reiners 2012, p.1).

Philosophy of phenomenology uses the methodological principle that scientific knowledge begins with a pure description of its subject matter. Descriptive phenomenology requires that the researcher remain unbiased and refrains from incorporating natural scientific theories, explanations, hypotheses and conceptualisations of the subject matter (Wertz 2005, pp.167-168; Moran 2000, p.2). Phenomenology deliberately restricts itself to describing carefully and without prejudice whatever is given to the experience in the actual manner in which it is given (Moran 2008, pp.265-266). Consequently, the aim of phenomenological inquiry is to understand the subjective nature of lived experiences from the perspective of those who experienced it, by exploring the meanings and explanations those individuals attribute to their experience (Cope 2005, p.168). To enable the application of the phenomenological approach one needs to understand the fundamental principles and methodological keywords related to this method. These keywords are: consciousness, experience, phenomenon and intentionality (Norlyk & Harder 2010; Giorgi 2008, 2006).

### **2.3.1 Consciousness**

Humans are conscious beings. Conscious beings humans are not merely affected by things in the environment; but are conscious of these things because humans are open to the world, to others and even to the self. In this sense, reflecting upon a partial stream of consciousness is accessing data (Wartenberg 2008, p.25; Giorgi 2007, p.73; Giorgi 2005, p.76; Giorgi 1997, pp. 236-238) (see 2.2.3 on p.29).

In this study, all participants were able to verbalise and lay bare their consciousness of the experiences that constituted their widowhood and their experiences with regard to their health needs and the health support by the primary health care services.

### **2.3.2 Experience**

Experience includes bodily awareness, embodied action, cognition, perception, volition and emotion. Experience is an “intentional” act directed towards an experienced object (Moran 2005, pp.3, 21; Husserl 1973, p.42; Spiegelberg 1964, p.327). In descriptive phenomenology experience is described as the “intuition” of “real objects”, thus objects that are in space and time regulated by causality and are given in ordinary perception (from time and space to objects and other people). In this sense, “intuition” is the broader term and “experience” the narrower one, as the latter refers to a narrower range of “presences”, those presences that serve to guide reality towards a proper understanding of human phenomena, thus how objects are perceived or what they mean (Wartenberg 2008, p.25; Spiegelberg 1964, p.326).

In this study, participants physically and psychologically lived through widowhood and understood the meaning thereof. Therefore they were able to share their experiences as perceived and the meaning they attached to these experiences with the researcher.

### **2.3.3 Phenomenon**

In phenomenology, “phenomenon” means that whatever is given or present itself is understood as accurate as it reveals itself to the consciousness of the person experiencing the awareness (Heidegger 1998, p.50). In descriptive phenomenology essences are the materials for fundamental descriptions of the “things themselves” that are objects for “intuition”. The analysis often requires that the “phenomenal meaning” be related to the “objective meaning” aimed at attaining greater clarity of the phenomenon. However, it is always the meaning of the object precisely as given that is the focus. Focusing on essences is not easy since our everyday thinking is powerfully influenced by information about contingent matters of fact, by scientific interpretations of things. As the result, to obtain this focus, it is necessary to perform various “epochs” or “abstentions” (Giorgi 2009, pp.9-10; Dahlberg et al. 2008, p.32; Cooper 2003, p.439; Giorgi 1997, pp.236-237). Epoch is seen as standing aside from one’s subjective experience to observe a particular phenomenon from a pure epistemological and totally objective perspective (Dahlberg et al. 2008, p.53). The researcher’s intention is to understand the phenomenon from the viewpoint of the lived experiences of the participants to discover the meaning of their experiences (Englander 2012, p.16).

In this study, the researcher only focused on the phenomenon under study, thus the experiences of widows regarding the health support by the primary health care services as given by the participants. Bracketing of preconceived opinions regarding the phenomenon under



study was done from the beginning to the end of the study. First, the researcher jotted down own knowledge regarding the study phenomenon. She discussed this knowledge with the study supervisors. During the interviews and data analysis the researcher revisited the identified issues to check if her opinions have not overridden those of the participants, as it was important that the researcher understood the phenomenon from the viewpoint of the lived experiences of widows with regards to the health support by the primary health services to discover the meaning of their experiences.

### **2.3.4 Intentionality**

Intentionality is the essential feature of consciousness and the “principle theme of phenomenology”. Intentionality refers to the internal directed character of consciousness, the essential interrelatedness between subjects and objects (Cooper 2003, p.440). In other words, consciousness always takes an object and the object always “passes beyond” the act in which it appears. Phenomenology is concerned with phenomena that are given to experiencing individuals, as nothing is possible if consciousness is not taken into account. In this sense, all of the givens must be understood in their given state (Cooper 2003, p.440; Giorgi 1997, p.238; McIntyre & Smith 1989, p.147). When a person experiences something, it is experienced and realised as something that has meaning (Dahlberg et al. 2008, p.47).

In this study, the researcher strove to focus on the essential meaning of the experiences of widows regarding their health needs and the support from the primary health care services. These experiences were seen as “given” to participants, to be understood in their “given state” to take into account participants’ consciousness of the real psychological meaning of the study phenomenon.

## **2.4 CRITIQUE OF PHENOMENOLOGICAL RESEARCH – AN OVERVIEW**

Researchers assert that descriptive phenomenological research has been subjected to internal as well as external critique (Norlyk & Harder 2010; Giorgi 2008; 2006; Moran 2000; Paley 1997; Crotty 1996). The most important internal critique came from Heidegger who rejected the three central facets of descriptive phenomenology. The external critique came from positivism and from the members of the Vienna Circle. Phenomenological research has been under attack for several accusations. Notably, some researchers have been critiqued for not adhering to the fundamental principles of phenomenology, misinterpreting key concepts of descriptive phenomenology and misusing the methodology of phenomenology or not meeting the criteria of

phenomenological strategies (Norlyk & Harder 2010; Giorgi 2008; 2006; Moran 2000; Paley 1997; Crotty 1996).

Researchers agree that employing phenomenology as a framework for conducting research is challenging, as phenomenology is primarily a philosophy rather than a scientific research method (Dahlberg et al. 2008; Giorgi 2008; Giorgi 1997; Giorgi 2000b; Caelli 2000; Caelli 2001). However, Giorgi (2000a) inspired nurses to continue doing phenomenological research through better insight and understanding of the original philosophy and related key concepts to apply this approach appropriately. In addition, Giorgi (2008) emphasised that the critique serves to ensure proper understanding of how to employ phenomenology and to provide adequate rationale for developing standards for submitting research identified as “phenomenological”. The critique is aimed at enabling researchers to adequately and appropriately pursue empirical research within the phenomenological tradition consistent with the original philosophy of phenomenology (Norlyk & Harder 2010, p.422; Giorgi 2008, p.1).

To overcome the critique surrounding the phenomenological approach, the researcher ensured that she understood the basic principles of phenomenology such as the need for “phenomenological reduction and eidetic reduction” and that the research approach applied was consistent with the key words: consciousness, experience, phenomenon and intentionality. Giorgi’s (2012, 2009) descriptive phenomenological method of data analysis was used, as it is compatible to descriptive phenomenology. The findings of this study were presented as participants’ concrete descriptions of the study phenomenon.

The researcher has acknowledged that research similar to the proposed study has been done before in South Africa; for example, in Limpopo Province, North West Province, (Maselesele 2005; Manyedi et al. 2003) and other countries such as Sweden, Nigeria, and Canada (Nnodim et al. 2013; Möller, Björkenstam, Ljung & Yngwe 2011; Lowe & McClement 2010). However, the studies used a qualitative, explorative and descriptive approach and open coding as a method of qualitative data analysis. In an attempt to understand the complexities and diversity of lived experiences the researchers did not employ basic principles of phenomenology such as the need for “phenomenological reduction and eidetic reduction”. In addition, it was not clear if the the research approach applied was consistent with the key words: consciousness, experience, phenomenon and intentionality related to the method employed in the study.

## 2.5 CONTEXT OF THE STUDY

This study was conducted in the City of Tshwane Metropolitan Municipality in Gauteng Province. According to Nkoane (2013), the City of Tshwane Metropolitan Municipality is one of the six metropolitan municipalities in South Africa. It forms the local government of Northern Gauteng Province. It is also the capital city of the Republic of South Africa. The City of Tshwane Metropolitan Municipality (formerly called "Pretoria") was established in 2000 and occupies a total area of 6,298 km<sup>2</sup> (2,432 sq mi) at the density of 460/km<sup>2</sup> (1,200/sq mi). The City of Tshwane Metropolitan Municipality is responsible for 14 local authorities and 105 wards, and caters for an estimated population of about 2,921,488. According to the latest census by Statistics South Africa (2011), the racial makeup of the population is as follows: Black African 75.4%, Coloured 2.0%, Indian Asian 1.8% and Whites 20.1%. The City of Tshwane is the metropolitan municipality that plays itself out in the unique multi-cultural South African society.

In this study, attention was given to widows residing in the following areas of the City of Tshwane Metropolitan Municipality: townships such as Atteridgeville, Mamelodi, Soshanguve and suburbs such as Pretoria North, Pretoria East (Lynwood, Menlopark, Meyerspark), Pretoria West (Danville, Philip Nel) and Centurion.

The researcher resides in one of the suburbs of the City of Tshwane. However, the researcher often visits the above-mentioned areas within the City of Tshwane for both personal and professional reasons. As a professional nurse, the researcher was invited to the widows' events by one of the churches in Soshanguve Township. It was during the events that the researcher became interested in the health-support needs of the widows and realised the usefulness of transforming her interest into a study on these health-support needs.

This study was conducted in two phases:

- Phase 1: The empirical phase of the study with an emphasis on the exploration and the description of the health-support needs of widows in the City of Tshwane
- Phase 2: The development of guidelines for the primary health care services to use in supporting widows in the City of Tshwane.

## **2.6 PHASE 1: EXPLORATION AND DESCRIPTION OF THE HEALTH-SUPPORT NEEDS OF WIDOWS IN THE CITY OF TSHWANE**

### **2.6.1 Phase 1: Research design**

A qualitative, descriptive phenomenological, contextual design was employed in Phase 1.

#### **2.6.1.1 Qualitative design**

A qualitative design is a systematic approach used to describe life experiences and give them deeper meaning to understand them without making assumptions. This kind of design is a way of gaining better understanding into various meanings of human experience as they naturally occur. A qualitative design follows real-life experiences and seemed to be a more effective method of investigating emotional responses, as it focuses on understanding the whole that is consistent with the holistic philosophy of nursing (Grove et al. 2015, p.20; Creswell 2014, p.185; LoBiondo-Wood & Haber 2014, p.8; Toles & Barroso 2014, p.96; Munhall 2012, p.5). Qualitative research provides an in-depth exploration and description of a phenomenon that is inductive in nature (Toles & Barroso, 2014, p.96; Botma et al. 2010, p.211). A phenomenological inquiry is inherently qualitative in nature and does not reduce human beings or experiences to parts that require separate investigation (Munhall 2012, pp.5, 169). In this sense, phenomenology subsequently questions our consciousness, "how we are in the world, how we experience the very world, and how we give meaning to the actual experiences of the world?" (Cope 2005, p.169).

The paragraphs immediately below set out the characteristics guiding qualitative research, as cited from Creswell (2014, pp.185-186) and applied to the study.

#### **a) Natural setting**

In qualitative research, data is collected at a place where participants experience the issue under study through direct, face-to-face interaction with the participants (Creswell 2014, p.185; Toles & Barroso 2014, p.124). In this study, attention was given to widows residing within the City of Tshwane. The interviews were conducted in a naturally occurring situation, at a place chosen by the participants, a place that was comfortable and familiar to them. The choice of setting enabled the researcher to observe how participants behaved within a context that was familiar to them.

### **b) Researcher as key instrument**

In qualitative research, researchers are regarded as essential tools as they tend to collect data themselves (Toles & Barroso 2014, p.125). In this study, all the data were collected by the researcher herself, with the use of unstructured phenomenological interviews. Moreover, as a psychiatric nurse, the researcher regarded herself as a skilled and experienced interviewer capable of conducting interviews.

### **c) Multiple sources of data**

Qualitative researchers do not rely on a single data source as they typically gather multiple forms of data such as data from interviews, observations, documents and audio-visual information (Grove, Burns & Gray 2013, p.286; Greeff 2011, p.359). In this study, unstructured phenomenological interviews were the primary data-gathering method as the researcher was seeking to understand the experiences of the participants. Face-to-face interviews enabled the researcher to be in close contact with the participants. All interviews were audio-recorded to capture all the data. In addition, the researcher made observational notes of verbal and non-verbal cues such as facial expressions and other gestures displayed by the participants.

### **d) Deductive data analysis**

Qualitative researchers build themes from the bottom up by organising the data into increasingly more abstract units of information. Qualitative researchers deductively look back at the data sourced in the themes to see if there is more evidence to support the themes or whether additional information is required. In this study, the widows' actual experiences regarding their health-support needs and support by the primary health care services were given meaning by the researcher in order to understand them. To arrive at the description of the essence, the data were analysed by searching for the meaning of widowhood and the support provided by the primary health care services.

### **e) Emergent design**

Emergent design implies that the initial plan for qualitative research cannot be tightly prescribed, as some or all phases of the research process might change after the researcher reaches the place of data collection. As a result there might be a need for an ongoing negotiation of consent with the participants (Toles & Barroso 2014, p.124). In this study, an initial broad open-ended question was asked for the purpose of initiating the expression of lived experiences regarding the phenomenon under study and the researcher, where appropriate, asked follow-up questions. In this study, participants were interviewed at a place chosen by them. For this

reason the sites visited varied. Five of the interviews were conducted at the participant's home while seven were conducted at the participant's place of work.

#### **f) Reflexivity and holistic account**

Qualitative researchers are required to reflect on how much their role in the study and their personal background, culture, and experiences hold potential for shaping their interpretations of the meaning they might ascribe to the data. Researchers try to develop a complex picture of the issue under study, reporting multiple perspectives and sketching the larger picture that emerges. In this study, the researcher kept a personal reflective journal to document her observations, assumptions, thoughts, and feelings and perceptions throughout the research and to examine her position on issues raised and the emerging themes. Reflective notes assisted the researcher to remain open to widows' experiences of the primary health care services and their health-support needs.

#### **2.6.1.2 Descriptive phenomenological design**

In descriptive phenomenology, three criteria must be implemented. These criteria are the perspective of natural attitude, the adoption of the attitude of phenomenological reduction, and the use of imaginative variation. The intent of descriptive phenomenology is to describe actual experiences as they are lived by the study participants based on an open life-world approach for understanding how meaning is created through embodied perception (Norlyk & Harder 2010; Giorgi 1997; Paley 1997).

In this study, the descriptive phenomenological method enabled the researcher to discover the essence of the complex experiences of widows with regard to the health support offered by the primary health care services in the City of Tshwane as this support was directly lived by the participants and described in their actual conscious experiences (Polit & Beck 2012, p.495; Burns & Grove 2011, p.76). The widows described their experiences of bereavement in terms of experiences such as sleep disturbances.

The steps consistently outlined in descriptive phenomenological studies include "phenomenological reduction", "intuiting", "analysing" and "describing" (Polit & Beck 2014, pp.270-271; Hamill & Sinclair 2010, p.16; Giorgi 2009, p.98; Dahlberg et al. 2008, p.98).

#### **a) Phenomenological reductions**

To meet the scientific psychological criteria, different levels of reduction are described: phenomenological reduction that breaks the natural attitude and brackets the world but not the

empirical subject; eidetic reduction that reduces the objects or givens to their essences; and, lastly, transcendental reduction that brackets the empirical subject as well as the world (Giorgi 2009, p.98; Giorgi 2008, p.2; 2006, p.354; Giorgi 1997, pp.239-240). Transcendental phenomenological reduction was not used in this study as it is used only on a philosophical level. Eidetic reduction is discussed as part of data analysis.

In this study, bracketing or phenomenological reduction was understood as the process of identifying and setting aside any preconceived beliefs, values and views about the issue under study with the intent to come face-to-face with the data in its exact form. Bracketing is an iterative process that involves preparing, evaluating and providing systematic ongoing feedback about the effectiveness of the bracketing by maintaining a reflexive journal in which the researcher writes down his or her observations, assumptions and confusions (Polit & Beck 2014, pp.270, 375, Todres & Holloway 2010, p.181; Giorgi 2008, p.3; Kleiman 2004, pp.13-16). In this sense, from the beginning to the end, the researcher focused on the clarification of the meanings of the phenomenon experienced by widows by setting aside her own values concerning the widows' experiences of the support from the primary health care services. The researcher allowed the multiple realities of the widows' life-world experiences of health needs to emerge and focused on the essential meaning of the perceptions of widows' lived experiences. As a psychiatric nurse, the researcher had certain pre-knowledge and perceptions regarding bereavement and widowhood that needed to be bracketed. The researcher focused only on what was given by the study participants and did not add or subtract anything but confronted the data in its pure form. The researcher jotted down any observations and confusion that she experienced during data collection in her reflexive journal.

### **b) Intuiting**

During this step, the researcher remained focused to the meanings attached to the phenomenon by those who had experienced it. The aim was to capture subjective "insider" meanings and what lived experience feels like for those who feel it. The researcher empathised with the participants by setting aside own judgments and biases and by walking in the participants' shoes. This "setting aside" behavior allowed the researcher to discover the lived world of the participant to grasp the deeper meanings of the world as they are given from a first-person point of view (Polit & Beck 2014, p.271; Giorgi 2012, pp.4-5; Hamill & Sinclair 2010, p.21; Flood 2010, p.9; Finlay 2009, pp.6, 12).

### **c) Analysing**

Analysing is the process of eliciting valuable statements, classifying the statements, and making sense of the essential meanings of the phenomenon (Polit & Beck 2014, p.271). In this study, the researcher ensured that the verbatim transcriptions of the recorded interviews were accurate and that they validly reflected the interview experience. The four steps of Giorgi's (2009, 2012) method were used to guide the data analysis of this study. This analysis will be described in detail later in this chapter (see Section 2.6.2.4).

### **d) Describing**

The descriptive phase occurs when the researcher reaches the state of understanding and describing the phenomenon under study. The researcher aims for a richer description of an experience in its density and richness. The true meanings of the experience for the individuals are described (Polit & Beck 2014, p.271; Finlay 2009, p.10). The important point is for the researcher not to separate a given experience from the concrete meaning structure that the person is trying to affirm in his or her daily life (De Castro 2003, p.48). In this study, the researcher described the uniqueness of the widow's experiences with regard to the meaning they attached to the services provided by the primary health care services in the City of Tshwane.

#### **2.6.1.3 Contextual design**

In contextual design the researcher has a preference for understanding events, actions and processes in a specific concrete and natural context where the research phenomenon occurs. The context was a specific urban area in South Africa. The contextual design produced a richer understanding of the social phenomenon of widows' experiences of the primary health care services (Babbie 2014, p.326; Babbie 2010, p.295; Babbie & Mouton, 2007, p.272).

### **2.6.2 Phase 1: Research method**

In this section the study population, sampling, data collection and data analysis will be discussed.

#### **2.6.2.1 Study population**

The study population in Phase 1 included widows who lived in the City of Tshwane, Gauteng Province in South Africa in the areas mentioned in Section 1.10.1, who had lost a spouse a year or more before but less than five years before the study, irrespective of the cause of death. In the South African culture, particularly within the Zulu, Tswana, Sotho and Pedi culture, widows



are expected to mourn for a period of at least one year without participating in social activities such as being a participant in research (Ramukumba 2011, p.158; Rosenblatt & Nkosi 2007, pp.77-80; Manyedi et al. 2003, p.69). Moreover, in the researcher's opinion, a period of one year was long enough for the participants to have experienced a broad range of health support. The population was widows aged between 25-65 years, from Sepedi, Sotho and Tswana ethnic groups. These ethnic groups form a larger portion of the population in the City of Tshwane and share similar cultural beliefs, values and practices. Inclusion of all ethnic groups in the City of Tshwane might have made it difficult for the researcher to obtain an essential experience because of too many different cultural beliefs and practices.

The study included only widows who had not remarried, since the term "widow" is ascribed only to a woman who has survived her husband and has not remarried (Olukayode 2015, p.67). The participants needed to have been living together with the deceased at the time of death because the literature indicates that there is evidence of association between kinship and the person's adaptation to widowhood (Lalive d'Epinay et al. 2010, pp.316-317; Mancini et al. 2009, p.1133; Schaefer & Moos 2001, p.156). The participants needed to be able to speak English well enough to participate in the interview. The study included 12 widows from heterosexual marriages, who utilised primary health care services for support and who indicated to the researcher that they were "emotionally ready" to participate in the study. See Table 2.1 for the profile of the participants immediately below.

**Table 2.1: Profile of the participants from Sotho, Tswana and Pedi cultural groups**

NO	PARTICIPANT	AGE	WIDOWHOOD PERIOD	EMPLOYMENT	NO.OF CHILDREN	AREA	AREA OF INTERVIEW
1.	MK (P1)	45	2 years	Shop assistant	2	Mamelodi	Home
2.	TM (P2)	25	3 years	Tertiary student	2	Mamelodi	Home
3.	NM (P3)	50	1 year	Helper (maid)	1	Soshanguve	Home
4.	PMM (P4)	40	3 years	House wife	3	Atteridgeville	Home
5.	TLM (P5)	41	5years	Nurse	2	PTA North	Work
6.	KPs (P6)	32	2 years	Teacher	2	Meyerspark	Work
7.	MKs (P7)	35	2 years	Social worker	2	Centurion	Work
8.	DL (P8)	47	4 years	Tailor	3	Soshanguve	Work

9.	MS (P9)	57	1 year 6 months	Typist	2	Soshanguve	Work
10.	MMW (P10)	62	5 years	Nurse	4	Attridgeville	Work
11.	DRK (11)	46	2 years	House wife	3	Danville	Home
12.	BRL (12)	29	1year 3 months	Clerk	3	Montana	Work

### 2.6.2.2 Sampling

In this study, a non-probability, purposive sampling method was used by identifying potential participants from available lists from widows' forum and lists of widows who attended widows' day events in one of the churches in Soshanguve Township. In qualitative research the focus is on the richer understanding of the participants' experiences and gives them meaning rather than the size of the sample. Notably, the quality of the content influences the sample size. Thus, when the quality is high with rich content; fewer participants are required to gain insight into the study phenomenon (Grove et al. 2015, p.275; Patton 2015, p.311; Grove et al. 2013, pp.362, 371; Polit & Beck 2012, p.521). A representative sample is essential when the aim of the research is to generalise the results across the whole population (Green & Thorogood 2014, p.121; Polit & Beck 2012, p.516; Strydom 2011, p.226).

In this study the attempt was to achieve a more comprehensive, contextual understanding of the phenomenon under study rather than generalising the results across the whole population (Creswell 2014, pp.203-204; Ellis & Hartley 2012, p.569; Ellis & Hartley 2009, p.490). In phenomenological research, the number of participants to interview cannot be decided in exact numbers before the project is running as the question of variation or diversity is more important than the number of participants (Polit & Beck 2014, p.287; Dahlberg et al. 2008, p.175). When selecting the participants for a phenomenological study, the researcher has to ask the question: Do you have the characteristics related to the purpose of the study or information about the specific phenomenon? (Holloway & Wheeler 2010, p.138; Procter, Allan & Lacey 2010, p.149; Macnee & McCabe 2008, p.121). The results of the study cannot be evaluated on the basis of the sampling size. However, the more complex a phenomenon is, the larger the group of participants (Dahlberg et al. 2008, p.175).

In this study, the researcher chose and included participants who had a specific experience of the phenomenon. Only widows who utilised the primary health care services within the City of Tshwane were included in the study. The sampling size of this study was 12 widows and this

number was considered adequate when saturation and verification of information were achieved. Saturation of information occurred when the researcher has gained in-depth information and meaning structure of the phenomenon being studied, and further sampling provided continuous repetition of information already collected from previous interviews (Englander 2012, pp.17-22; Burns & Grove 2011, p.317; Strydom & Delpont 2011, p.393; Giorgi 2009, pp.198-199). However, saturation is not a common concept in life-world research since life-world research holds the ontological and epistemological thought that meanings have no limits, as they always become greater in scope and extensive in meaning (Dahlberg et al. 2008, pp.175-176).

### **2.6.2.3 Data collection**

The researcher assumed phenomenological reduction as described in Section 2.6.1.2a. The researcher's preconceptions regarding the health support needs of widows and the support from the primary health care services were set aside to ensure that the researcher did not allow her assumptions to shape the data collection or impose her understanding and construction of the data (Polit & Beck 2014, p.270; Hamill & Sinclair 2010, p.16; Gearing 2004, p.1430; Finlay 2002b, p.537). The researcher stayed aware of her own values and how they might influence question phrasing. The researcher knew what needed to be bracketed, attempted to understand the phenomenon correctly as described by the participants, and checked understanding with her supervisors (Hamill & Sinclair 2010, p.18).

In the phenomenological approach, data collection is based on the absolute insight that meanings are associated to the life-world and come to be in a close relationship between the researcher and the phenomenon. Since the phenomenon is seen as an object that reveals itself to a subject or is observed by a subject, data collection in reflective life-world studies is also an intersubjective relationship (Section 2.6.3). The life-world researcher should adopt an open approach to find a way through all these meaning relations to perceive the phenomenon, its different character and significance (Dahlberg et al. 2008, p.172). The following factors, namely access of participants, information sessions and interviews were taken into consideration:

#### **a) Access of participants**

Once potential participants were identified, the researcher contacted them in person to explore their eagerness to partake in this study. Once they had agreed to participate in this study, appointments were made with each participant to be interviewed at a place, time and date mostly convenient to her. The appointments with individual participants were made

telephonically or in person well in advance and the researcher confirmed the appointments prior to the scheduled date of data collection.

### **b) Information session**

An information session was held with participants before the main interview started to give them information about the process of the study. During this session, the researcher introduced herself to the participants and rapport was established. The participant's demographic data was collected to check if she met the study inclusion criteria. The participants were reassured about the credibility of the researcher to conduct this study. The researcher is qualified in advanced psychiatric nursing and is equipped to deal with the emotional implications that the interview might have for the participant. Furthermore, participants were made aware of the necessary steps taken by the researcher to ensure that this research was ethically sound (Refer to Annexure A: Approval certificate 107/2015).

### **c) Interviews**

In phenomenological research, in-depth interviewing is the main mode of data collection (Marshall & Rossman 2016, p.153; Flood 2010, p.11). In particular, the unstructured individual phenomenological interviews were the primary data-gathering method because the researcher was seeking to understand the experiences of the participants. The researcher herself conducted the interviews in English. Interviews gave the researcher an opportunity to be in subject-subject contact with the participants in a naturally occurring situation to gain a first-person description of the experience. During this contact, the researcher was able to provide a context in which participants felt free. The researcher was able to build rapport and trust with the participants to facilitate adequate data collection. The rapport and trust allowed the widows the opportunity to elaborate on their lived experiences. The researcher presented herself as the listener and asked participants to give accounts of their experience of a phenomenon. The researcher was able to shift from the subject-subject relation to the subject-phenomenon relation to encounter the phenomenon via the widow's descriptions (Englander 2012, pp.25, 34; Starks & Trinidad 2007, p.1375).

The factors-research venue and time frame for the interview process were taken into consideration. These factors as well as establishment of rapport, communication techniques and the post-interview debriefing session are discussed in the paragraphs that follow.

- **Research venue**

The research venue has already been described as changing from participant to participant so that participants could choose a place where they would feel as comfortable and free as possible (Fouché & Schurink 2011, p.332). As the result, five of the interviews were conducted at the participant's home while seven were at the participant's place of work. The researcher checked and ensured that the setting chosen was not noisy or distracting, provided privacy, and had seating arrangements that encouraged interaction (Burns & Grove 2011, p.321; Greeff 2011, p.350). Moreover, the participants had informed their family members or colleagues that they did not want to be disturbed.

- **Time frame**

Interviews with participants took about 30 to 55 minutes depending on the data available and continued until the participant had nothing more to say (Polit & Beck 2012, pp. 62, 521).

- **Establishment of rapport and trust**

Qualitative data researchers need to create an atmosphere that safely allows participants to share experiences and feelings (Polit & Beck 2012, p.535). In this study, the participant was greeted and the researcher introduced herself and allowed the participant the opportunity to introduce herself to establish rapport and trust. The researcher thanked the participant for her willingness to be involved in this study. The process of this research was explained and the researcher asked the participant the permission to record the interview and explained the purpose of doing so.

The participant was informed that the recorded interview would be transcribed and the transcripts would be used solely for research purposes. The participant was reassured that her identity would be kept anonymous and that the research data would be documented in such a way that it could not be linked to her name. As a result, during the interview participants looked relaxed and spontaneous in answering the research questions. After the interview, each participant was thanked for her participation.

- **Communication techniques**

In unstructured, in-depth phenomenological interviews often there is no set of prepared questions but only a grand tour question that is less rigid and makes it possible to follow the intent and thoughts of the participants. However, along with the overview question there are often additional questions that are derived from the conversation (Toles & Barroso 2014, p.102;

Polit & Beck 2012, p.536). Once the participant looked relaxed and ready for the interview, an initial broad open-ended question was asked to facilitate the interview without leading the discussion: *"Tell me about your experiences of widowhood"*. In addition, follow-up questions were asked: *"What are your experiences regarding the support that you received from the primary health care services such as clinics following the death of your spouse?"* and *"What support did/do you need from the primary health care services following the death of your spouse?"* (Refer to Annexure C). The researcher asked a less emotional question first to allay anxiety. Moreover, participants readily responded to all questions that were asked. The researcher asked the widows for a description of a situation in which they experienced the phenomenon to discover the meaning of the phenomenon. The use of open-ended questions yield in-depth responses about the experience and leaves the direction of the answer up to the individual participant (Patton 2015, p.14; Boswell 2014, p.274). In this study, the use of open-ended questions allowed widows to verbalise and elaborate on their lived experiences with regard to the health support provided by the primary health care services (Englander 2012, p.27; Holloway & Wheeler 2010, p.89). This open communication enabled the researcher to have extensive description of the experiences that widows had gone through (Giorgi 2009, p.122).

Various communication techniques such as paraphrasing, clarification, exploration and reflecting were used as needed to facilitate the progress of the interview. Paraphrasing was used during the interviews to ensure that research questions were well understood. Furthermore, the researcher ensured that paraphrasing was posed accurately in order not to distort the meaning of the message. Clarification was used to check whether understanding was accurate to avoid making invalid assumptions and missing valuable information. The researcher encouraged the participants to be specific and as detailed as possible when answering questions to avoid a superficial level of communication. The technique of reflection was used to remind participants of what was said and for the participant to recognise that her point of view was valuable (Townsend 2015, pp.141-144; Burger 2013, pp.320-325; Greeff 2011, pp.345-346).

- **Debriefing session**

Immediately after the interview, the researcher asked each participant to state if she would need any counseling and or emotional support. However, all 12 participants indicated that there was no need for counseling. The researcher made them aware that they could still contact her if they

needed emotional support or referral to appropriate services. However, none of the 12 participants contacted the researcher for emotional support or referral to appropriate services.

#### **2.6.2.4 Data analysis**

Data analysis is the method used to lessen the amount of data in an orderly form to give meaning to the data (Polit & Beck 2014, pp.300-301; Burns & Grove 2011, p.535). After data were collected, the researcher prepared the data by transcribing the audio-taped interviews verbatim (Green & Thorogood 2014, p.208). Descriptive phenomenological data analysis is about understanding phenomena and finding their precise meaning (Dahlberg et al. 2008, p.231). Within phenomenology, a more precise meaning is given to the word "experience". Experience is described as the intuition of "real objects" that are in space and time, and are given in ordinary perception. The analysis often requires that the "phenomenal meaning" be related to the "objective meaning" to attain clarity. However, the focus is on the meaning of the phenomenon precisely as given (Giorgi 1997, pp.236-237).

In this study, the researcher attempted to understand the meaning of the experiences of widows with regard to the primary health care services and the description of the health-support needs of the widows in the City of Tshwane based solely upon what was presented in the data. Thus, the researcher stayed with the empirical original data that were given by the participants (Giorgi 2009, p.127; Dahlberg et al. 2008, p.241). The emphasis was on openness and sensitivity towards the life-world description, the phenomenon and its meaning (Dahlberg et al. 2008, p.231) to describe the essence of the phenomenon as accurately as possible (Giorgio 2009, p.91). The researcher and an independent coder analysed the transcribed interviews before discussing them in terms of the available literature. The assumption of the eidetic reduction was the first step that guided the process of data analysis. Thereafter the four steps of Giorgi's (2012, 2009) descriptive phenomenological method of data analysis as used in the study will be discussed.

##### **a) Assumption of the eidetic reduction**

Eidetic reduction is a process of reducing a particular object to its essence during data analysis (Giorgi 2008, p.90) as the researcher concentrates upon the inherent components of phenomena, which are the general underpinnings by which phenomena are meaningfully cohesive (Dahlberg et al. 2008, p.54). The researcher brings to consciousness an instance of the phenomenon to be explored, whether actual or factual by using the process of free imaginative variation. The aim is to discover the inherent characteristics of the phenomenon

being studied, taking into consideration that if the imaginative elimination of an aspect causes the phenomenon to collapse, the aspect is essential. On the other hand, if the variation of an aspect of the given hardly changes what is presented then that aspect is not essential (Giorgi 2008, p.3; 2006, p.355).

#### **b) Reading to search for sense of the whole**

The transcribed interviews were read through entirely within the phenomenological scientific reduction to comprehend the general sense of the entire description. This "reading" enabled the researcher to have a clear comprehension of the experience of the participant from the consciousness and the standpoint of the participant (De Castro 2003, p.47).

#### **c) Re-reading the description and demarcating spontaneous shifts in meaning**

The researcher went back to the beginning of the description and reread to make sense of the whole. The researcher made note of thoughts that came to mind while reading and writing it down. The ultimate goal of the task was to grasp a sense of the whole meaning of the experience (Giorgi 1997, p.245).

#### **d) Generation and determination of natural meaning units**

The researcher reread the entire transcript and made an appropriate mark in the data every time she experienced a significant shift in meaning (process of constituting parts). This process was aided by the method of free imaginative variation searching for essences. At this stage, the researcher had manageable units and began to understand the data more deeply consistent with the scientific discipline; in this case, a nursing discipline. Thorough understanding of the meaning units facilitated the organisation and expression of raw data into disciplinary language (Giorgi 2009, p.131; Giorgi 1997, p.247; Dahlberg et al. 2008, p.243).

#### **e) Synthesising the reflections and insights into a consistent statement**

At this stage, the researcher focused on the intentionality of the experience. The researcher went back to the beginning of the description and the reflections and insights were summarised into a consistent statement that expressed the participants' experiences. Thus, the researcher asked the questions: what is the essential structure of the phenomenon or experience? And how does that phenomenon or experience take place? With the help of free imaginative variation the researcher described the essential structure of the concrete, lived experience (Giorgi 2008, p.2; Giorgi 1997, p.247).



## 2.7 RIGOUR OF THE STUDY

In qualitative research, rigour is appraised in association to attentiveness of data gathering and precision of data analysis (Grove et al. 2015, p.68). Most importantly, the researcher's honesty about his or her personal opinions, preconceived thoughts and values regarding the phenomenon is vital (Starks & Trinidad 2007, p.1376). In line with descriptive phenomenological research rigour was established in this study through reflexivity and bracketing as summarised in Table 2.2.

**Table 2.2: Overview of strategies to ensure rigour of the study**

STRATEGY	CRITERIA	TECHNIQUE
Reflexivity	Self awareness	<ul style="list-style-type: none"> <li>- Prior to the research, the researcher engaged in self-talk regarding the phenomenon under study: conscious, thoughtful awareness of her personal values, beliefs and attitudes.</li> <li>- Personal reflective journal was kept and the researcher bracketed her beliefs as a professional nurse with years of experience as an advanced psychiatric nurse.</li> </ul>
	Reflexive embodied empathy	<ul style="list-style-type: none"> <li>- Face-to-face individual interviews were conducted.</li> <li>- Non-verbal cues were observed and recorded.</li> <li>- Sensitivity was exercised towards the verbalised health-support needs.</li> </ul>
	Reflective notes	<ul style="list-style-type: none"> <li>- Personal reflective journal was kept, for example the researcher believed that widowhood was a societal issue rather than an individual issue.</li> <li>- Researcher learnt to accept the uniqueness and differences in others.</li> <li>- Recorded observations of non-verbal</li> </ul>

		behavior were kept as field notes (Chapter 3, 3.3).
Bracketing	Abstract formulation	<ul style="list-style-type: none"> <li>- This study is grounded in a phenomenological philosophical framework.</li> <li>o Researcher's ontological assumptions: The researcher set aside her own values and allowed the multiple realities of the widows' life-world experiences of health-support needs to emerge.</li> <li>o Researcher's epistemological assumptions: Interactive mode of data collection was used and the researcher focused on the meaning of the perceptions of lived experiences.</li> </ul>
	Research praxis	<ul style="list-style-type: none"> <li>- Bracketing of preconceived opinions regarding the phenomenon was done from the beginning to the end of research. The researcher jotted down own knowledge regarding the phenomenon. The researcher revisited the findings to check if her opinions had not overridden those of the participants</li> </ul>
	Reintegration	<ul style="list-style-type: none"> <li>- Raw data of the research was analysed and discussed in terms of the available literature.</li> <li>o Literature synthesis on the phenomenon was delayed until data collection and analysis</li> </ul>

(Giorgi 2009; Wojnar & Swanson, 2007; Cope 2005; Finlay 2005; 2002b)

### **2.7.1 Reflexivity**

To increase the rigour of descriptive phenomenological research, it is vital for researchers to find ways to analyse how subjective and intersubjective elements influence their research. Researchers should recognise the implicit, “hidden agenda” that they bring to the research process, as the primary aim is to explore phenomena from the level of lived experience and not to explore or confirm one’s own perceptions (Giorgi 2009; Wojnar & Swanson 2007; Cope 2005). Reflexivity was applied through self-awareness, reflexive embodied empathy and reflective notes. To be reflexive, the researcher had an ongoing conversation about the experience and attempted to disentangle her perceptions and interpretations from the phenomenon being studied (Patton 2015, p.70; Finlay 2002b, pp.531-534).

Through the use of reflexivity, the researcher engaged in thoughtful, conscious self-awareness of her role in the research process. The process of engaging in reflexive analysis started from the time the research was conceived when the researcher reflected with her supervisors on both the topic and her own relationship to that topic. Throughout the research, the researcher continuously evaluated her subjective responses, intersubjective dynamics and the research process itself to understand the phenomenon of widowhood (Hamil & Sinclair 2010, p.18-21).

#### **2.7.1.1 Self-awareness**

Reflexivity demands the researcher to develop a “thoughtful, conscious self-awareness” (Finlay 2002b, p.532). The strategy of reflexivity was used to allow the researcher to reflect critically on the self, scrutinising and taking note of own values that could influence data gathering and analysis. The researcher jotted down notes about her opinions, assumptions or judgments regarding the phenomenon under study (Cope 2005, p.181; Finlay 2002b, p.537), for example, the researcher believed that widowhood was a societal issue rather than an individual issue. However, the researcher learnt to accept the uniqueness and differences in others. This learning allowed the researcher to become aware of her own presuppositions regarding the phenomenon so that she could set them aside and attempt not to impose them on the participants (Cope 2005, p.181; Finlay 2002b, p.537).

#### **2.7.1.2 Reflexive embodied empathy**

During the process of reflexivity, one fundamental condition required is the researcher’s ability to empathise. Notably, the process of empathising requires the researcher to be entirely immersed into the participant, putting aside his or her own opinions and walking into the participant’s life-world. In this study, the researcher left behind her own life-world and

understandings to envision herself into the other's situation in an attempt to see the world through the other's eyes. This attempt was manifested in the researcher's determination to perceive and understand the participants' life-world (Patton 2015, p.59; Hamill & Sinclair 2010, pp.21-22; Spiegelberg 1975 & Depraz 2001 as cited in Finlay 2005, pp.278, 290).

The researcher's capacity to understand the phenomenon under study was enhanced through reflexive awareness during which the researcher became fully and thoughtfully involved, taking seriously how the participant speaks (Finlay 2005, pp.277-278). The use of empathy enabled the researcher to be sensitive enough to access inner experiences and the world of the participant to expose the essences of the lived experience of the support rendered by the primary health care services following widowhood (Patton 2015, p.59; Munhall 2012, p.158; Hamill & Sinclair 2010, pp.21-22).

### **2.7.1.3 Reflective notes**

The researcher kept a personal reflective journal to document her observations, thoughts, feelings, confusions and perceptions throughout the research and examined her position on issues raised and the emerging themes. Reflective notes assisted the researcher to remain open to the experiences of widows regarding the primary health care services and their health-support needs (Creswell 2014, p.186; Polit & Beck 2014, pp.294-295; Munhall 2012, p.158).

### **2.7.2 Bracketing**

During bracketing (phenomenological reduction), the researcher's preconceptions were set aside to ensure that the researcher did not allow her assumptions to shape the data collection or impose her understanding and construction of the data (Hamill & Sinclair 2010, p. 18). In this study, before the researcher could perform the reduction, the researcher had to possess qualities such as being aware of her own values and how these values might influence question phrasing. The researcher knew what needed to be bracketed, understood the phenomenon correctly as described by the participants and checked her own understanding with supervisors (Hamill & Sinclair 2010, p.18-21).

Bracketing comprises three general but distinctive phases as will be described in sections 2.7.2.1 to 2.7.2.3.

### **2.7.2.1 Abstract formulation**

Abstract formulation has two essential elements, which are orientation standpoint and theoretical framework. The orientation standpoint comprised the researcher's epistemological and ontological perspective (see Section 2.2). Consistent with phenomenological inquiry, no specific theoretical framework, hypothesis or constructs were followed or developed, as the study was grounded in a phenomenological philosophical framework (Finlay 2005, p.276).

### **2.7.2.2 Research praxis**

This phase encapsulates the fundamental elements of bracketing, which are foundational focus, internal (researcher) supposition, external (phenomenon) supposition, temporal structure and parenthesis (boundary) composition. In this study, three main foundational foci in bracketing were followed. First, the researcher identified and set aside preconceived beliefs, opinions and previous experiences regarding the aspect of widowhood (Polit & Beck 2014, pp.270-271; Hamill & Sinclair 2010, p.16; Giorgi 2009, p.98; Dahlberg 2008, p.98). Second, the researcher focused on the essences and structure of the phenomenon to uncover the meaning of the widows' experiences of the support given by the primary health care services following the death of the spouse. Third, the researcher attempted to set aside presuppositions and her own understandings of the phenomenon to see the world as new (Finlay 2005).

The internal suppositions were made up of personal suppositions of the researcher based on the researcher's personal knowledge, history, culture, assumptions, beliefs, experiences, values and viewpoints. External suppositions were centred on the phenomenon being investigated, such as its history, values or beliefs of the phenomenon, definition of the phenomenon, and larger environmental factors. Moreover, it was important that the researcher provided the temporal structure of bracketing to delineate the start point, length of time it occurred and the end point of bracketing within the confines of her specific research. Furthermore, the researcher had to indicate the boundaries (parenthesis) of bracketing (Finlay 2005; Finlay 2002b).

In this study bracketing was considered throughout the entire research process, from the beginning to the end. Before starting with the research, the researcher wrote down what she knew about the topic and what she thought the issues were, in this way bringing these issues to the consciousness. The researcher revisited the identified issues throughout the project to ensure that her ideas, culture and values had not overridden those of the participants (Hamill & Sinclair 2010, p.20-22).

### **2.7.2.3 Re-integration**

This phase focused on the unbracketing and subsequent reinvestment of the bracketed data into a larger investigation. This process involved the folding of the bracketing technique back into the larger research and required an interpretation or reintegration of the data into the equation after the data derived from within the brackets had been achieved (Finlay 2005).

In this study, the researcher ensured that the data possessed everything essential to the completeness of the widows' experiences regarding the health support provided by the primary health care services. The researcher discussed the research process, her thoughts about possible meaning units that required clarification and the findings of this study with supervisors who had experience in descriptive phenomenological research.

## **2.8 PHASE 2: DEVELOPMENT OF GUIDELINES FOR THE PRIMARY HEALTH CARE SERVICES TO SUPPORT WIDOWS**

Phase 2 of this study focused on the development of the guidelines for the primary health care services to promote adequate and appropriate health support for widows. The development of the guidelines was grounded in the empirical data collected in Phase 1 supported with sufficient literature findings. A literature search of relevant sources was undertaken. A literature synthesis was conducted to enrich the findings of this study and to create a fuller understanding of the essence and constituents (Dahlberg et al. 2008, pp.272-273). Guidelines were drafted and formulated by selecting appropriate statements from the empirical data (Refer to Annexure H). During the formulation of draft preliminary guidelines, the researcher observed various principles related to the development of the guidelines. These principles included clarity, validity, relevance, comprehensiveness, applicability, effectiveness and acceptability (see Chapter 5, 5.3.1) (Mahtani 2015; Agree Collaboration 2010; 2003-2013; Parahoo 2006; Thompson & Dowding 2002).

### **2.8.1 Phase 2: Research design**

In this phase, the development and validation of guidelines was directed by the framework developed by the researcher based on AGREE II (2010) instrument: advancing guideline development, reporting and evaluation in healthcare, and AGREE II (2003-2013) instrument: appraisal of guidelines for research and evaluation. The framework incorporated the Delphi technique to ensure reliable guidelines. The Delphi technique is a method for obtaining judgments and views from an expert panel about a topic of interest with the agenda of seeking

formal consensus about an issue (draft guidelines) without direct confrontation (Polit & Beck 2012, p.267; Keeney, Hasson & McKenna 2011, p.3; Bowker et al. 2008, pp.85-95; Parahoo 2006, p.199).

### **2.8.2 Population**

The most important aspect of the Delphi technique is choosing an appropriate group of experts who are qualified and knowledgeable to answer the questions and give relevant inputs (Keeney et al. 2011, pp.7-8; Bowker et al. 2008, p.85; Okoli & Pawlowski 2004, pp.16-18). The study was explained to all participants personally or per electronic mail communication and they were all oriented about their responsibilities considering the Delphi rounds.

### **2.8.3 Sampling**

The researcher compiled a list of prospective participants based on their expertise and purposively selected them based on the specified inclusion criteria. The researcher included 16 qualified experts from academic, private, government and non-government organisations in the area of qualitative research, policy and or guideline development, healthcare, bereavement counseling, or human behavior (Keeney et al. 2011, p.10). Participants in the validation of guidelines needed to have had at least five years' experience in an area of specialisation. In the researcher's opinion, a period of five years is long enough for the person to have gained the necessary skills and experience in the area of expertise. In this study, the researcher included academics such as researchers who are skilled and experienced in qualitative research, policy and guideline development, mental health nurses, psychiatrists, psychologists, social workers and church ministers or health care promoters.

### **2.8.4 Data collection**

The process of data collection was conducted in three rounds. The researcher facilitated the process of data collection in each round while the respondents remained anonymous to each other (Green & Thorogood 2014, p.128; Okoli & Pawlowski 2004, pp.19-20). Each participating expert was given a period of about two weeks to respond to the validation of the preliminary guidelines formulated and adapted after each round. First, the researcher drafted the preliminary guidelines based on the empirical data (statements originally expressed by participants) and the relevant literature. Expert participants were each given or e-mailed the drafted guidelines with an instrument to evaluate the validity of the guidelines according to a Likert scale as well as open-ended comments. After the analysis of the data by the researcher after each round, the guidelines were refined and adapted based on the feedback received

from participants and the same experts were given the refined guidelines. The feedback process given in each round allowed and encouraged the Delphi participants to reassess their initial judgments. Comments and evaluation after each round occurred until members of the panel came to a consensus (Green & Thorogood 2014, p.128; Bowker et al. 2008, p.88; Hsu & Sandford 2007, p.2).

#### **2.8.4.1 Round 1**

During this round, the initial preliminary guidelines drafted by the researcher based on the findings of Phase 1 and the relevant literature were sent to Delphi respondents to give their opinions freely and independently without being influenced by anyone (Polit & Beck 2012, p.267; Keeney et al. 2011, p.11). Each expert participant was provided with the drafted preliminary guidelines with an instrument to evaluate the validity according to a Likert scale as well as open-ended comments (Annexure I). After receiving respondents' responses, the researcher analysed the data and converted the collected data into the second round of refined guidelines (Bowker et al. 2008, pp.88-90; Hsu & Sandfort 2007, p.2).

#### **2.8.4.2 Round 2**

Feedback on the refined guidelines inclusive of the ratings from the Likert scale and a summary of comments given by the respondents was provided to all experts to observe how their views differed from the views of others. Feedback gave each respondent an opportunity to gain deeper understanding of the issue at hand and become more problem-solving oriented. Thus, in a Delphi study, the results of previous iterations regarding specific statements and/or items could be changed by individual panel members in subsequent rounds based on their ability to review and assess the comments and feedback provided by other Delphi panelists (Keeney et al. 2011, pp.11-12; Bowker et al. 2008, pp.90-93; Hsu & Sandfort 2007, p.2). This procedure offered the researcher the opportunity to evaluate whether her opinions differed from those of Delphi panelists. The researcher had an opportunity to stick to her decision or choose to concur with the group (Botma et al. 2010, p.254; Hsu & Sandfort 2007, p.3). The researcher refined guidelines based on the feedback received from participants in round 2 and then the refined guidelines were circulated again for comments and evaluation.

#### **2.8.4.3 Round 3**

This was the final round. The list of remaining items including their ratings, minority opinions and items achieving consensus were distributed to the panelists. This gave the panelists the final opportunity to revise their judgments. The process was thus repeated as needed until some



degree of consensus was reached and the final guidelines were assembled and organised by the researcher (Annexure K) (Botma et al. 2010, p.254; Bowker et al. 2008, pp.93-94; Hsu & Sandfort 2007, p.34).

#### **2.8.4.4 Data analysis**

In the Delphi process, data analysis could involve both qualitative data in the form of open-ended comments made by respondents and quantitative data in a form of Likert scale rating from 1-4 (Hsu & Sandfort 2007, p.4). In this study, rating 1 meant that the respondent strongly disagreed with the guideline; rating 2 meant that the respondent disagreed; rating 3 meant that the respondent agreed and rating 4 meant that the respondent strongly agreed with the guideline. The ratings were based on whether the developed guideline was clear, valid, relevant, comprehensive, applicable, effective, flexible and acceptable to the primary health care services (see Chapter 5, 5.3.1). The ratings were analysed using an excel spread sheet. The comments were analysed according to qualitative data analysis. The researcher read through, identified and clustered the common themes highlighted by Delphi respondents (Bowker et al. 2008, pp.90-94; Hsu & Sandfort 2007, p.4).

## **2.9 SUMMARY**

In this chapter, the searcher's paradigmatic perspective and the methodology of the study were described in detail. The qualitative, descriptive phenomenological and contextual design and method of Phase 1 and the consensus design and method that were used in Phase 2 of this study were addressed. The findings on widows' health-support needs in the City of Tshwane will be addressed in Chapter 3.

## CHAPTER 3

### DISCUSSION OF THE RESEARCH FINDINGS FROM PHASE 1

#### 3.1 INTRODUCTION

Chapter 3 discusses the findings of Phase 1 of this study deduced from the phenomenological analysis of the participants' interview transcripts, as well as the field notes recorded by the researcher. The 12 participants that were interviewed resided in different townships and suburbs within the City of Tshwane Metropolitan Municipality. Their ages ranged between 25-65 years. Participants were from Sepedi, Sotho and Tswana ethnic groups (see Table 2.1 in Chapter 2). The researcher herself conducted the interviews in English at a place chosen by the participant. As the result, five of the interviews were conducted at the participant's home while seven were at the participant's place of work. All interviews were audio-recorded and were transcribed by the researcher. A copy of a transcript is included as Annexure D.

The transcribed individual interviews were analysed by the researcher and the independent coder. The assumption of the eidetic reduction was the first step that guided the process of data analysis. Thereafter the four steps of Giorgi's (2012, 2009) descriptive phenomenological method of data analysis was used (see Chapter 2, 2.6.2.4). The essence of the widow's experiences, as well as the constituents related to widowhood, support needs and health support required by widows from the primary health care services were deduced from the transcribed interviews. In this chapter, the essence of the experiences of widows regarding the support by primary health care services is presented followed by the descriptions of the constituents of the essence and the researcher's own emphasis on the constituents.

The essence of the findings was intuited through eidetic discovery with the help of free imaginative variation. Essence expresses what necessarily must belong to the phenomenon under study if it has to appear as a phenomenon of a given type. Moreover, essence makes the essential characteristics of a phenomenon understandable (Dahlberg et al. 2008, pp.245-252; Giorgi 2009, pp.67-86). The findings consist of a presentation of the essence on an abstract level followed by an in-depth description of the constituents – the meanings that constitute the

essence. The range of nuances of meanings attached to the phenomenon are reflected in the description of the constituents and illustrated with direct quotations from the interviews—expressed in the voices of the participants (Giorgi 2009, pp.129-130). The essence of widows’ experiences of widowhood, as well as the constituents related to widowhood experiences, widows’ experiences of support and health support required by widows from the primary health care services are summarised in Table 3.1.

**Table 3.1: Essence and constituents representing the experiences of widows**

<b>No.</b>	<b>ESSENTIAL MEANINGS</b>	<b>CONSTITUENTS</b>
<b>1.</b>	<b>Essence of widows’ experiences of widowhood</b>	<ul style="list-style-type: none"> <li>- Widowhood is an embodied experience</li> <li>- Widowhood is an intense emotional experience</li> <li>- Widowhood has a cognitive impact</li> <li>- Widowhood is experienced on an existential level</li> <li>- Widowhood is a socially disruptive experience (Mourning is subject to cultural expectations)</li> <li>- Widows need to feel in control</li> <li>- Widows need to accept what happened</li> <li>- Widows need to resume a meaningful/normal life</li> </ul>
<b>2.</b>	<b>Widows’ essential experiences of support</b>	<ul style="list-style-type: none"> <li>- Support system: family/friends</li> <li>- Support system: work</li> <li>- Support system: spiritual support</li> <li>- Support system: peer group</li> <li>- Support system: primary health care services</li> </ul>
<b>3.</b>	<b>Health support required by widows from the primary health care services</b>	<p><b>Preliminary guidelines</b></p> <ul style="list-style-type: none"> <li>- Care related to widowhood needs</li> <li>- Appropriate referral</li> <li>- Peer support</li> </ul>

## **3.2 DISCUSSION OF THE FINDINGS**

The essence of widows' experiences of widowhood, widows' essential experiences of support, and health support required by widows from the primary health care services were identified and supported by constituents of the essence. The constituents enabled the researcher to understand what the phenomenological essences of the experience were. The essence and the constituents that emerged enabled the researcher to develop guidelines for the primary health care services to support widows in the City of Tshwane, Gauteng Province (see Chapter 5, 5.4). The findings are discussed and illustrated by verbatim quotations in italics. The participant's number is indicated in brackets, for example, (P1).

### **3.2.1 ESSENCE OF THE WIDOWS' EXPERIENCES OF WIDOWHOOD**

The essence of the widows' experience was that widowhood is an intense emotional experience that affects women on a physical, cognitive, emotional, existential and social level. Women described embodied experiences, intense emotions, and cognitive and social disruptions as part of their experiences. They contemplated the meaning of life and their very existence. While the widows were trying to make meaning of their losses, they sometimes experienced the social and cultural environment as restrictive; for example, certain cultural expectations with regard to mourning. Women verbalised their health-support needs as they wished to resume a meaningful life, be in control of their emotions and be able to accept the inevitable losses they experienced.

The essence of the experience was subsequently discussed under the eight constituents that emerged from the data analysis: widowhood as an embodied experience; widowhood as an intense emotional experience; cognitive impact related to the effects of widowhood; widowhood experienced on an existential level; widowhood as a socially disruptive experience; the need to feel in control; and the need to accept what happened and the need to resume a meaningful or normal life.

#### **3.2.1.1 Widowhood is an embodied experience**

Widowhood is an embodied experience, and the participants revealed how they felt the experience of widowhood in their bodies. Participants had experienced some physical problems since the onset of widowhood and widowhood had affected their physical health in certain ways (P1, P2, P3, P4, P5, P6 and P10). This was illustrated in the following excerpts from the interviews: *"...I did not have energy...I just stayed there..."* (P6); *"...I also suffered from lack of appetite as you can imagine...I didn't eat well at all...I couldn't finish two slices of bread it was*

*just too much and because of that I lost a lot of weight...I struggled to lose weight but this now just happened naturally...*" (P10); *...I felt chest pains but never had energy to go to the clinic. I forced myself to go to the clinic because the pain was killing me...I needed these pains to go away and I need my sleep!*" (P1); *...My body felt weak*" (P4); *...I felt numb as if I lost part of my body*" (P5); *...getting out of bed was a mission...my body was so heavy*" (P2); *...I panicked each time I thought of him...I sometimes felt my heart sinking*" (P3). The effect of the embodied experiences of widowhood was evident when one participant verbalised how she used to wake up in the middle of the night following the death of her husband as illustrated in the transcript: *"I had some physical problems after the death of my husband...one of them was that I would wake up at night and promptly 2 o'clock every night and I am not an insomniac...you know naturally...I sleep and I sleep until the next morning until my alarm goes off but during those days...I think maybe almost a year after my husband's passing I found myself waking up in the middle of the night and when I look at my watch is almost the same time 2 o'clock in the morning...I don't sleep well at night because I am thinking a lot..."* (P10). Participants believed that widowhood made them vulnerable to physical health problems as some did not have energy, lacked appetite, lost weight and started waking up in the middle of the night.

### **3.2.1.2 Widowhood is an intense emotional experience**

Widowhood is an intense emotional experience and some participants experienced emotions such as feelings of loss and loneliness, anger, hurt, betrayal and worry. The emotional impact was sometimes experienced as sadness that overcame the participant in a sudden, intense way as illustrated in the passage: *"I cried...I cried...I cried and that one makes me cry if I think about it I cry..."* (P9). The emotional experiences also had recurrent effects experienced in an intrusive way as illustrated in the passage: *"...the memory of that day haunts me...I still cannot take it out of my mind. I still keep playing it in my mind...it cannot get away. When I am sitting quietly it just comes back. It can't leave me...I still have these memories..."* (P8). The emotions expressed by participants seemed to be accompanied by memories, which occurred without warning. These intense emotions put continuous strain on the participants.

The feeling of loss and loneliness was articulated by participants P1, P3, P6 and P11. This was illustrated in the following excerpts from the interviews: *"...I felt so lost and really did not know where to start"* (P3); *"...yes I felt lonely and empty without my husband"* (P1); *...I felt so alone even when my friends were there...I just couldn't feel them..."* (P6). It was evident that the prolonged period one participant had spent with her late husband led to more devastating effects of loss as illustrated in the quotation: *"...I felt so empty...my life was meaningless..."*

*(Taking a deep breath)...more than twenty-five years of our marriage was lost...I felt lost...I wondered how my life would be from that day...the day I lost him? All these years...he was the first person I saw when I opened my eyes in the morning and the last one I saw in the evening...I missed him so much...life had no meaning without him...*" (P11). The participants embraced and valued the time that they had spent with the lost spouses and, in the process, perceived that life had no meaning without their husbands.

Participants expressed feelings of anger, hurt and betrayal towards the world, towards God and towards their husbands for having left them (P4, P6, P9, P10, P11 and P12). The emotional experience of widowhood was influenced by responses from other people. One participant was hurt by the reaction of her neighbours who accused her of killing her husband and she expressed feelings of betrayal and disbelief as illustrated in the passage: *"...this really broke my heart...how can our own neighbours accuse us of such a thing? We have known each other for so long...more than twenty something years ago..."* (P4). On the other hand some of the participants expressed feelings of anger and betrayal towards their dead husbands, their families, God and the world as participants commented as follows: *"I had mixed emotions but the biggest emotion that I had was that of anger towards my in-laws"* (P11); *"...I was angry at my husband for having gone so soon..."* (P9); *"...I was angry at God for having taken my husband..why me?"* (P6); *"...I was angry at the world...I was angry at...literally everybody especially couples...I also looked at a family and accused them sometimes of not being supportive enough..."* (P10); *"...my family was just too much for me...I wished they could just leave me alone...they made me mad..."* (P12). It was evident that the participants' emotional responses to widowhood was influenced by both their internal and external environments, as they expressed inner feelings such as anger as well as external influences, for example, the neighbours betrayal that was perceived by the widow to be making it difficult for her to maintain a positive orientation in life.

All women in this study had children and were mostly concerned about the future of their children as they expressed uncertainty about whether they would survive raising the children alone (P1, P3, P7, P11 and P12), for example: *"...my children are so young to be losing their father. What will we be without their father?"* (P3); *"...How are we going to cope with life? I am worried a lot about my children..."* (P11); *"...what kind of a future will my children have without their father? Will I cope raising them alone?"* (P1); *"...I need to be there for my children...who will take care of them if something bad had happened to me?"* (P12); *"...I am not sure anymore because what happened was unexpected. I can't let anything separate me from my children..."*

(P7). It sounded as if the widows doubted their abilities to cope facing life without their partners and raising their children alone. They were concerned and emotionally disturbed by the thought of being separated from their children.

### **3.2.1.3 Widowhood has a cognitive impact**

Widowhood has a cognitive impact, as some of the participants experienced negative effects on their psychological-well being, namely lack of concentration, forgetfulness, recurrent memories and suicidal ideations (P3, P4, P5, P8, P10, P11 and P12). These are illuminated as follows with an excerpt from the interviews: *"...I was forgetting important things like fetching my kids from school"* (P3); *"...the problem was real to me...I was losing my mind...I couldn't focus..."* (P12). The disruptive effect of the lack of concentration was evident when one participant described how she used to lose concentration while driving as illustrated in the passage: *"I would be driving...and the robots are red...I would stop because the robots are red and the robot further than the one that stopped me opens and I will just move I don't care if that one is red...but God was so merciful...I never had an accident but I think I was not concentrating...lack of concentration and you know forgetfulness were my most important..."* (P10).

Some of the participants expressed difficulty to forget about their unfortunate circumstances as they described that they had recurrent and intrusive memories of their widowhood experiences (P8 and P11) as illustrated in the passages: *"...the memory of that day haunts me...I still cannot take it out of my mind. I still keep playing it in my mind...it cannot get away. When I am sitting quietly it just comes back. It can't leave me and it bothers me a lot"* (P8); *"...I will never forget what they did...the memories of their actions...how they treated me is always there...it is hanging in my mind most of the time..."* (P11). The disruptive effects of widowhood on the cognitive level of functioning were evident when some participants verbalised that they had suicidal thoughts as life had no meaning (P4 and P5) as illustrated in the passage: *"I wished I could just disappear or die"* (P4); and one participant expressed that she even attempted to end her life and her child's life: *"...I just felt like I also want to die...there is no meaning for me to live anymore...I even tried to kill myself and my child...'During the time when I was frustrated and I started thinking about suicide; I became a burden to myself and I did not know how to handle it..."* (P5). Participants perceived that widowhood affected their psychological well being, which put their lives (safety) and that of others at risk as evidenced by a loss of concentration while driving and having suicidal thoughts.

#### **3.2.1.4 Widowhood is experienced on an existential level**

Four of the women in this study experienced an existential crisis or turning point arising from their circumstances. Participants experienced the loss as a disruption and they were not sure how to proceed with their lives as illustrated in the passages: *“Shoo...Moving on with my life was not easy...is still not easy. Facing each day without him is so difficult and I wonder if it will ever be ok...”* (P6); *“...and then even to support my children is so difficult because now I am alone”* (P9); *“...because initially like I said that I was angry with God...it took me about six months for me to go back to church, I didn’t go to church...I would just stay home”* (P10). Participants questioned their very existence and asked themselves how to face life’s challenges. “To be, or not to be”, was the question uttered by most widows in this study as one of the participants put it as follows: *“...because I didn’t know where to start after the death of my husband...whether I should finish the house that we were building or whether I should continue with the pregnancy or whether I should continue with life itself...”* (P5). Widowhood seems to be seen as a major disruption in one’s life as widows in the study felt like they had ceased to exist. Widows perceived that life had no meaning to them and asked themselves how they would move on with their lives.

#### **3.2.1.5 Widowhood is a socially disruptive experience**

Mourning is subject to cultural expectations, as it was evident in the experiences of participants in this study that culture still dictated their experiences of widowhood. In traditional families, it is common practice that widows should behave in a certain way until the end of a mourning period. For example, some of the participants (P3 and P6) expressed that they were expected to wear black clothes as a sign of mourning even when not feeling like it as participants explained: *“...as a widow my culture expects me to mourn for my husband by wearing the black clothes. I wore them for a year even when I did not feel like it! I just wanted to do the right thing by respecting our culture. I do not want to underestimate culture. Culture means a lot to me and I respect it”* (P6);...*“I was so miserable, facing the day with those black clothes”* (P3). Widowhood experiences and traditional restrictions disrupted some participants’ social level of functioning, some widows (P3 and P12) felt alienated as illustrated in the passages: *“My in-laws are very traditional...I had to wear a black clothes for six months and I was not allowed to do some stuff...like visiting a friend...not even a neighbor. I was allowed to go to work or to the shops. I felt so lost as if I am a foreigner within my own community. I felt like I did not belong here anymore...I was just a stranger even to myself”* (P3);...*“It felt like I was cursed... nothing will be joyful in my life... my spirit was so down and it looked so dark...”* (P12).



Feelings of rejection and disrespect were experienced by participants (P4, P6, P8 and P10) as people sometimes treat widows in a stigmatised way as illuminated in the following excerpt: *"I would feel that people were staring at me. I still remember one woman who preferred to stand up rather than sitting next to me in the waiting area...She just stood there...she did not want to sit next to a widow...She noticed that I was still in mourning...mourning because I was still wearing my black clothes."* (P6). One participant described how she felt lost and uncomfortable in her own community to an extent that it did not feel like home anymore: *"I don't feel comfortable attending the events in the community anymore...things are not the same anymore...I used to be involved in the community...attend funerals...stokvels but not anymore. I lost interest in this community"* (P4). However, despite the support rendered by friends and relatives; some of the widows (P8 and P10) felt uncomfortable being around female friends or relatives who still had husbands as they were afraid it would lead to accusations of being interested in the male friends as illustrated, for example, in the following participants' comments: *"...I just feel out of place when I am around them (male friends). I am afraid even to talk to them...you know because ehm...I don't want to be accused of being interested in them...so I just keep my distance...when you are a widow...other women are threatened by your presence around their partners...so I try by all means to avoid the situation. I would prefer it if they don't come to me with their partners..."* (P8); *..."I realized that what was negative was tension between...you know...my friends...especially when they are with their husbands is like you are a threat to them that now because you are single their husband's will make passes at you and maybe you will also be tempted to have relationships with their husbands...that's one thing that I realized during my...my immediate widowhood...that people are not comfortable around you"* (P10). Widows felt the need to adapt to cultural and/or traditional expectations despite the sense of discomfort in social situations brought about by their widowhood experiences.

### **3.2.1.6 Widows need to feel in control**

At the time of the interviews, some of the participants verbalised their desperate need to feel in control of their lives and not let widowhood and the accompanying emotions take over their lives. Some women in this study felt pessimistic about their future as they wished to feel better and be in control while adapting to their changed circumstances, as illustrated in the following transcripts: *"...being in control of my feelings will make me feel better"* (P7); *..."I wanted to understand what was wrong with me, so that I know what I needed to do about it...so that I feel better. I need to get better and will do anything to feel better"* (P6); *..."I am hanging on...I believe that with time I will get used to the idea of not having him around and be able to move on with my life...start to enjoy life again...I want to wake up in the morning and not worry...and*

*just have a happy day like other people because worrying a lot only makes me sad...I don't want to feel sad again. I just want to be happy and in charge of my life again"* (P3). The intense desire to feel in control is illustrated in this quotation: *"...the confusion is driving me crazy...sometimes I need to feel in control so that I do not panic each time I use that road...being in control of my feelings will make me feel better..."* (P2). The widows seemed desperate to understand their unfortunate circumstances and be in control of their lives while adapting to the circumstances.

### **3.2.1.7 Widows need to accept what happened**

Participants verbalised the need to accept what happened as doing so would help them to regain hope and move on with their lives (P2, P6, P7 and P10) as illustrated in the next quotation: *"I need to feel better again, to be hopeful and spent each day without feeling hopeless and be prepared for the day...I don't need to deny my pain and I need to know that whatever the problem I am facing will not last forever but will come to pass. I need to accept what happened to my husband and move on with my life* (P7). Key factors believed to be helpful towards progress to accept the situation were a sense of healing and peace as illustrated in the following passages of the interviews: *"I needed answers to make closure you know...I thought driving there will make me understand and make peace with the fact that my husband is gone...I could not take it..."* (P2); *"...I'm beginning to...to feel...not really happiness but peace...I'm at peace and I have accepted his passing and...the other thing that makes me happy is the fact that the children have also...I think healed...when I look at them when we talk about him no one cries anymore we just laugh...in the beginning we all cried when we talked about him...so now it shows that we are moving on..."* (P10). One participant verbalised how talking about things in her life and staying positive made it easier to accept the circumstances as illustrated in the interview: *"I learnt to talk and laugh about things irrespective of my situation...because I cannot change what happened to my husband. Laughing about them makes it easy for me to accept my situation and be comfortable talking about them..."* (P6). The sense of accepting their circumstances enabled the widows to reconcile themselves with their loss and make the changes necessary to adapt and move on with their lives.

### **3.2.1.8 Widows need to resume a meaningful/normal life**

Some of the participants expressed the need to resume a meaningful or normal life and live on a day-to-day basis, enjoying life, not feeling affected by their losses. This was stated as follows by one participant: *"I am hanging on...I believe that with time I will get used to the idea of not having him around and be able to move on with my life...start to enjoy life again...I want to wake*

*up in the morning and not worry...and just have a happy day like other people because worrying a lot only makes me sad...I don't want to feel sad again. I just want to be happy...I want to improve and feel happy again. I want to enjoy my life...enjoy things that I am doing and start going out with friends again without feeling bad about it. I know my husband will want me to be happy...He was a happy person...we were happy...I want to feel happy again"* (P6). One of the participants commented that seeing other widows living meaningful or normal lives instilled a sense of hope for a better future and a positive outlook on life, as illustrated in this transcript: *"I have hope that I will be happy again because I can see that other widows are happy again...this gives me a hope that I will also be happy again..."* (P12). Some of the participants verbalised that they are already experiencing a meaningful life, as their painful circumstances had brought about positive changes: *"I am hurt about my husband's death but at least something positive came out of it. Today I am a better person than I was three years ago...I know how to pray...how to love and be there for others and that is enough for me. I am happy about it"* (P7); *..."I am feeling ok because now I can look after my children because you know I just wanted to be alone...now I can see that I am much better I can even talk to other people"* (P9). One participant commented that widowhood experiences brought about positive change in her life and enabled her to help other widows. She found happiness in helping and supporting others: *"...but the positive thing that came out of this...the death of my husband was the fact that I decided to become a counsellor to widows to give them the support I thought I lacked...today I motivate other widows in the community...I am happy that I am using my negative situation to do something positive by helping others...that makes me happy..."* (P10). Participants felt the need to restore meaning in their lives. Moreover, witnessing other widows moving on and in turn receiving the support from fellow widows seemed to enable them to maintain a positive orientation in life, which in turn enhanced their spiritual and psychosocial wellbeing.

### **3.2.2 WIDOWS' ESSENTIAL EXPERIENCES OF SUPPORT**

Participants received their support from different sources, namely, family members, friends, colleagues, peer group members, employers, spiritual counsellors and health care providers. Widows valued and needed support from all sources as it filled them with hope and contributed to their emotional healing. They considered themselves fortunate to have access to different sources of social and spiritual support. Support from other widows was considered a special source of comfort and hope. The support from the primary health care services was however not client-centered and widows who were not helped felt as if they were treated as a statistic; their support needs were not seen, not addressed and not met. The widows that received some

advice, care or referral from the clinics were grateful and appreciative. Widows' need for support and the need for person-centred care from the primary health care services are discussed as the next constituents.

### **3.2.2.1 Support system: family/friends**

The experience of support from others was significant for all the participants and was considered to play a valuable role in the emotional, spiritual and physical functioning of all the widows. The importance of support from family and friends, especially support from the in-laws, was emphasised by all participants. Some of the participants (P1, P3, P5, and P7) verbalised that they were fortunate to have social support as they appreciated the value of the support, as illustrated in the following quotation: *"My friends and family support me. They are good to me..."* (P3);...*"They...they are there when I need them. Things are tough for me at times and they are always there to listen to me. They keep me busy so that I keep my mind...I keep my mind occupied and not think about my problems"; They always invite me to spend time with them...talking and laughing about things. That really helps..."* (P7). The need for support from the in-laws was expressed by most participants. Participants felt fortunate to be supported by in-laws, as it gave them hope and peace of mind as illustrated in two of the participants' transcripts: *"...my family is here you know...my in-laws still cares for me. They call me almost every day just to check on me and the kids...my mother in-law stayed with me for at least two weeks after my husband's death...But she has her own life...home to take care of and I understand you know"* (P1); *"...especially with the support that I got from my in-laws. They supported me very much and without their support I don't think I could have made...I could have made it because with their support I could stand and see that there is still life for me...to live and my children,...I just felt blessed being in their life or having them in my life...I felt so blessed and it was encouraging me and trusting God...their God that they trust on and...Feeling that at least after all my in-laws are not fighting me...meaning that...wherever my husband is...he is happy because we are united in the family"* (P5). Participants appreciated the support they received from family members and friends. Participants perceived any type of support, be it instrumental, spiritual, emotional support or compassionate caring from significant others, as essential. In addition, widows were positive about the support as they felt blessed and hopeful for the future.

To some of the participants (P4 and P12), the lack of support from family and friends including the in-laws was a serious concern as illustrated in the passages: *"...my in-laws betrayed me...even if I need them...I don't trust them anymore..."* (P4);...*"I invited them to my children's graduation party but they never came or send a word or anything...this worries me a lot because*

*my children will still need to get married in future... "ke mang a tlo ba tlhokomelang" (who will take care of them?)...I mean the aunts are the ones who should be leading...I mean they are the ones who should be leading the way...you know our tradition...there are always expectations...certain things that can only be done by the in-laws. This hurts me a lot...it worries me...how am I going to handle it when it comes...it bothers me a lot..." (P12). It was clear that the support from significant others, especially the in-laws, was regarded as an integral factor that enabled widows to cope with what had happened to them and assisting them with the process of healing.*

### **3.2.2.2 Support system: work**

The value of the support received from employers and colleagues was expressed by some participants (P2, P3, P5 and P10) as was evident in the following passages: *"...my colleague is very supportive...she also lost her husband...I often call her when feeling that all is becoming too much for me..." (P2); "...My employer is a very understanding person. She is a Christian, she always tells me that God is there for me but some things are just too much for me to handle" (P3);..."My colleague does come when she has time.....She has been nice to me and the kids...at least someone cares you know..." (P10). The impact that the support provided by colleagues, both practically and emotionally, was illustrated by one participant as follows: *"...my colleagues helped me a lot...there were there from day one when I was still confused...not knowing where to begin...they carried me through...some of them used their own transport to help me organise the funeral...they counseled me...they are there for me when I want to talk" (P5). The ongoing support widows received from their work environment was much appreciated as it seemed to have enabled widows to emotionally cope with their unfortunate circumstances.**

### **3.2.2.3 Support system: spiritual support**

The value of spiritual support was emphasised by some of the participants (P3, P5, P6 and P10). Their spiritual well being was enhanced through church attendance, counselling from priests and prayers from church members. Widows prayed together and met with other widows at church to support each other as illustrated in the following passages: *" Talking to my family and pastor helps a lot...they care and that really helps. We pray together and it helps a lot" (P3);..."My priest is always counselling me whenever I am at church. That really makes me feel better...every year during women's month in August our church organises something...something for widows. We meet as widows...we talk about our problems...we give each other support...that helps a lot" (P6); "...church members pray for me always...we pray together" (P10). The need for spiritual support was illustrated when one participant commented*

that despite financial stability, spiritual support and having faith in God surpasses all the support: *"...you can have money or maybe you can't have money but the most important thing is that as a widow you must trust in God...as the Bible says...God is the husband of widows...so people must be encouraged to trust in God..."* (P5). It was clear that receiving spiritual support from church leaders or fellow church members and having faith in God provided widows with emotional comfort and enhanced their process of healing.

#### **3.2.2.4 Support system: peer group**

Support from other widows appears to be an important factor in increasing the widow's sense of belonging and security. One widow put it as follows: *"It taught me that sometimes people that you least expect are the ones who help you...I told you that my in-laws were not there for me...but having other people...widows around me...to help me was helpful...you know is true that...what they say..."**"God will never forsake you...a good Samaritan will always be there...those people helped me a lot"* (P12). The value of mutual understanding amongst fellow widows is illuminated as follows: *"...I still remember before the burial of my husband during the week...people from my work place came and when they came they were like seven or eight people and amongst those people there was one lady whom the husband died before...and I knew that this person is a widow. Those people were talking and talking trying to...to counsel me...trying to say whatever they could say...read verses...they talked to me but that person...that lady who was a widow by then she...she couldn't utter a word...she didn't even say anything but she was seated there...I am telling you when they are gone...I just felt like I could say that one should remain with me because I knew" (that) this person knows what I am feeling...how I am feeling...I experienced that so is very much helpful to...to be supported by the person who knows what you are going through...that made me strong...knowing that at least other people...other widows are there to support me...it made it easier...they gave me strength and hope. Seeing them being so willing to support...it was touching...maybe is because they have been there before..."* (P5). Moreover, it was clear that being in contact with another widow while feeling vulnerable triggered a feeling of sympathy for the other widow as was illustrated in the passage: *"...when I see a widow either in a mall or shop...especially these young ones...this very young ones...I feel like just going to them and hugging them...and like I say to me is a sign of healing because if I can feel sorry for somebody it means I am healing because in the beginning I felt sorry for me and me only...so now I can look at another widow and just think...I have been there...I know what you are going through and I am sorry..."* (P10). Widows perceived that being supported by other widows who had been through similar experiences was

helpful as it brought them a sense of comfort and the capacity to enhance their process of healing.

### **3.2.2.5 Support system: primary health care services**

Most of the participants in this study expressed the need for support by the primary health care services, such as clinics (P1, P3, P4, P7, P8, P9, P10 and P11). Generally, health care providers such as nurses and psychologists were seen as an important part of the support system. Participants expressed a need for health care providers “*being there to listen*” and giving relevant information, especially during the first weeks and months following the start of widowhood. However, in this study widows experienced encounters with health providers as both positive and negative.

During negative encounters with health care providers within the primary health care services, some of the participants (P1 and P3) experienced feelings of disappointment at how they were treated by nurses at the local clinics: nurses who seemed not to be concerned or displayed a lack of commitment towards the widows’ needs and the inadequate or incompetent care rendered by nurses: “*I am not happy about the care that I received from the clinic (paused then silence). I waited for three hours, only to be told that I must try to take it easy and the sister only gave me Panado...she could have checked me thoroughly...I wanted her to tell me that I will be ok, that the pain will be ok. At least take her time to check what was wrong with me. I felt that she was in a hurry. I was just another client who only needed to waste her time*” (P1). The feelings of disappointment were expressed as follows: “*...the nurses there are impatient...they do not have time for us...time to listen. All they care about is pushing the queue...going to the clinic was just a waste of time...I needed someone to talk to but the sister was rushing me...I remember her telling me that she must see another patient before her going to the tea time...it was as if I was wasting her time. I could see that she was not interested in things that I was saying. She just wrote on the file without checking me. It simply means that she does not care and I was only wasting her time. I was not impressed at all...I was there to get help...not to be treated like I am...I am nothing...*” (P3). Participants perceived the approach of health care providers as negative as it was not “*caring*” and “*nurturing*”. They felt a sense of dissatisfaction with the services rendered.

Moreover, some of the participants (P1 and P10) expressed the lack of person-centred care from the primary health care services in that their needs as widows were not met: “*...the thing is that I realized that the sisters at the clinic are not concerned about our problems...widows are*

*not given the attention that they deserve...she just looked at me...that's all..." (P1);... "The support is there but the support is like general...is not directed at widows per se...you still go there they check you...give you whatever it is that they need to give you, is like they are robots...they work like robots...they just check you and off you go...their support is not for widows...the support is for everybody else with physical needs...you know when they deal with you...because our primary health services are over loaded and under staffed...this people work like...they work like robots as I said...fast and in a hurry to push...push the queue because we always complain that you can go there and not get attended then go the following day...so I think maybe they are also trying to...to satisfy us...I am not happy about the support from the clinic...you know I feel that we are a statistic...you are just one in a million...you are just in a group...they do not look at your situation...as a widow...so I can't say I'm...I am not angry with them but I am not happy..." (P10). However, when participants' individual expectations were met such a situation had a positive effect on their level of satisfaction. They experienced person-centred care rendered by the primary health care services as positive and non-judgmental: *"I am fine with the support...talking to the nurses and the psychologist makes me feel better...I was comfortable talking to the nurses especially because they did not know me or judged me I feel comfortable talking to them...they are not judging me. I am happy with the care that I received from the clinic, they respected me and never made me feel uncomfortable and I was free to talk about my problems..." (P4). It was clear that widows were not happy with the generalised care rendered by health care providers at the local clinics and preferred individualised care to meet their specific needs. However, widows valued the non-judgmental and the caring approach displayed by some of the health care providers (nurses and psychologists) as they made them feel welcome and respected.**

The need or the desire for adequate attention from the primary health care services was expressed by some of the participants who were grateful to those health care providers who had shown a sense of understanding, guidance and "being there" as was articulated as follows: *"They all listened to me...the sister and the psychologist...they were understanding...and what they said to me made sense...it was as if they were reading my mind...what I was thinking...Ehhh..." (P4); "...They gave me the attention I needed and I have learnt a lot from them. They brought my smile back and motivated me...but they helped me at the clinics. The sisters helped me...they were all giving themselves time for me. They listened...they listened to me and their advice helped me...they motivated me a lot. I am grateful for their support..." (P7). Participants were happy with the way that health care providers at the local clinics managed them, as they perceived that they were given the adequate attention that they needed.*



Participants experienced health care providers as sources of information, advice and reassurance (P4 and P8). Some of the participants were happy with the attention they received as illustrated in the following transcripts: *"They advised me to write all my fears and feelings down...then we spoke about them each time I went to the clinic for my check- up...Talking to the nurses at the clinic helped me but I only go there once a month. The sister said it will be better with time I should take my medications, come for checkups..."* (P4); *"...I was young so they advised me about contraceptives and how to protect myself from infections should I decide to get involved with someone else...the clinic is my place of support and I am happy with their support as I indicated that they were there when I needed them the most...when I needed information...they gave it...my child was immunized as needed even when I could not take him there...they supported me even today. They tried their best to make me feel better..."* (P8). These participants were happy with the assistance, information and advice that they received from the local clinics as it was helpful and made them feel better.

Participants (P1, P9 and P11) verbalised that they received medication from the health care services which was appreciated by some of the participants: *"...I am getting my blood pressure medication from the clinic...so the sister advised me to take it easy and not worry a lot about my situation...I can't complain because I still get my medication from the clinic...and I am happy with that..."* (P11); *"...so I went to the clinic and then they advised me...they gave me the multivitamins so that I can eat..."* (P9). However, one participant seemed not to be happy with the general pain medication that she received from the clinic: *"I am not happy about the care that I received from the clinic (paused then silence)...I waited for three hours, only to be told that I must try to take it easy and the sister only gave me a mere Panado!"* (P1). In addition to the service rendered by nurses at the clinic, some of the participants (P4 and P7) seemed to be happy that they were appropriately referred to other health care team members such as a psychologist or social worker, as illustrated in the quotations: *"The nurse also referred me to the clinic psychologist...she has also been helpful..."* (P4); *"... The social worker was there for me...I am glad that I was taken to her..."* (P7). Some of the participants were satisfied with the type of medication that was received from the clinic while one participant was disappointed as she indicated that she waited too long only to be given a "mere" "Panado". In addition, referral to other health care providers like psychologists or social worker seemed to be appreciated by widows as it was considered to be helpful.

### **3.2.3 HEALTH SUPPORT REQUIRED BY WIDOWS FROM THE PRIMARY HEALTH CARE SERVICES**

Going through the painful mourning period, women attempted to find help from the primary health care services. As already indicated, some were disappointed and frustrated with the lack of person-centred care reflected in long waiting times, judgmental approaches and generalised care. While some widows received person-centred care, mental health education, advice and medication from the primary health care services, others expressed the very need to receive person-centred care based on their unique needs. Participants recommended person-centered care, appropriate referral pathways and establishment of peer support groups for widows.

#### **3.2.3.1 Care related to widowhood needs**

In line with the human rights and patients' rights charter setting "the right to receive appropriate health care services" (Constitution of RSA 1996, 2003, Chapter 2, Section 7 & 27), participants (P1 and P10) recommended that primary health care should be person-centred and appropriate to the specific needs of a widow. They expressed a need to be acknowledged as experiencing the plight of a widow: *"I think something should be done...I don't know what?...but something should be done to sort of highlight the plight of a widow and to sort of highlight the fact that widowhood has some impact on your health maybe...I don't know how it can be done but like I say...in the clinics they do have some form of support groups because when the nurses talk to patients they would group them...I think maybe once in a while they can just say who are widows here amongst you?...and you know sort of attend to the widows as individuals...I know it will be like asking a lot but widows really need attention"* (P10). In addition, participants specified that the focus of care for a widow should be appropriately related to widowhood needs: *"I would like the services to be considerate of the widows...the system should have emergency support or special support for widows...for widows as needed"* (P1). Participants perceived that it was essential that the health care system acknowledge that widowhood affects the health of individuals and special support or attention should be given to the widows' needs.

Some of the participants expressed a general feeling of dissatisfaction regarding the time health care providers spent when attending to them: *"The sisters should take their time during consultation with widows because I realised that as a widow I cannot just pull up my socks and move on with my life...at least be good listeners"* (P6); *"...they helped me at the clinic...but I think that they should do something with this long wait...we always arrive earlier...so they should be there on time and start working"* (P12). A home visit by health care providers such as nurses

was recommended as a valuable resource: *"I would have liked the nurses to do home visits to clients including widows. The death of my husband was painful for me...I did not feel like going out...I just wanted to stay in bed...I sometimes wished I could talk to someone...a professional...someone who can tell me things will be ok...but I did not have the energy to go to the clinic. Home visits by a nurse could have helped me a lot"* (P7). Participants felt that health care providers should be available and make time when assisting and managing widows by allowing widows enough time to tell their stories. In addition, participants were not happy with the amount of time they spent at the clinic as a result of long queues. It was recommended that home visits by the nurses would be helpful to the widows, especially when widows are still lacking the energy to seek help from the clinic.

As a single parent, a widow is likely to feel inadequate to care for male children: *"...as a widow raising male children is not easy..."* (P3). It was therefore recommended that mentoring of young boys by male figures in the community would be helpful: *"...mentoring will help because I don't know how to handle the challenges that older boys go through...so having a male figure to guide them will help...someone to be a role model or this boys to be guided at the clinic regarding boys' issues because talking to them is not easy..."*; *"...I wish there could be parental guidance classes at the clinic or in the community especially for young widows...young widows who are still learning this single parenting...or may be start a support group or mentoring groups for young boys and girls...for our children to have good male role models...father figures may be...people who can mentor them around the community because raising a boy child is not easy"* (P8). Participants expressed the need for good role modelling by male figures in the community. It was regarded as being important to their children's growth and development since raising a boy child alone as a widow was not easy.

A greater need of information was also expressed, as lack of information led to frustration as illustrated in this quotation: *"I feel that widows should be given information regarding the steps that they will experience following the death of their husband...what needs to be done. I was quite frustrated after my husband's death...I did not know where to go...where to start...because I did not have information and it was frustrating...to give us relevant information...I did not even know about estate lawyers...things like that...it was frustrating"* (P11). It was then recommended that clinics, especially nurses working at the clinic near the community should be sources of information as this participant put it: *"I think the clinics could assist us...they are near us because they are available in the community...so we can always go to the clinic to get information. At least they should have information regarding all this..."* (P11). It was clear that

participants expected local clinics to be their primary source of information during difficult times, not only on health related issues, but regarding the grieving process.

### **3.2.3.2 Appropriate referral**

Widowhood is complex; as a result widows suffer from various challenges and are in need of appropriate referral to available support systems. Appropriate referral is considered to play a valuable role in rendering support to widows: *"I think the most important support that widows need from the primary health care services is the psychological support...you need some psychotherapy...people who can just sit with you or have support groups,...if they gave us time...they would maybe even refer us to relevant services to stay with you and say I can see you have this condition but I think you need somebody...a professional that can talk to you about this...so maybe if this can be brought out...I know they would say there is no money...the government (laughing) has no money for such services but these are very important services...so they could have maybe a resident psychologist...maybe it could help widows a lot...the social workers or someone should assist us with this..."* (P10); *"...they can refer that person to the spiritual...father or the pastor...that is the support that...the widows need"* (P5). Moreover, some of the participants seemed to be happy that they were appropriately referred to other health care team members such as a psychologist as illustrated in the passage: *"The nurse also referred me to the clinic psychologist...she has also been helpful..."* (P4); *"...I even saw the psychologist...she was also nice"* (P2). The care rendered by nurses at primary health care services was greatly appreciated. However, it was clear that participants expected that widows need to be appropriately referred to other health care team members such as psychologist, social workers or spiritual counselors for relevant services such as psychotherapy.

### **3.2.3.3 Peer support**

The need for support from other widows appeared to be regarded as an important factor in freeing widows from the sense of rejection and enhancing a sense of acceptance and belonging. In addition, the value of mutual understanding amongst individuals who experienced widowhood seems to promote a sense of security. As a result, some of the participants (P5, P10 and P12) recommended that support groups for widows need to be established and encouraged amongst widows as illustrated in the next quotations: *"Sister, I think I will be more comfortable talking to someone who went through the same experience...who was a widow herself...someone who understand me better...to give me a hope...to tell me that things will be ok...and advice me how to handle my frustration and stress..."* (P12); *"...I wish...there could be support groups for widows...you know where widows meet under their guidance...I mean*

*guidance by a professional such as nurses at the clinics...because I realised that widows go through same challenges...through same health problems...” (P10); “... yoo...it...it means a lot to me because they know how do I feel when I say I am hurt or when I cry they know that this thing does happen because even themselves are still crying and they know the pain...they will support you and help you...ehhh knowing how to do it because they have been in the situation before’...” (P5). Participants felt that widows go through similar challenges and engaging with other widows would make them feel comfortable as they would be better understood. In addition, fellow widows would give them advice on how to handle their frustrations and in turn instill them with a sense of hope.*

### **3.3 DISCUSSION OF FIELD NOTES**

It is vital for the researcher to keep daily records of what transpires during data collection and analysis process to minimise loss of important data (Polit & Beck 2014, p.294; Langford & Young 2013, p.141; Greeff 2011, p.359). In this study, field notes in a form of observational and personal notes were taken during each of the interviews conducted with 12 widows. The value of taking field notes was explained to each participant to allay anxiety. All participants gave the researcher the permission to record the interview and to write field notes. Immediately after each interview, the researcher jotted down her impressions to help her remember and explore the process of the interview with each participant exactly as it happened from the beginning to the end (Polit & Beck 2014, p.294; Greeff 2011, p.359).

#### **3.3.1 Observational notes**

Observational notes are the researcher’s descriptions of actual events and conversations with the participants inclusive of the dates, times and settings within which they occurred (Polit & Beck 2014, pp.294-295). In this study, extensive notes were made based on what the researcher observed and thought about during the course of the research process with the widows (Grove et al. 2013, p.286; Greeff, p.359). The researcher also made theoretical notes with an attempt to understand the data and attach meaning to observations (Polit & Beck 2014, p.294). Observations relating to dates, times, settings, actions, behaviors and communication style were noted and analysed as set out below:

##### **3.3.1.1 Dates**

Irrespective of the researcher confirming the appointment dates well in advance and the day before the set dates, during the visits; some of the participants seemed not prepared to

participate and wanted to postpone the appointment complaining of ill-health while some had other things to attend to. The researcher postponed appointments as required to accommodate the needs of the participants. Despite the delays, no participant withdrew from the study.

### **3.3.1.2 Time**

During the interviews, some of the participants could not wait to start with the interview while others seemed to delay the interview process. As the result, the researcher had to patiently wait up to 15-30 minutes for some of the participants to be settled. Moreover, before starting with the interview questions, the researcher confirmed if the participant was relaxed and ready.

### **3.3.1.3 Setting**

As indicated, interviews were conducted at a place chosen by the participant. As the result, five of the interviews were conducted at the participant's home while seven were at the participant's place of work. During the day of the data collection, the researcher checked and ensured that the setting chosen was less distractive (less noise). Moreover, participants informed their family members or colleagues that they did not want to be disturbed. However; in some instances; there were some noises in the background and direct interruptions by younger children who insisted to be around the mother in cases where interviews were conducted at home. Irrespective of the distractions, interviews continued until data saturation was achieved.

### **3.3.1.4 Actions, behaviors and communication style**

During the first meeting with a potential participant, the researcher explained the intentions of the research and discussed the research questions with the participant. The first three potential participants asked to be given the interview guide so that they can prepare themselves for the interview. As the result, the researcher made the decision to give all participants the guide as it seemed that prior preparation instilled some sort of confidence. Moreover, it was observed that participants took effort to prepare for the interview and were observed to be referring back to their prepared notes when a question was asked.

Irrespective of some delays, once the research question was asked, the participants were observed to be spontaneous and extensive in their answering. Three participants even verbalised that they never realised how much they wanted to talk about their widowhood experiences and thanked the researcher for the opportunity. One participant who was observed to be highly emotional even stated that she wished that she could be given the platform more often to address other widows in order to share her experiences as talking about it made her

feel relieved as if she took off the load that she was carrying on her shoulders. This may well be the reason why nearly all participants indicated that they had no further questions after the interview but asked the researcher to call them or even visit them again in future.

### **3.3.2 Personal notes**

These are the researcher's comments regarding personal experiences, insights, thoughts, feelings and reactions during the research process (Polit & Beck 2014, pp.294, 387). During data collection and data analysis the researcher experienced some emotions which were clearly noted in the journal. In the researcher's personal experience during face to face individual interviews with the widows, it was observed that the widows appeared mostly sad, frustrated and not to be coping well. As the result, the sadness in the widow's eyes stressed the researcher as she felt and wished that she could somehow take their pain away to make them feel better. On several occasions, the researcher felt overwhelmed and could feel tears in her eyes as the widows spontaneously described their devastating experiences. In some instances, the researcher experienced empathetic feelings as some of the widows looked young and vulnerable to be facing life without a partner and raising children without their father. Personal notes also included reflexive notes aimed at assisting the researcher to bracket own experiences regarding the support widows receive from the primary health care services.

### **3.4 SUMMARY**

In this chapter, the essence of the experiences of widows, widows' essential experiences of support and the health support required by widows from the primary health care services were described. Constituents associated with the experiences of widows regarding the health support by the primary health care services were described, highlighting both negative and positive encounters of widows with their support systems. Field notes in the form of observational notes and personal notes were described. The constituents of what was observed and heard from the perspective of the participants were illuminated with verbatim quotations. Literature synthesis will be discussed in Chapter 4 of this thesis.

## CHAPTER 4

### LITERATURE SYNTHESIS

#### 4.1 INTRODUCTION

The findings of this study were described in Chapter 3. The focus was on the essence of the experience of widowhood, widows' experiences of support and the health support they required from primary health care services. The essence was identified and supported by its constituents. Chapter 4 presents a literature synthesis in relation to the findings of this study.

#### 4.2 DISCUSSION OF THE ESSENCE, CONSTITUENTS AND LITERATURE SYNTHESIS

The inclusion of the literature in the findings was conducted in accordance with a descriptive phenomenological approach. The literature search of relevant sources was done to enrich the findings of this study and create a fuller understanding of the essence and its constituents. Philosophical and theoretical descriptions that relate to the phenomenon under study were used to further illuminate the findings to clarify meanings that are present in the data (Dahlberg et al. 2008, pp.272-273).

The findings of this study showed parallels with the phenomenologist, Merleau-Ponty's philosophy (1908-1961). Merleau-Ponty was Husserl's most prominent French successor who investigated the grounds and possibilities of phenomenology. In addition, like Husserl, Merleau-Ponty (1939) investigated the grounds of our being in the world and our knowledge of it by emphasising the bodily structure of being. Merleau-Ponty was trying to account for the relationship between the human and the world with emphasis on both its uniqueness and the general being. Accordingly, for Merleau-Ponty, the awareness and the understanding of the life-world is a necessary condition for knowledge and as humans we are in one way or another connected with everything and everyone (Dahlberg et al. 2008, pp.24-39). The findings of this study described the essence of the lived experiences of widows regarding the primary health care services and may enable the primary health care nurses to gain a deeper understanding of the health-support needs of widows.



#### **4.2.1 Essence of widow's experiences of widowhood**

A literature synthesis with regard to the essence of the widow's experiences of widowhood is described. This synthesis is described in sections 4.2.1.1 to 4.2.1.8.

##### **4.2.1.1 Widowhood is an embodied experience**

From a phenomenological perspective, Merleau-Ponty (1962, pp.59, 82) wrote *"Positive psychology of perception reflects that allowing consciousness to be enclosed in the body affects the action of the world in itself. Individuals are led to describe the object and the world as they appear to consciousness and are conscious of the world through the medium of their bodies"*. It is through the body and the bodily experience that the surrounding world becomes meaningful. The body is not only an object as it has sensible qualities. The body differs from other things because it is sensitive to itself and gives us access to being. Individuals feel, think, taste, touch, hear and are conscious through the opportunities the body offers (Munhall 2012, p.128; Kwant 1966, p.55; Merleau-Ponty 1962, pp.59, 82, 236). When we are sick our bodies sense the problem and at the same time become obstacles that keep us from immediate or spontaneous engagement with the world. Widowhood is an embodied experience integrated in a woman's subjective body, according to which the body senses the discomfort and the changes that are taking place in the body. During the embodied moment crucial and spontaneous decisions are made where people acknowledge the discomfort and either draw on their own capacity to handle the problem or seek help from others, such as primary health care services (Dahlberg et al. 2008, pp.41-46).

In this study, women experienced physical health problems such as general fatigue, lack of appetite, loss of weight, feeling a burden, lacking interest in things and disturbed sleeping patterns following widowhood (see Chapter 3, 3.2.1.1). Some of the embodied experiences existed prior to the husband's death. However, people experience worsening of these health problems and are diagnosed with new conditions in the early bereavement period (DiGiacomo, Lewis, Nolan, Phillips & Davidson 2013, p.4; Utz et al. 2012 p.465). Motherhood and ageing are associated with an increase in chronic health conditions; however, the experience of widowhood adds an additional level of vulnerability to physical problems, mental health problems and death (DiGiacomo, Davidson, Byles & Nolan 2013, p.1069; Morina & Emmelkamp 2012, pp.4-5).

#### **4.2.1.2 Widowhood is an intense emotional experience**

The philosophy of the "body as object and mechanistic physiology" states that to feel an emotion is to be involved in a situation that one struggles to face but from which one cannot turn away (Merleau-Ponty 1962, p.86). The person recognises the overwhelming emotional reaction related to a particular experience; in this case, experiences of widowhood. According to Merleau-Ponty's (1964, p.150) philosophy of the visible and the invisible, the emotions or ideas we are speaking of would not be better known to us if we had no body and no sensibility as they would be inaccessible to us. Emotions are thus also essentially embodied experiences.

In the findings of this study, it is seen that following widowhood, women sensed the emotional impact in relation to being a widow. Living through widowhood challenges, women experienced some changes within their emotional well-being as they experienced emotions such as loss and loneliness, anger, hurt, betrayal, and worry (see Chapter 3, 3.2.1.2). These emotions, being embodied experiences, are closely related to widows' psychological and physical health. In agreement with the findings of this study, the literature reflects that there is an increased incidence of poor psychological health such as depression, anxiety, yearning and loneliness in recently widowed women (DiGiacomo et al. 2013, p.4, Schaal, Dusingizemungu, Jacob, Neuner & Elbert 2012, p.106; Asai et al. 2010, pp.40-41; Coleman & Neimeyer 2010, p.820; Khosravan, Salehi, Ahmadi, Sharif & Zamani 2010, p.208). The unexpected death or unpreparedness for the death of a loved one is associated with higher levels of grief experiences, somatic symptoms as well as anxiety symptoms (McKiernan et al. 2013, p.15). Moreover, poor health at the time of widowhood leads to higher risks of complicated grief and major depressive disorder (Utz et al. 2012, p.465). In addition, people suffering from complicated grief symptoms are less able to enhance and suppress emotional expression (Gupta & Bonanno 2011, p.639). Hopelessness related to spousal death changes the lifestyles of widows and also leads to health risks (Khosravan et al. 2010, p.208). Intensive longing or yearning for the deceased is the most reported symptom. Widows feel utterly alone even when they are with others. Widows feel that life is meaningless and empty, and are preoccupied with thoughts about the deceased (Asai et al. 2010, p.40; Schaal, Jacob, Dusingizemungu & Elbert 2010, p.6; Schaal et al. 2009, p.209).

Perceived anger towards self and others is the most common contributor to the risk of complicated bereavement (DiGiacomo et.al. 2013, p.4; Asai et al. 2010, p.40). Finding meaning in the death and a worldview of accepting death are the predictors of a lower level of anger (Kim 2009, pp.41-42). Moreover; people with high social contact and high social support experience less anger and fewer intrusive thoughts, while those who have low social support but high social

contact experience greater anger (Ha & Ingersoll-Dayton 2011, pp.358-360). Social resources are correlated with the bereavement outcome where higher levels of instrumental and emotional support are associated with lower levels of depressive symptoms and anxiety (Kim & Kim 2016, pp.165, 174-181; Bergman, Haley & Small 2010, p.449). Moreover, people whose income declined as a result of the loss or who were lacking in financial means experienced more grief, anger, emotional loneliness and more depressive symptoms respectively. However, the person's mental health improves over time (Van der Houwen, Stroebe, Stroebe, Schut, Van den Bout & Meij 2010, p.205).

#### **4.2.1.3 Widowhood has a cognitive impact**

Widows experience negative effects with regard to their psychological well being. These effects can be lack of concentration, forgetfulness, recurrent memories and suicidal ideation (see Chapter 3, 3.2.1.3). The findings of this study assert that widows are active participants within the situation and the process of widowhood is experienced in a unique manner by each individual. Women who participated in this study attempted to provide meaning to their experiences through changes in their behaviour that represented their reality as they thought about and felt it. "We are always thinking" says Merleau-Ponty. "We are a thinking experience. Thinking is more a situation than an act. We cannot stop thinking because we are open to a field of thought..." (Kwant 1966, p.238).

Widows experience difficulty forgetting about their unfortunate circumstances and have recurrent and intrusive memories of their widowhood experiences that make it difficult for them to adjust adequately to their unfortunate circumstances. Moreover, bereavement is associated with poorer memory performance within certain sub-groups (Rosnick, Small & Burton 2010, pp.262-265). The theory of "association" and the "projection of memories" states that past experience is not imported into present perception by a mechanism of association but is revealed in present consciousness itself. As a result, in order to serve the purpose of perception, memories need to have been made possible by the physiognomic character of the data in which the person recognises former experiences. The appeal to memory presupposes what it is supposed to explain. The present does not cancel its past, nor will its future cancel its present. Memory reopens time lost to us and invites us to capture the situation evoked (Merleau-Ponty 1962, pp.19, 70, 85); consciousness is "memory" (Merleau-Ponty 1964, p.156).

In this study, women recalled their widowhood experiences and made it clear that they experienced difficulties forgetting about their unfortunate circumstances, as they had recurrent

and intrusive memories of their widowhood experiences. As a result, widows readily recalled both positive and negative experiences of widowhood. Widows in this study verbalised their past experiences, their present support needs, and the health support that they required from the primary health care services.

#### **4.2.1.4 Widowhood is experienced on an existential level**

Man is a conscious being, aware of himself from the beginning to the end. Hence, on the higher level of awareness man speaks about himself. The act of speaking implies a development and a promotion of human existence. Notably, by speaking man transforms reality into meaning. However, even on the level where man does not yet speak, man already is consciousness because awareness precedes speaking and any form of critical reflection. Expression transforms our awareness into reflective consciousness. We have access in being because we exist in being and our openness arises from our involvement in being (Kwant 1966, pp.22-28, 75-77, 220). The philosophy of "reflection" and "interrogation" assert that the world is what we see and if we are to speak of falsity, we need to have the experiences of the truth. The essential is to know precisely what the being of the world means. What Merleau-Ponty means by this is that we develop an attitude towards the world as we become moulded by repeated experiences. Choice is never absolute; it cannot be exercised out of nothing. But neither are we completely determined. It says we make sense of the world based on our bodily perceptions – as such widows are struggling to make sense of their worlds based on their changed perception of the world after their husbands died - they are in this process of meaning making (Merleau-Ponty 1964, pp.3-6, 12, 159).

In this study, widows continued to be living under the given widowhood circumstances that were unexplainable to them. Widowhood experiences stressed their freedom of choice and their ability to take responsibility for the consequences of their own acts. Women were discovering the experiences of widowhood for themselves, realising the truths in relation to their widowhood experiences as they were observed and lived by them.

Widows experience an existential crisis arising from their circumstances as they experience the loss as a disruption and ask themselves how they are going to face life's challenges (see Chapter 3, 3.2.1.4). Widows experience a sense of emptiness, a loss of identity, an uncertain direction and future, a changed view of life and new responsibilities (Tomarken, Roth, Holland, Ganz, Schachter, Kose, et al. 2012, p.775). In addition, widowed people perceive that life itself is questioning them to understand the meaning of the spouse's death and ascribed a belief that

external forces control their life events, which in turn increase symptoms of distress related to their spouse's death (Chan & Chan 2011, p.157).

#### **4.2.1.5 Widowhood is a socially disruptive experience**

Life-world theory signifies how people relate to and interact with the world. Notably, people judge the world in relation to their experience of it (Dahlberg et al. 2008, pp.37-38, 56-57). Gray (2009, pp.5, 16, 23) asserts that people who regard their neighborhood (world) as a positive social environment, where people interact with one another experience wider levels of support. However, parallel to the findings of this study, the culture of the family and the society regard certain behavior as appropriate grief reactions (Black & Santanello 2012, pp.476-479). Traditional restrictions disrupt the widow's social level of functioning, as widows feel alienated, rejected, disrespected and uncomfortable in the community (see Chapter 3, 3.2.1.5). Widows face threatening behaviours and social abuse even within the circle of family or friends. Suspicion and sexual allegations are the most significant behaviours (Khosravan, Salehi, Ahmadi & Mansoorian 2013, p.276).

#### **4.2.1.6 Widows need to feel in control**

Widows need to feel in control of their lives and the feeling seems to be stimulating a sense of positive self-concept (see Chapter 3, 3.2.1.6). However, self-concept is a flexible, dynamic adaptive resource and self-esteem changes during the adjustment to major life stress such as spousal loss (Montpetit, Bergeman & Bisconti 2010, pp.606, 613). What we call "vision" rises from the power of thought. Henceforth, exactly what we think we see (Merleau-Ponty 1964, p.29). Man is not strong enough to remain free because when he no longer dominates, he is dominated (Kwant 1966, p.146). In this study, widows perceived that they encountered different challenges that affected their sense of being in control of their widowhood experiences dominated by their thoughts. To survive the difficulties surrounding widowhood, most women kept faith in their support systems, especially their spiritual support system. The women's trust in God kept them hopeful and gave them a vision for a better future for them and their dependants (see Chapter 3, 3.2.1.6).

Finding balance and learning to handle the difficult emotions, thoughts and activities of grief assist widows in moving forward, feeling in control, and looking forward to the future (Holtlander et al. 2011, p.256). However, even months later, the widows' descriptions of their challenges indicate more pronounced strain and hassle (DiGiacomo et al. 2013, p.4). Many aged widows experience a decline in their standard of living upon widowhood, a pattern which is

pronounced amongst those with limited education (Weaver 2010, pp.89, 100-102). In a study by Nnodim et al. (2013, pp.51-53), it was recommended by widows that government as a whole should do more for widows through the implementation of all rights obligations, the institution of social services programmes, and by establishing widows' associations. Appropriate interventions by the government will enable widows to be in control by voicing their concerns so that they could be helped to feel in control and live meaningful lives.

#### **4.2.1.7 Widows need to accept what happened**

Merleau-Ponty (1964, p.13) states that a genuine conversation with ourselves gives us access to thoughts that we did not know ourselves capable of. In addition, "perceptual faith" allows people to understand well beyond what they know and are capable of. People believe in the real world and are aware of the presence of other persons. This coincides with Roy's adaptation model (1976), which asserts that people are adaptive systems in constant exchange of information, matter and energy coming from the external environment. Moreover, whatever comes from within the system enables the person's acceptance and adaptation (George 2014, p.314). In this study, women reflected on their experiences of widowhood and questioned their circumstances to gain a deeper understanding of their past experiences, present situations and future hopes to understand well beyond what they know and are capable of. The support that widows received from their external environment as they interacted with fellow widows and other systems of support enabled them to accept and adapt to their widowhood circumstances.

Widows need to accept what happened through healing, peace and staying positive in life (see Chapter 3, 3.2.1.7). Deficits in coping flexibility are indicative of pathology in bereaved people (Burton, Yan, Pat-Horenczyk, Chan, Ho & Bonanno 2012, pp.18-19). Moreover, stress-related growth among recently bereaved people is the result of a complex interplay of one's demographic characteristics, situational factors associated with the spousal loss, as well as the coping process that one adopted during the earliest stages of bereavement (Caserta, Lund, Utz & De Vries 2009, p.469). Widows perceive that accepting the unfortunate circumstances in one's life leads to a sense of healing, of peace, and a positive outlook on life and, therefore, less stress and less complicated grief.

Accepting one's misfortunes allows people to feel relief, feeling proud of what they have achieved, being aware of their recovery, feeling released from care and being eager to forgive (Asai et al. 2010, p.41). The concept of time proved to be instrumental to the acceptance of spousal death as widows expressed difficulty in accepting the death of the spouse when they

perceived the timing of death as inappropriate (Chan & Chan 2011, p.151; Hauksdóttir, Valdimarsdóttir, Fürst, Onelöv & Steineck 2010, p.356). Early experiences of non-acceptance predict more intense grief experiences later on. Health practitioners should pay close attention to expressions of non-acceptance in the early aftermath of loss, as these experiences of grief are more predictive of chronic grieving (Holland, Futterman, Thompson, Moran & Gallagher-Thompson 2013, pp.126, 135-137). Furthermore, acceptance of the loss is necessary to overcome the emotional pain of the loss, which leads to the emotional acceptance of the loss and the changes in one's life (Tomarken et al. 2012, p.775). People with a higher level of social support and personal strength find meaning and a greater sense of acceptance over time (Kim, Kjervik, Belyea & Choi 2011, p.210).

#### **4.2.1.8 Widows need to resume a meaningful /normal life**

Every instant experience can be co-ordinated with that of the previous instant and the person's perspective of the consciousness (Merleau-Ponty 1962, p.54). According to phenomenology, our belongingness to the world enables us to experience that things are meaningful to us. It is believed that things bear explicit and implicit meaning that can be explicated, illuminated and clarified. As a result, people do not have to look far nor try harder to find meaning as we live in a world where phenomena have meaning for us. There is always intentional relationship with the things that make up our everyday lives. The intentional structures enable people to understand meanings of the world, how they come to be and how they can be understood (Dahlberg et al. 2008, pp.48-51). Reflection on our lives is the rebirth of light "an awareness of who we really are", enabling us to return to what has been forgotten (Kwant 1966, p.121). In this study, widows belonged to their immediate social environment and their support systems had some effect on them. The effects of the support rendered to widows were meaningful to them as the support enabled them to have a sense of belonging. As a result, widows engaged with their external environment and sought meaningful support from people that were readily available to them, such as family and friends, in order to resume a meaningful life.

Widows need to adjust and resume a meaningful or normal life, living on a day-to-day basis and not feeling affected by their widowhood circumstances (see Chapter 3, 3.2.1.8). New roles, identities and new relationships are associated with positive adjustment while denial, avoidance of restoration changes and distraction of grief were associated with poor adjustment (Bennet, Gibbons & Mackenzie-Smith 2010, pp.324-327). Different coping strategies such as avoidance, distancing, emotional expression, seeking support, continuing bonds and reconstruction of life are being used by bereaved people (Asai et al. 2010, p.43).

Some of the widows resume their normal life avoiding the past and by being reluctant to talk about the past. Widows perceived that the events of the past were completed along with the death of the spouse. These widows avoided being in touch with their feelings by devoting themselves to their jobs or other activities (Chan & Chan 2011, pp.154-157; Asai et al. 2010, p.43). However, in an effort to resume a normal life and make meaning of their unfortunate circumstances, some of the widows made cognitive or behavioral efforts to keep bonds with the deceased. In so doing, widows looked back on their memories, having inner conversations with the deceased and living up to the wishes of the deceased. Others visited the graveyard, kept possessions of the deceased and searched for ways to meet or feel the deceased and accept their loss (Asai et al. 2010, p.43). Widows who were able to accept spousal death often searched for meaning from the past to help them face the present and the future (Chan & Chan 2011, p.155). Widows expressed future-oriented feelings towards the self by being eager to find a purpose and wanting to help others (Asai et al. 2010, p.42). However, widows struggled to perceive meaning in the meaningless, where their identity seemed to be stripped away and they were forced to see a different self. In addition, numbing the pain, struggling to control feelings, feeling sad, yet trying to maintain close emotional relationships and meaningful activities, and the process of change and self-management dominated by resilience were identified as themes related to the widows' struggle to establish a new identity in their everyday life (Holm & Severinsson 2012, pp.115-116; Wilson & Supiano 2011, p.86; Holtlander & Duggleby 2010, p.117).

Widows perceived a need to look deep into themselves to review their lives in order to determine a future that will make sense of their senseless circumstances (DeMichele 2009, pp.106-111). People attempt to reconstruct their lives by making cognitive resolutions regarding their bereavement and by making social commitments to make sense of their psychological state. They also employed coping strategies to accept their loss and tried to help others by sharing their experiences. Moreover, parallel to this study widows perceived that seeing other widows living meaningful or normal lives instilled a sense of hope for a better future and a positive outlook on life (Asai et al. 2010, p.43).

#### **4.2.2 Widows' essential experiences of support**

Consciousness or an experience means to be in communication with the world, the body and other people, to be with other people instead of being beside them (Merleau-Ponty 1962, p.96). The theory of experience shows parallels to King's (1981/1990a) conceptual system and the theory of goal attainment. The conceptual system and the theory of goal attainment state that



people belong to a social system in which interaction is the observable verbal and non-verbal goal-directed behaviors of two or more people sharing mutual presence and purpose (George 2014, pp.258-260). In this study, widows belonged to a social environment and they interacted with other people within the environment, seeking meaningful support in order to survive the difficulties of widowhood. Women were directly affected by both what was said to them by people within their immediate environment and by other people's response towards them only because they were widows. Irrespective of negative encounters with the social environment, widows still yearned to be with other people instead of being beside them.

The importance of support from family and friends, employers, church, colleagues and other widows was emphasised by most widows (see Chapter 3, 3.2.2.1). Widows sought emotional support, informational support, instrumental and social support from family, friends, church members, mental health professionals and from other widows. However, parallel to the findings of this study widows verbalised both negative and positive encounters related to the support systems (Wilson & Supiano 2011, p.82; Asai et al. 2010, p.43; Shih et al. 2010, p.862). Moreover, the convoy model of social relations asserts that the exchange of support to or from others increases and decreases over time, depending on the changing needs and changing roles (Antonucci 2001, pp.247-453). All in all, religious or spiritual experiences appear to be protective of the development of prolonged grief reactions. These experiences protect people against problematic grief. People with higher levels of depressive symptoms, anxiety and grief were more likely to report seeing a minister, priest or other clergy to help them handle feelings of grief, loneliness, or missing their spouse at six months post-loss. Religious beliefs and spirituality may be used as coping methods to facilitate the mourning process and help people to find meaning in the loss and more positive emotions (Bergman et al. 2010, p.451; Schaal et al. 2010, p.6; Van der Houwen et al. 2010, p.206). People with intrinsic religious beliefs experienced fewer coping problems by maintaining positive attitudes and taking multiple actions for adaptation while those with extrinsic religious beliefs had more negative adaptive attitudes such as withdrawal and low self-esteem, and practised fewer faith-related activities (Shih et al. 2010, pp.860-862). Having higher religiosity was realised to be directly related to a greater degree of personal strength (Kim et al. 2011, pp.210-211), as people drew upon their religious beliefs as a way to find meaning and make sense of what happened (Caserta et al. 2009, pp.463, 470-471).

Most widows expressed the need for and the value of social support. Social relationships available prior to widowhood or those available in early stages of widowhood do not appear to

explain individual differences in adaptation to loss (Anusic & Lucas 2014, pp.369, 375). Widows described how support and companionship offered during early days by friends decreased overtime, which negatively affected their adaptation to widowhood (Collins 2014, p.73). However, widows appreciated the value of the social support from friends, colleagues and their in-laws as it gave them hope, peace of mind and the ability to adapt to their circumstances. Those who lacked the support from family, friends, and peers realised how valuable this support would have been, as lower levels of perceived social support were related to worse mental health (Van der Houwen et al. 2010, p.211).

The support rendered by families, relatives, neighbours and widowed friends was reported as both instrumental and emotional. The support included encouragement, keeping widows company, providing caring and good listening, check-in phone calls, advice, informational support about health, and encouragement to express feelings by writing a diary (Shih et al. 2010, p.862). However, widows believed that because of the male-dominant culture, they were treated unfairly in society and their rights were trampled upon, which in turn threatened their social support. Widows adopted a set of "self-restricting" behaviours in order to prevent being socially stigmatised or being bothered by male attention or feminine behavioral clichés. Moreover, the sense of lack of social support and isolation was associated with increased distress following conjugal bereavement (Wilson & Supiano 2011, p.83).

In addition, the need for and the value of person-centred care were expressed by most widows. According to Merleau-Ponty (1964, pp.116-119), all that people need to do is to situate themselves within the being they are dealing with instead of looking at the being from the outside. Moreover, each one speaks with all that he is, with his ideas, obsessions, secret history, which others lay bare by formulating them as ideas. Each person is led by what he said and the response he received. Furthermore, thought is a relationship with oneself and with the world as well as the other (Merleau-Ponty 1964, p.145). In this study, all women were widows and faced similar challenges related to widowhood. However, during the interview each one of them was treated as a unique person possessing a unique history, unique coping skills and systems of support. A phenomenological interview with each widow was led on by what she said based on her own experiences, thoughts and feelings. Throughout the one-to-one phenomenological interviews, the researcher focused on the widow as a unique person and valued the lived experiences of the person.

A person-centred approach is based on the theory and philosophy of the psychologist Dr. Carl Rogers (1902-1987). Rogers (1959) called his therapeutic approach “client-centred or “person-centred” because of the focus on the person’s subjective view of the world. A person-centred approach is a unique approach to understanding personality and human relationships that is widely applied in various domains such as psychotherapy and patient care. The approach is known for promoting “unconditional positive regard”, which is described as welcoming the individual “without negative judgment of basic worth” (Rogers 1961). In this study, widows expressed dissatisfaction regarding the care given by the nurses at the local clinics, as it was perceived to be generalised and not meeting the unique needs of the widows.

Irrespective of dissatisfaction with the care rendered, health care providers such as nurses and psychologists were seen as components of an important support system necessary to render health care services. Notably, widows experienced encounters with health providers as both positive and negative, as they experienced some challenges (see Chapter 3, 3.2.2.2). In the cases where perceived anger and self-blame were evident, the feelings generally reflected participants’ perceptions of inadequate care provided by health care professionals, health care organisations or health care systems (DiGiacomo et al. 2013, p.4). Bereavement interventions are generally discussed in terms of both psychosocial and emotional expression as a means of coping, learning about managing practical concerns and role adaptation; and a mind-body approach (Nseir & Larkey 2013, pp.498-507). People practised modest person-focused efforts such as participating in intellectual activities or social activities and learning alternative ways to solve problems, setting priorities in doing things and learning to negotiate with others in order to cope with their loss. It is perceived that early grief interventions for uncomplicated grief add no considerable benefit over the course of time and may have the potential for a more harmful effect, possibly interfering with the “natural grieving process” (Shih et al. 2010, p.862). However, widows who received primary bereavement care may not have improved as much as they might have if they had not received the intervention (García, Landa, Grandes, Pombo & Mauriz 2013, p.305).

Brief interventions that combine a reduced number of psychological support sessions with lower costs were found to be acceptable by grieving persons. Brief interventions led to an increased adherence to the programme along with high effectiveness as the bereaved felt that they were supported throughout their mourning process (Barbosa, Sa’ & Rocha 2014, pp.354-360). Nonetheless, as in any other treatment; bereavement interventions have their own indications,

and possible adverse effects and all of these needs to be taken into consideration (García et al. 2013, p.305).

#### **4.2.3 Health support required by widows from the primary health care services**

Health support required by widows from the primary health care services included person-centred care, appropriate referral and peer support, which are subsequently discussed.

##### **4.2.3.1 Person-centred care**

What a person thinks is the truth of his or her life, is also perceived by the person as truth of the world and of other lives. However, what people cannot have in common is a world that is numerically the same. People could only rejoin one another in the common signification of thoughts (Merleau-Ponty 1964, pp.48, 61). According to the theory of modeling and role-modeling, the nurse always acknowledges the uniqueness and individuality of the client. Moreover, the nurse appreciates that at some level people know what makes them sick and what makes them well. The role of the nurse is to assess the person's needs, the ability to mobilise resources needed and to facilitate the use of the available resources (George 2014, p.545). Rogers's person-centred approach is based on constructs such as self-concept, the need for positive regard, psychological climate of a therapeutic relationship as conditions of personality change (Rogers 1961, pp.244-269).

The client's concept of self is regarded as a construct central to the client-centred theory of therapy or personality. The construct is based on how the person perceives himself or herself and the value he or she attaches to the characteristic. In this regard, it is essential that the therapist is endeavoring to think and empathise with the client within the client's own frame of reference, respecting the client's own valuing process. Moreover, it is essential that the therapist or health provider possesses a warm caring unconditional positive regard for the client by creating a therapeutic climate with no conditions of worth attached to it. The therapeutic change would occur in a client when he or she perceives that he or she is therapeutically understood. The inner changes taking place in therapy causes the person to be less defensive. Moreover, the person socialises and accepts the reality in him or herself and in the social environment (Rogers 1961, pp.248, 259, 263, 283).

In this study, widows expressed that health care providers, especially nurses at the local clinics should serve as role models by "being there" for widows in need of support based on the individuality and the uniqueness of the widow. Moreover, primary health care nurses should not

think for the widow but make time to listen intently to what the widow states. Widows made it clear that people know what makes them sick, what makes them well and nurses need to rely upon widows' self-evaluations based within their own experiences. As the result, the role of the nurse should be to identify the widow's needs based on the widow's frame of reference. Nurses should unconditionally mobilise appropriate resources and ensure that widows utilise the available resources as needed. Widows recommended that primary health care should be person-centred and nurses need to acknowledge the plight of widowhood (see Chapter 3, 3.2.3.1). The need to tailor bereavement interventions according to widows' needs was highlighted (Lund et al. 2010). It was emphasised that it should be kept in mind that cultural differences have an impact on bereavement interventions and the amount of emotional disclosure deemed appropriate or the manner in which grieving or mourning is expressed within a particular culture may cause variations in bereavement interventions (Nseir & Larkey 2013, p.510). Many interventions have been developed to assist people with the emotional, practical and social problems accompanying the loss of a loved one which are provided by different professionals and organizations (Bergman et al. 2010, p.442). Health professionals need to appreciate individual differences (DiGiacomo et al. 2013, p.1077). Depending on the person's needs, services could range from grief therapy, cognitive-behavioral therapy, support groups, pastoral counseling, widow-widow programs, psycho educational programs and pharmacotherapy (Bergman et al. 2010, p.442).

#### **4.2.3.2 Appropriate referral**

In the phenomenology of perception, Merleau-Ponty (1962, p.195) explains that our field of clarity is only a section of a larger field. Man lives in visible reality but visible reality does not coincide with all reality. Henceforth, man becomes aware of his limits and admits his limits. With the help of critical thinking, man can make a distinction between the meaningless and the meaningful aspects of a situation (Kwant 1966, pp.81, 95). Orlando's (1972) theory of nursing requires nurses to understand their professional responsibilities, and those of other multidisciplinary team members. This understanding enables nurses to effectively fulfill their professional function and realise their limitations so that they can effectively collaborate with health care professionals from other disciplines. In this sense, nurses need to refer clients to other services or disciplines based on the specific needs of the client (George 2014, p.183).

In this study, the need for appropriate referral to available support systems such as psychological counselling is considered to have a valuable role in rendering support to widows. Other studies confirm that the loss of a spouse increases the possibility of people getting

psychiatric care and psychotropic medication, both for severe and minor psychiatric conditions (Möller et al. 2011, pp.261, 266). Widows reported higher use of primary health care services than other services; however, only three percent of widowed individuals consulted a mental health professional such as a social worker or psychologist (Morina & Emmelkamp 2012, p.5; Bergman et al. 2010, p.448). Health-seeking behaviour amongst older widows was influenced by socio-economic and demographic determinants as it was found that older widows living in urban areas had a greater likelihood of accessing health care services compared to those living in rural areas (Agrawal & Keshri 2014, p.3). Treatment-seeking barriers in mental health services included poor access to care, stigmatisation, lack of awareness of mental health problems and lack of knowledge of where to seek help (Ward, Clark & Heidrich 2009, p.1596).

Bereavement support was under-utilised as some individuals perceived this type of support to be for people who had more severe difficulties than they were experiencing, while others explained that they had not been offered this type of support. However, some widows had accessed either individualised services or group bereavement services at least once and the service was much appreciated (DiGiacomo et al. 2013, p.7). Other studies revealed that nurses emphasise the necessity for rapport and trust between nurses and clients for successful referrals. Nurses state that referral pathways could be integrated with other care to save time, as referral pathways are often considered too lengthy and not readily accessible to nurses (Annells, Allen, Nunn, Lang, Petrie, Clark & Robins 2010, pp.214, 219-222). The need to educate physicians and clergy, and the importance of an accessible, comprehensive range of community-based bereavement services were emphasised (Bergman et al. 2010, pp.441, 454).

#### **4.2.3.3 Peer support**

According to the philosophy of reflective life-world research, people do not have direct access to another's emotions and cannot directly access what the other person is experiencing. The mental and emotional life of others is never directly presented to us. However, people have the possibility of understanding another person's experiences through empathy (Dahlberg et al. 2008, p.61). Elliston (1977, p.216) highlighted that to understand the nature of empathy, we need to "immerse ourselves in the everyday experiences of others to describe the meaning of what presents itself" and what others are going through. As humans, we are most likely to understand others if we had similar experiences. However, every life-world is unique and, even if people have similar experiences, there is always something unique to the other's life-world (Dahlberg et al. 2008, pp.61-63). Merleau-Ponty (1964, pp.78-80) asserts that there is no perception of the other and one cannot install him or herself in the other person even if people

undergo similar experiences, as everyone has a private landscape as the sole original of humanity.

In this study, it was revealed that even though women went through similar experiences of widowhood, every woman possessed unique skills of coping and managed things differently when exposed to similar circumstances. Widows in this study had different views regarding their systems of support, but expressed the wish to support and be supported by other widows in the same situation. The need for support from other widows appears to be a general feeling and an important factor in freeing widows' from the sense of rejection, enhancing a sense of acceptance, belonging and security (see Chapter 3, 3.2.3.3). People who are coping well with the loss of their spouses are able to empathise and help others because of their experiences (Wilson & Supiano 2011, p.84). Parallel to the results of this study, widows perceive that seeing other widows living meaningful or normal life instilled a sense of hope for a better future and a positive outlook on life (Asai et al. 2010, p.43). Widows are glad and willing to participate in intervention groups with other widows and their high satisfaction with the interventions reflects the benefits of group interaction opportunities to share personal experiences regarding the loss of a spouse. In addition, widows feel positive about what they had learned and are motivated to attend meetings (Lund et al. 2010, p.301). Widows found new intimate relationship through support groups and families were happy about it (Oosterhoff, Anh, Yen, Wright & Hardon 2010, p.28).

#### **4.3 SUMMARY**

Chapter 4 provided an extensive literature synthesis related to the topic. Moreover, the findings of this study were integrated with the applicable theories and philosophies. Chapter 5 of this study will focus on the development, validation and the description of preliminary guidelines for primary health care services using the framework developed by the researcher based on the AGREE II (2010) instrument: advancing guideline development, reporting and evaluation in healthcare, and AGREE II (2003-2013) instrument: appraisal of guidelines for research and evaluation incorporating the Delphi technique to ensure reliable guidelines.

## CHAPTER 5

### DEVELOPMENT AND THE DESCRIPTION OF THE GUIDELINES IN PHASE 2

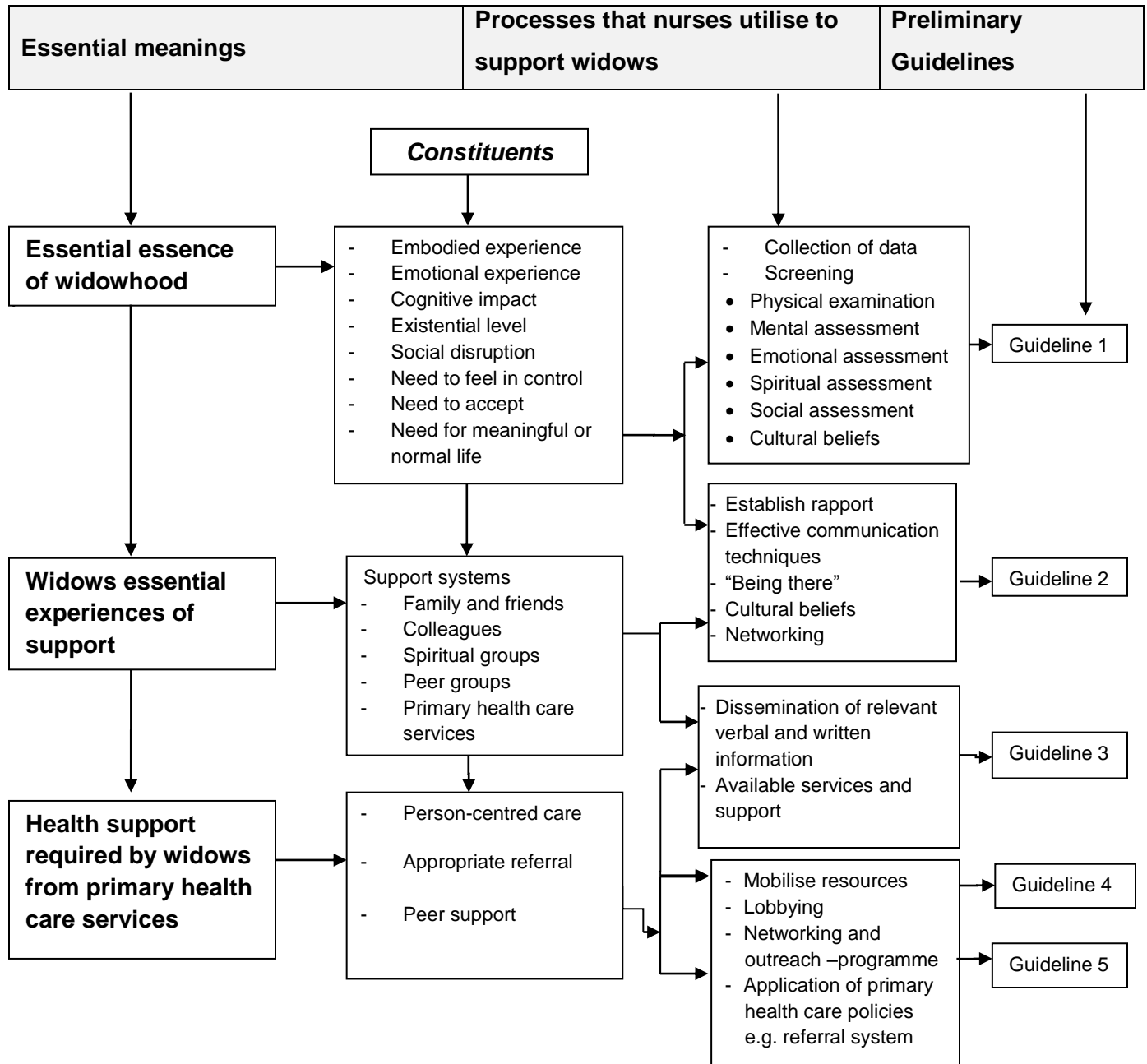
#### 5.1 INTRODUCTION

Chapter 4 comprised a literature synthesis that integrated with the findings of this study. Essence and constituents associated with the experiences of widowhood and the health support given by primary health care services were discussed, highlighting both positive and negative encounters widows had with the primary health care services. Chapter 5 is concerned with phase 2 of this study: The development of guidelines for the primary health care services to support widows within the City of Tshwane.

The development of the guidelines was based on the empirical data obtained from the participants in phase 1 and the literature related to the topic. Guidelines were drafted and formulated by selecting appropriate statements from the empirical data. The findings were described to reflect the essence of widows' health-support needs and their experiences of the support rendered by the nurses in primary health care services. The draft guidelines were developed by the researcher in accordance with (1) guiding attributes in the guideline development (see Section 5.3.1); (2) a summary of the essence and constituents of widows' experiences of widowhood; and widows' experiences of support and health support from the primary health care services (see Chapter 3, Table 3.1). The development and validation of these guidelines were done using the framework developed by the researcher based on the AGREE II (2010) instrument: advancing guideline development, reporting and evaluation in healthcare, and AGREE II (2003-2013) instrument: appraisal of guidelines for research and evaluation (see Section 5.3.2). The framework incorporated the Delphi technique, which was used to validate the guidelines through establishing experts' consensus to ensure reliable guidelines. The draft guidelines with incorporation of the suggestions made by experts in the Delphi rounds are outlined in this chapter. Figure 5.1 presents the framework of the integration of empirical findings that guided the development of the guidelines.



**Figure 5.1: Framework of the integration of empirical findings that guided formulation of preliminary guidelines**



## **5.2 REFLECTION ON KNOWLEDGE DEVELOPMENT IN NURSING**

Nursing practice is responsive to and is highly determined by the health needs of the society it serves. In this sense, health care practices occurring in the nursing field are the result of what is happening across the whole population. Nurses should be trained to acquire the necessary theoretical knowledge and practical skills to become safe practitioners (Ellis & Hartley 2012, pp.3, 126). A reflection on knowledge development in a nursing discipline guided the researcher in the formulation of the preliminary guidelines for the primary health care services to support widows. Chinn and Kramer (2011, pp.207-208) assert that to add value to knowledge development that makes sense in the practical situation, the processing of research data must be based within the empirical structures of knowledge. The concept “knowledge” refers to practical understanding that is expressed in the manner that can be communicated with others in a meaningful way in a given situation. Most importantly, the “knowledge of a discipline” or “empirical knowledge” refers to knowledge that has been judged based on standards, values and worldviews that are shared by members of a particular discipline. In this sense, members should have the capacity to accurately understand structures that encompass a particular discipline to be effective practitioners (Chinn & Kramer 2011, pp.3-4). Cannon and Robinson (2014, p.65) assert that the major reason for conducting nursing research is to establish a solid body of nursing knowledge that promotes both quality nursing care and good health outcomes. In this study, using the research findings and a synthesis of the applicable literature and theories the researcher was able to draft preliminary guidelines based within the empirical structures of the knowledge of nursing. The five preliminary guidelines were validated by experts with academic and/or practical experience in the study phenomenon to ensure quality guidelines.

## **5.3 DEVELOPMENT AND VALIDATION OF THE GUIDELINES**

It is evident in the findings of this study and the available literature that it is vital to develop guidelines that engage nurses in the primary health care services to strengthen the support rendered to widows.

Guidelines are systematically developed standards of practice recommended by a team of experts in a particular discipline. Guidelines help practitioners and clients in making appropriate decisions regarding relevant health care for particular situations. The aim of the guidelines in the health sector is to achieve significant health outcomes by reducing inappropriate practice variation. Guidelines could come from many sources such as local hospitals, state programmes,

health plans, patient advocacy organisations, government agencies or international organisations (Mahtani 2015, n.p.; Stanhope 2014, p.295; Polit & Beck 2012, p.31; Agree Collaboration 2010, p.839; 2003-2013, p.1; Parahoo 2006, p.427). Guideline recommendations may differ as a result of some variations in systems of care, the availability of technologies or resources, the process or methods used to develop them, and traditions of care giving or cultural considerations (Lum, Rapuano & Coleman 2011, p.1015).

In this study, guidelines are regarded as principles and recommendations for health support programmes and services within the primary health care services. These principles and recommendations facilitate the rendering of adequate and appropriate health support for widows so that they can move towards a holistic state (physical, psychological, social and spiritual) of optimal health. The development and validation of the guidelines will be discussed in accordance with: (1) the guiding attributes in the guideline development and validation process; and (2) the adapted methodology for guideline development and validation for primary health care services to support widows.

### **5.3.1 Guiding attributes in the guideline development and validation process**

During the process of the formulation, development and validation of guidelines the researcher observed various attributes related to guideline development in order to ensure quality guidelines. These included attributes such as validity, reliability, applicability clarity, relevance, comprehensiveness, effectiveness, flexibility, acceptability, documentation and scheduled review (Mahtani 2015; Agree Collaboration 2010; 2003-2013; Tan 2006; Institute of Medicine 1990). These attributes derived from the mentioned sources, are described in the paragraphs immediately below.

#### **5.3.1.1 Validity**

“Validity“ refers to the ability of the guidelines to produce the desired results based on the truth or facts. In this study, the guidelines are based on the findings and the available literature related to the findings. The validity of the guidelines in this study was ensured through obtaining the inputs and recommendations from a panel of experts using the Delphi technique.

#### **5.3.1.2 Reliability**

Reliability is the capacity of the guidelines to be relied upon or depended on. Reliability implies that given the same circumstances, the primary health care nurses in the local clinics would

interpret and apply the guidelines similarly. A panel of experts validated the guidelines to ensure reliability.

#### **5.3.1.3 Applicability**

Applicability is the capacity of the guidelines to be put into practice or particular use by appropriate individuals. In this study, the target users of the guidelines are the nurses working in the primary health care services and rendering care and support to widows. The applicability was judged by a panel of Delphi experts, but will only be put to test when implemented in practice.

#### **5.3.1.4 Clarity**

Clarity requires the state or the quality of the guideline to be clear, easily understandable, unambiguous and logical. The guidelines should be specific in stating their intention. In this study the intention of the guidelines was to strengthen the support rendered to widows by the primary health care nurses. A panel of experts ensured the simplicity of the guidelines by validating the guidelines.

#### **5.3.1.5 Relevance**

The guidelines should be related to the matter at hand. In this study, the guidelines are relevant in terms of the health support needs of widows, as judged by the panel of experts. All efforts or interventions by the primary health care services should promote the health of widows to ensure optimal well being.

#### **5.3.1.6 Comprehensiveness**

The guidelines should show extensive understanding of the matter at hand. In this study, the guidelines were based on the extensive understanding of the health support needs of widows as explained by them. The guidelines focus on the physical, psychological, social and spiritual levels of optimal health.

#### **5.3.1.7 Effectiveness**

“Effectiveness” refers to the capacity of the guidelines to have the desired effect. In this study, the guidelines could enable the nurses in the primary health care services to render adequate and appropriate health support to widows in order to move towards a holistic state of optimal health. The effectiveness of the health support will be determined by the widows’ experiences when the guidelines are implemented in practice.

### **5.3.1.8 Acceptability**

The guidelines should be adequate enough to satisfy the needs, requirements or standards of a particular service. In this study, the guidelines are realistic and in line with the vision and mission of the National Department of Health and the Gauteng Department of Health: *“To provide quality health service – aiming to promote a long and healthy life for all South Africans and improve the healthcare delivery system by focusing on access, equity, efficiency, quality and sustainability to transform people’s lives”* (Department of Health 2017). The acceptability of the guidelines was validated by a panel of experts through a Delphi technique.

### **5.3.1.9 Flexibility**

Flexibility is the ability of the guidelines to accommodate to another’s wishes or changing conditions. The design of the guidelines should focus on a client-centred decision-making process based on individuals’ perceptions and preferences. In this study, the widows’ recommendations regarding their need for client-centred care in phase 1 were taken into account during the process of guideline development.

### **5.3.1.10 Documentation**

Documentation is thorough record keeping from the beginning to the end of the research project. In this study, the participants involved and evidence used were accurately documented and described in the research report. The record of developed guidelines will be kept for future review and updating.

### **5.3.1.11 Review and updating of the guidelines**

The guidelines should include statements about when they should be reviewed and updated in order to be in line with the new evidence guiding the particular discipline. It is therefore recommended that the study guidelines be revised every three to five years.

## **5.3.2 Methodology for guideline development and validation**

A methodology for the development of guidelines provides an outline of how the researcher planned to conduct the process of the development of the guidelines and positioning the guidelines within the larger field of guideline development (Agree Collaboration 2003-2013, p.1). In this study, the development of guidelines was directed by the methodology developed by the researcher based on the AGREE II (2010) instrument: advancing guideline development, reporting and evaluation in healthcare, and AGREE II (2003-2013) instrument: appraisal of guidelines for research and evaluation. The AGREE II instrument was used by the researcher

as it clearly outlines the framework to: (1) provide a methodological strategy for the development of guidelines; (2) informs what information and how information should be reported in guidelines; and (3) assess the quality of the guidelines (Agree Collaboration 2003-2013, p.1). The validation of the guidelines was guided by the Delphi technique.

### 5.3.2.1 Overview of structure and content of AGREE II

The AGREE II (2010, p.841; 2003-2013, pp.2-3) instrument consists of 23 items organised within six domains. Each domain captures a unique dimension of the quality of the guidelines. These are outlined in Table 5.1.

**Table 5.1: Structure and content of AGREE II (2010, 2003-2013)**

<b>DOMAINS</b>	<b>ITEMS</b>
<b>DOMAIN 1: Scope and purpose</b>	<ol style="list-style-type: none"> <li>1. Overall objective(s) of the guidelines</li> <li>2. Health question(s) covered by the guidelines</li> <li>3. Population (patients, public, etc) to whom the guidelines are meant to apply</li> </ol>
<b>DOMAIN 2: Stakeholder involvement</b>	<ol style="list-style-type: none"> <li>4. Guideline development group</li> <li>5. Views and preferences of the target population</li> <li>6. Target users of the guidelines</li> </ol>
<b>DOMAIN 3: Rigour of development</b>	<ol style="list-style-type: none"> <li>7. Systematic methods used to search for evidence</li> <li>8. Criteria for selecting the evidence</li> <li>9. Strengths and limitations of the body of evidence</li> <li>10. Methods for formulating the recommendation</li> <li>11. Health benefits, side effects and risks involved</li> <li>12. Explicit link between the recommendations and the supporting evidence</li> <li>13. Review of guidelines by external experts</li> <li>14. Procedure for updating the guidelines</li> </ol>
<b>DOMAIN 4: Clarity of presentation</b>	<ol style="list-style-type: none"> <li>15. Recommendations specific and unambiguous</li> <li>16. Different options for management of condition or health issues</li> <li>17. Key recommendations are easily identifiable</li> </ol>
<b>DOMAIN 5: Applicability</b>	<ol style="list-style-type: none"> <li>18. Guidelines provide advice and/or tools on how recommendations can be put into practice</li> <li>19. Guidelines describe facilitators and barriers to its application</li> <li>20. Potential resource implications of applying the recommendations</li> <li>21. The guidelines present monitoring and/or auditing criteria</li> </ol>
<b>DOMAIN 6: Editorial independence</b>	<ol style="list-style-type: none"> <li>22. Views of the funding body have not influenced the contents of the guidelines</li> <li>23. Competing interests of guideline Development group</li> </ol>

**Adapted from AGREE II (2010, p.841; 2003-2013, pp.2-3)**

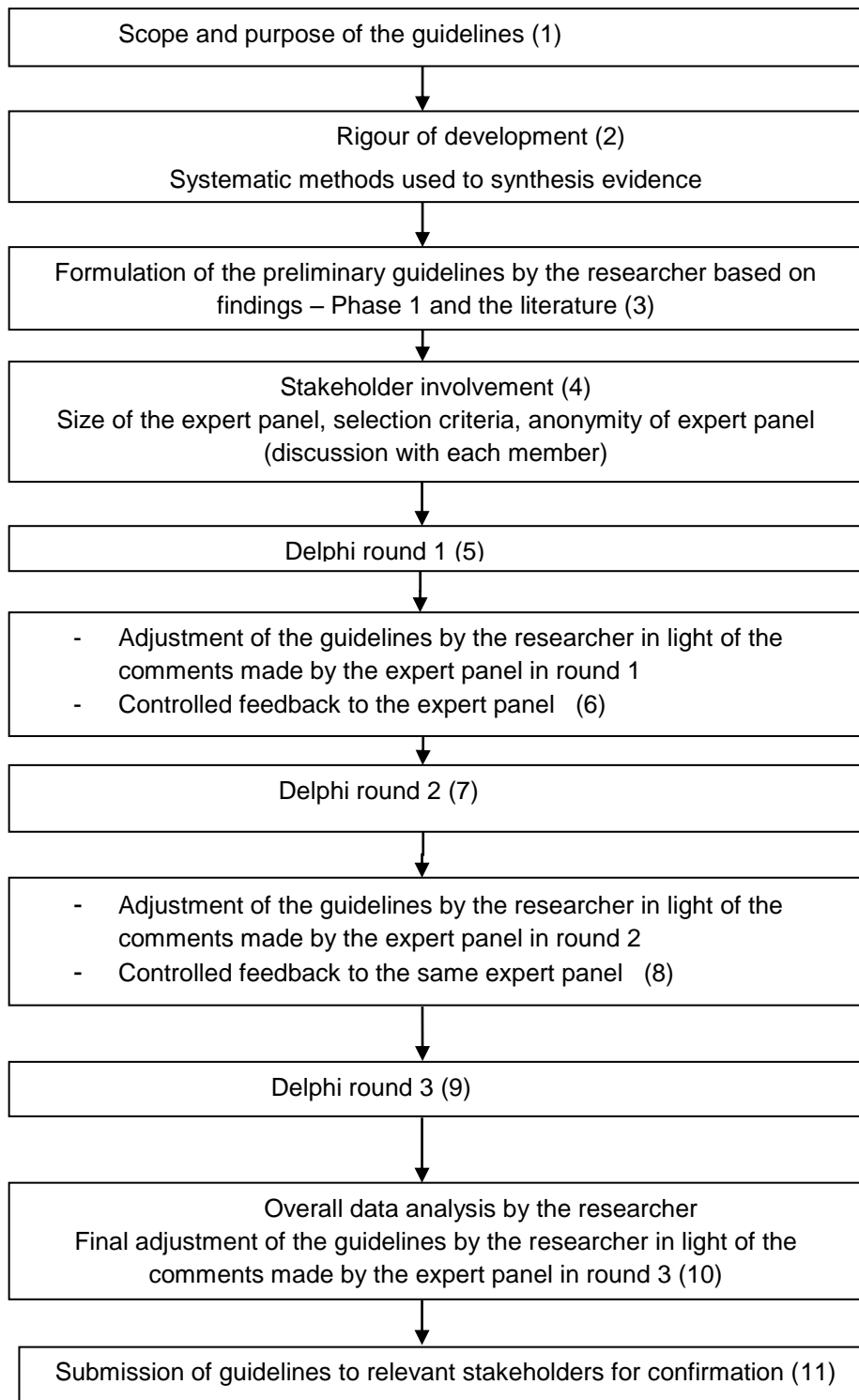
### **5.3.2.2 The validation of the preliminary guidelines using the Delphi technique**

The Delphi technique is a method for obtaining judgments and views from a panel of experts about a topic of interest. The purpose is to reach agreement on the issue without direct confrontation (Green & Thorogood 2014, p.128; Botma et al. 2010, p.253; Bowker et al. 2008, pp.3, 85-95). In this study, the process of data collection from the Delphi experts was conducted in subsequent rounds of one to two weeks each until consensus had been reached. During each round, the Delphi experts were expected to read through the draft guidelines, rate the guidelines and then write comments outlining their opinions. The ratings and comments of each Delphi expert were compared with the ratings and comments fellow experts gave. Participants remained anonymous from each other and the controlled feedback was facilitated by the researcher (Keeney et al. 2011; Keeney 2010; Hsu & Sandford 2007; Okoli & Pawlowski 2004). Summaries of the views, ratings and refined guidelines were e-mailed back to each expert. In each round, participants were given an opportunity to change their responses and concur with the views of the group or choose to stay within their own views (Green & Thorogood 2014, p.128).

The researcher, after intensive understanding of the AGREE II (2010; 2003-2013) framework of guideline development and the Delphi technique for validation of the guidelines, adapted and consolidated certain aspects of the framework according to the study objectives and methodology. The adapted framework for guideline development and validation are outlined in Section 5.3.2.3.

### **5.3.2.3 Framework for guideline development and validation used in the study**

The researcher followed specific steps to develop and validate the guidelines for the primary health care services to support widows. The researcher chose some of the domains and items of the AGREE II (2010; 2003-2013) instrument to develop the guidelines and combined them with the Delphi technique of guideline validation. Figure 5.2 presents the adapted framework that guided the researcher in the development and validation of guidelines.



**FIGURE 5.2 Framework that guided the development and validation of the guidelines**



The paragraphs immediately below set out the application of the steps set out in Figure 5.2 that guided the development and validation of the guidelines.

### **Step 1: Scope and purpose of the guidelines**

In this step, the scope and purpose of the guidelines are clearly defined. The scope and purpose of the guidelines outlined the overall aim of the guidelines, health questions and the target population (Agree Collaboration 2010, p.841; 2003-2013, p.10). In this study, the purpose of the guidelines was to promote the health support rendered to widows by the primary health care services. The overall aim of the guidelines was to enhance the optimal wellbeing of widows. The scope of the guidelines was derived from the findings in phase 1 of this study, which were the essences of widowhood experiences, the support rendered to widows by different systems of support, and the health support required by widows from primary health care services. In this study, the scope of practice for the guidelines included the nurses in the primary health care services and the widows who were the primary recipients of primary health care services.

### **Step 2: Rigour of development**

Rigour of development relates to the process used to gather and synthesise the evidence, methods to formulate recommendations and to update them using the guiding attributes set out in Section 5.3.1 (Agree Collaboration 2010, p.841; 2003-2013, pp.2, 10; Tan 2006, pp.197-199; Institute of Medicine 1990, p.59). In this study, systematic methods were used to collect the evidence. A literature synthesis on the scope of the content was conducted during the empirical phase of this study. A few studies (García et al. 2013; Nseir & Larkey 2013; Zhang, El-Jawahri & Prigerson 2006; Manyedi et al. 2003) outlined broad guidelines, interventions and programmes of support rendered to bereaved individuals in general, without outlining the clear implementation of these. In this study, the panel of experts involved in the development and validation of guidelines included qualified experts, nationally and internationally.

### **Step 3: Formulation of the preliminary guidelines by the researcher**

Preliminary guidelines were drafted and formulated on the basis of the findings from phase 1 and the available literature. The researcher selected appropriate statements from the findings to formulate the preliminary guidelines. In addition, the researcher took into account what the widows wanted and valued. As a result, recommendations by widows were integrated into the guidelines (Krahn & Naglie 2008, p.436). A literature synthesis of the relevant sources was

conducted to confirm if the formulated statements collated with what had been published (Thompson & Dowding 2002, p.151). Table 3.1 (see Chapter 3) outlined the essential meanings and constituents representing the experiences of widows that guided the formulation of the draft guidelines. The draft guidelines developed by the researcher and validated by Delphi experts were outlined in chapter 5 (5.4) and Annexure K.

#### **Step 4: Stakeholder involvement**

This step focuses on the extent to which the appropriate stakeholders validated the guidelines and represent the views of its intended users. The guideline development group included individuals from all the relevant professional groups (Agree Collaboration 2010, p.841; 2003-2013 pp.2, 10). The validation of the preliminary guidelines drafted by the researcher was carried out through the Delphi technique. The Delphi technique determines that the size of expert panel should consist of 10 to 18 members (Keeney et al. 2011, p.8). Bowker et al. (2008, pp.86-87) highlight that to ensure the credibility, trustworthiness and the acceptability of the guidelines at least some of the participants in guideline development and validation should have expert knowledge in the particular discipline or subject. This expertise forms the basis of the participants' relevant inputs. Furthermore, most guidelines influence multiple disciplines; therefore, it is essential that the group is representative of a multidisciplinary team. Most importantly, in the Delphi method the panel of experts is asked to participate independently within the specified time frames. As a result, the level of commitment, willingness and motivation of the group is an essential factor determining the effectiveness of the project.

In this study, experts who are qualified and knowledgeable were requested to participate in the validation of the drafted guidelines. The researcher requested national and international experts in government and non-governmental organisations in the area of healthcare, human behaviour, bereavement, research, and policy- and guideline development. The experts were purposively selected based on their expertise. The researcher invited 25 potential participants who met the requirements in accordance with the abovementioned inclusion criteria. Sixteen experts responded and participated in the Delphi process. Table 5.2 presents descriptive information of the Delphi expert panel.

The researcher ensured the anonymity of the expert panel. The researcher e-mailed the following documents to each participant: (1) a letter of invitation outlining the instructions, study objectives, summary of the findings (Annexure F); (2) an information leaflet including the

consent form (Annexure E); and (3) an instrument to validate the five draft guidelines (Annexure I).

**Table 5.2: Descriptive information of the Delphi expert panel**

No.	Professional qualification	Occupation	Employer	Experience in the area of healthcare, human behaviour, bereavement, research, policy and guideline development
1.	Bachelor in Social work Honors in Social work M Th (Practical theology) D Litt et Phil (Religious knowledge)	Social worker Pastor	Gauteng Department of Social Development, public sector. El-Bethel Christian Fellowship	Counselling and writing reports to the Master of the High Court on the estate of the deceased where it involves the surviving spouse and minor children. Experience in bereavement counselling and conducting trauma debriefing.
2.	Diploma in General Nursing Diploma in Midwifery B Cur (Health Science Education and Health Service management B Cur (Honors) M Cur in Community Nursing.	Retired senior lecturer.	Previously employed by Gauteng Department of Health, public sector	Thirty-two years' experience in nursing. Coordinated Community Nursing Science programme at a local clinic, worked as a nursing instructor in Community Nursing Science and General Nursing Science, Chairperson of research committee at a nursing college, coordinates widow's support groups in the workplace and within the community.

3.	<p>Diploma in Nursing (General, Community &amp; Psychiatry) and Midwifery</p> <p>Diploma in Clinical Nursing Science, health assessment, treatment and care</p>	<p>Compliance Inspector</p>	<p>Office of Health Standards Compliance (OHSC)</p>	<p>Nineteen years' experience in health-care delivery systems in both public and private setting, worked in primary health care setting managing mobile primary health care using comprehensive primary health care approach, experience in both public and private sectors both locally and abroad (United Kingdom – six years). Experience in policy and guideline regulation, inspecting health establishments for compliance with norms and standards.</p>
4.	<p>Registered nurse</p> <p>Doctorate in Clinical Nursing</p>	<p>Nursing instructor</p> <p>Research supervisor</p>	<p>University of North West</p>	<p>Worked in primary health care setting, experience in research, supervises post-graduate studies in the field of nursing, e.g. supervised study on the support needs of Batswana widows.</p>
5.	<p>Diploma in Nursing (General, Community &amp; Psychiatric) and Midwifery</p> <p>B Cur (Health Science Education and Health Service management</p> <p>M Cur in Clinical Nursing</p> <p>Assessor and moderator</p>	<p>Registered nurse</p> <p>Nursing school principal</p>	<p>Private nursing school</p>	<p>Twenty-five years' experience in mental health nursing, nursing education. Experience in research – secretary of research committee at a nursing college, experience in policy and guideline development as a principal in a nursing school.</p>

6.	Diploma in General Nursing Science Diploma in Midwifery Bachelor of Nursing Science (BNSc) Masters in Public Health.	Nursing instructor in Nursing Science	College of Medicine, University of Lagos, Idi-Araba, Nigeria	Experience in primary health care setting and health development organisations such as Red cross, Catholic relief services/Nigeria and Family Health International Nigeria supporting the bereaved families. Member of the Counselling committee.
7.	Diploma in General Nursing Diploma in Midwifery Diploma in Nursing education B Cur (Health Science Education and Health Service management Registered Psychometrist	Assistant Director – Head of Department: Academic	Gauteng Department of Health, public sector	Thirty-five years' experience in primary health care setting, Academic Head of Department: Diploma in Clinical Nursing Science, Health Assessment, Treatment and Care. Member of research committee and internal guidelines and policy development committee.
8.	Bachelor of Nursing Science (BNSc) Masters in Community Health Nursing (MSc) PhD student in Community Health Nursing	Nursing instructor in Nursing Science	College of Medicine, University of Lagos, Idi-Araba, Nigeria	Experience in clinical nursing in hospital setting. Coordinates social support groups of Saint Vincent de Paul (charity organization). Member of nongovernmental organisation taking care of the bereaved families, member of the counselling committee. Experience in research, supervises students in undergraduate studies in the field of nursing.

9.	MB Ch B, Certificate in Medicine and Law. Diploma in Nursing (General, Community & Psychiatric) and Midwifery	Psychiatrist, Head of Department: Psychiatric unit	Gauteng Department of Health, Mamelodi Regional Hospital (public sector)	Thirty years' experience in the field of healthcare, human behaviour, research, and development of mental health care protocols. 1987-2000: professional nurse at a psychiatric hospital 2005-2011: registrar in the Department of Psychiatry at Dr. George Mukhari hospital. 2012 to date, medical officer and Head of Department of Psychiatric Unit in Mamelodi regional hospital.
10.	Bachelor in Social work Masters in Social work Counselling Psych USC	Social worker, Therapist	Elim Clinic (private sector)	Fifteen years experience in social work, therapy and counseling of individuals undergoing life stresses – traumatic experiences such as grief and bereavement Coordinates awareness and exhibitions to empower individuals on day-to-day life challenges and stressors.
11.	Diploma in General nursing Diploma in Midwifery Diploma in Community Nursing Science Diploma in Clinical Nursing Science, health assessment, treatment and care Diploma in Occupational Health Post graduate Diploma in Public Health B Cur (Health Science	Nurse instructor in Clinical Nursing Science, Health assessment, treatment and care	Gauteng Department of Health component: SG Lourens Nursing College (public sector)	Thirty-four years' experience in healthcare: primary health care services managing both minor and chronic health problems, Referral of clients presenting with mental health issues (conversant with referral systems in the primary health care). Member of research committee dealing with research, policy and

	Education and Health Service management			<p>guideline development.</p> <p>Contributed to the standardisation of policy and guideline development of IMCI, EPI, Strategic Plan on HIV and AIDS, STI and TB (Familiar with principles of policy and guideline development).</p> <p>Involved in the clinical accompaniment of nursing students: Clinical Nursing Science, Health assessment, treatment and care</p>
12.	<p>Diploma in General nursing</p> <p>Diploma in Midwifery</p> <p>Diploma in Community Nursing Science</p> <p>Diploma in Clinical Nursing Science, M &amp; S Critical Care Nursing</p> <p>Diploma in Clinical Nursing Science: health assessment, treatment and care</p> <p>Post graduate Diploma in Public Health</p>	Nursing instructor in Clinical Nursing Science, Health assessment, treatment and care	Gauteng Department of Health component: SG Lourens Nursing College (public sector)	<p>Forty-one years' experience in the field of health care: caring for terminally ill patients who needed palliative care: supported relatives who lost loved ones. Member of counselling committee in the local church-actively involved in taking care of bereaved families. Involved in clinical accompaniment of students: Clinical Nursing Science, Health assessment, treatment and care.</p>
13.	<p>Masters in Counseling Psychology</p> <p>Honors in Psychology</p> <p>B Cur (Health Science Education and Health Service management</p>	Psychologist	Private practice :Vista clinic	<p>Twenty-six years' experience in human behaviour.</p> <p>1991-1999 experience in psychiatric nursing at Vista clinic.</p> <p>2002-2002 Experience as family counsellor and psychologist</p>

				2002 to date – Private counsellor and psychologist of in- and out-patients undergoing life stresses – traumatic experiences such as grief and bereavement, depressive disorders at Vista clinic. Coordinates individuals' therapy and support groups.
14.	Honors in Psychology Masters in Counseling Psychology	Counseling psychologist	Private practice	Six-year' experience as a counselling psychologist. Counselling of individuals undergoing life transitions and different life stresses; e.g. traumatic experiences such as grief and bereavement – conducts individual, group and family therapies (short-term and long-term sessions).
15.	Doctorate in Philosophy (Nursing Science) M Cur in Nursing Education B Cur (Health Science Education and Health Service management Advanced Diploma in Nursing Science Diploma in Nursing (General, Community & Psychiatry) and Midwifery.	Nursing instructor	University of Namibia	Worked as a registered nurse at Onandjokwe Lutheran Hospital providing care to terminally ill patients and counselling members of the bereaved families. Mentoring of students on how to assist and provide support to parents of dying children, dying patients, bereaved family. Conducted research and developed guidelines as part of PhD thesis and gained experience in guideline development.



				Supervise students on research projects including programme- and guideline development.
16.	Registered nurse Doctorate in Psychiatric Nursing Science	Nursing instructor	University of Namibia	Four years experience as a mental health nurse in acute ward. Three-and-a-half years' experience as primary care worker for employee assistance programme Fifteen years' experience as Lifeline counselor Twenty-six years' experience as a lecturer in Mental Health Nursing.

### Step 5: Delphi round 1

Twenty-five selected potential Delphi participants were e-mailed the letter of invitation, which outlined the title of the study, the objectives of the study, and a summary of the findings of the study, deadlines, and conditions of participation. Informed consent leaflets (Annexure E and Annexure F) and the instrument outlining the five preliminary guidelines and the set criteria of rating the guidelines (Annexure I) were included as attachments to the e-mail.

Initially 18 experts agreed to participate. However, only 16 experts signed the consent form and participated in Delphi round 1. The participants were given one to two weeks to work on the preliminary guidelines and rate the guidelines in accordance with the attributes of quality guidelines. Participants used the 4-point Likert scale to measure their level of agreement and then made comments on the provided section. The participants were expected to scan the last signed page of the consent and provide his or her biographical information (Annexure G) and return all the documents to the researcher by e-mail. The descriptive information on the professional and academic experience of the 16 Delphi experts enabled the researcher to describe the sample.

Responses from the expert panel (Annexure J) were analysed by the researcher. The ratings of each guideline on the 4-point Likert scale were collated and are presented in Table 6.1 (see Chapter 6). A qualitative analysis of the comments, inputs and recommendations by the Delphi experts was carried out and applicable refinements were identified (Bowker et al. 2008, pp.90-94; Hsu & Sandford 2007, p.4).

### **Step 6: Adjustment of the guidelines by the researcher**

In light of the comments, inputs and recommendations made by the expert panel in round 1, the researcher made adjustment to the five guidelines. The controlled feedback to the expert panel was sent by e-mail by the researcher.

### **Step 7: Delphi round 2**

In this step, the expert panel that worked on the guidelines in round one was sent the guidelines modified by the researcher based on the comments and recommendations made by the same expert panel in round one. A cover letter presented a summary of the findings of round 1, the objectives of round 2, and the deadlines for round 2. The expert panel was again given one to two weeks to work on the guidelines for further analysis, adjustment and confirmation. During this round, the expert panel had an opportunity to observe how their opinions differed from others'. This observation gave them the opportunity to either maintain the ranking of their initial thoughts or decide to change their ratings accordingly (Bowker et al. 2008, pp.90-94; Hsu & Sandford 2007, p.4). The expert panel was again expected to return their responses by e-mail to the researcher. Reminders were sent to all 16 members who participated in round 1. However, only 14 panelists responded. Two of the panelists did not respond despite several reminders sent to them by e-mail. Their reasons for not participating are not known to the researcher.

Thirteen of the experts either agreed or strongly agreed with all aspects of the five draft guidelines. However, experts recommended some minor changes in the phrasing of the sentences and suggested minor additions to guidelines 1, 2, 3 and 4. One expert only rated the guidelines and disagreed with the criterion of the applicability of guideline 2 but did not give an explanation or recommendations.

### **Step 8: Adjustment of the guidelines by the researcher**

During this step, the researcher analysed the ratings and the comments made by the expert panel in round 2 of the validation of the guidelines. The ratings of each guideline on the 4-point Likert scale were collated and are presented in Table 6.2 (see Chapter 6). The researcher, after extensively studying the comments and recommendations, adjusted the guidelines accordingly and sent controlled feedback to the expert panel by e-mail.

### **Step 9: Delphi round 3**

Round 3 was the final round. All 16 panelists who participated in round 1 inclusive of the two who had not responded in round 2 were given the final opportunity to revise their judgments (Bowker et al. 2008, pp.90-94; Hsu & Sandford 2007, p.4). The cover letter outlined the objectives of round 3, gave a summary of the findings of round 2, and informed the panelists of the deadlines for round 3.

Fifteen participants responded during this round. Thirteen of the panelists strongly agreed with all the aspects of the five guidelines and one participant agreed with some of the aspects of guidelines one to four. However, one participant did not rate the guidelines, indicated that she maintained her ratings of the previous round, and recommended some additions to the wording of the criteria of validity, comprehensiveness and flexibility. During this round, none of the participants disagreed, or strongly disagreed with any of the aspects of all the guidelines. One participant did not respond during this round despite several reminders sent to her by e-mail, so her reasons for not participating are not known to the researcher. As a result, the researcher concluded that consensus had been reached. The ratings of each guideline on the 4-point Likert scale were collated and are presented in Table 6.3 (see Chapter 6).

### **Step 10: Overall data analysis by the researcher**

The researcher reviewed the guidelines and ensured that all the data was analysed and the guidelines adjusted in line with the comments made by the participants in all the rounds. The researcher made suggested changes. Each of the five draft guidelines was outlined and supported by the rationale for its inclusion. The specific actions required to facilitate the actualisation of the guideline were also outlined.

## **Step 11: Submission of guidelines to relevant stakeholders**

During this step, draft guidelines were presented to widows who participated in the study and to relevant stakeholders. These stakeholders were mainly nurse experts who are skilled in research, policy development and primary health care services. Widows confirmed whether the guidelines met their health support needs. The nurse experts also confirmed whether the guidelines met the health support needs of widows and the attributes of quality guidelines. The aim of this step was to confirm whether the developed guidelines would provide a framework for rendering adequate and appropriate health support to widows. The final guidelines for the promotion of the health support of widows by primary health care services will be made available to stakeholders.

### **5.4 GUIDELINES TO PROMOTE THE SUPPORT OF WIDOWS BY THE PRIMARY HEALTH CARE SERVICES**

The specific objective that formed the basis of this study in phase 2 was to develop guidelines for the primary health care services to promote health support for widows in the City of Tshwane in Gauteng Province.

The essence of widows' experiences of widowhood, widow's experiences of support and the health support required by widows from the primary health care services led to the development of the guidelines.

The essence of the widows' experience is that widowhood is an intense emotional experience that affects women on a physical, cognitive, emotional, existential and social level. Women described embodied experiences, intense emotions, and cognitive and social disruptions as part of their experiences. Women verbalised their health support needs as they wished to resume a meaningful life, be in control of their emotions and be able to accept the inevitable losses they have experienced. The experience of support from others was significant for all the participants and was considered to play a valuable role in the emotional, spiritual and physical functioning of all the widows.

The guidelines were drafted and formulated based on the empirical data (Phase I) and an extensive literature synthesis. The intention of the guidelines is to assist the primary health care services, particularly community nurses, to promote health support for widows in the City of Tshwane. In this study, draft guidelines were viewed as providing the framework for the nurses

in primary health care services to: (1) assess, define and clarify the health support needs of widows; and (2) promote the health support for widows through mobilisation of relevant resources.

The five draft guidelines that were formulated by the researcher and validated by 16 Delphi expert participants are outlined in this section. These guidelines include the changes suggested by the Delphi expert panel described in Table 5.2 of this chapter. The changes are reflected in bold. In this section, guidelines are outlined separately and each of the five draft guidelines is followed by the rationale for its inclusion and the actions needed for implementing the guidelines.

**Guideline 1:** Nurses in primary health care services conduct **comprehensive health assessment** and integrated screening of the widows to identify their health support needs **in terms** of their physical, cognitive, emotional, spiritual **and social** wellbeing.

#### **a) Rationale**

In this study, widows communicated that they presented with physical, emotional, cognitive and spiritual health problems. Widows questioned how they were managed or treated by the primary health care nurses at the local clinics and were not satisfied with the nurses' approach: the way nurses asked them about their health needs or assessed them and the limited time spent during assessment.

Nurses often come into contact with clients in vulnerable conditions at their most desperate times (Munhall 2012, p.25). It is critical that a comprehensive health assessment and integrated screening are conducted to enable nurses to obtain valid baseline data about the health status during the first contact with the client (Setswe, Naudé & Zungu 2011, p.34). Adequate information enables nurses to formulate accurate diagnoses (Mehtar 2016, p.xxvii; Uys & Middleton 2014, p.198). Uys and Middleton (2014, p.75) assert that to be able to attend to the needs of clients at the primary care level, a comprehensive approach is essential for early detection of health needs. The approach is used to screen individuals at physical, psychological, emotional, spiritual and social levels to obtain the total picture of individuals' well being. Nurses gather information from their clients and consider it in view of the knowledge acquired during their education and training. Making use of their knowledge, nurses decide how to manage individual clients. The length of time spent on assessment and integrated screening of the

individual should not influence the quality of the service and health outcomes at all levels of care (Uys & Middleton 2014, pp.43-44, 198-199, 214, 231). Nurses need to be conversant with the pieces of legislation and policies that have direct impact on healthcare services such as the National Health Act no.61 of 2003 (Mthembu 2016, p.5). Health-related legislation should be made available and easily accessible to serve as guidelines in executing nursing duties appropriately without these guidelines being misinterpreted (Hattingh et al. 2012, p.84).

In this study, widows questioned the general approach that nurses at the local clinics used to provide care to widows. Some of the widows communicated that they experienced health care received from the nurses not to be “person-centred” and were not satisfied with the generalised care that they received. However, some of the widows appreciated the health care professionals who treated them well and allowed them to take their time to tell their “own story” openly.

Client-centred care is one of the factors that are embraced in the entire health care system with the intent of promoting and sustaining the quality of care. The process of client-centred care should be outlined to achieve the specific needs of the individual without infringing the cultural or religious beliefs of those involved in the caring (Ferguson, Ward, Gard, Sheppard & McMurtry 2013, p.286; Van Wyk, Leech & Mtshali 2011, p.30). The approach enhances patient satisfaction as it improves an individual’s perspective about life circumstances and results in positive behavioural changes (Ekman, Swedberg, Taft, Lindseth, Norberg, Brink, Carrison et al. 2011, p.3; Hudson, Fortin, Haggerty, Lambert & Eve-Poitras 2011, p.158). Moreover, the Batho Pele principles are founded on the belief that “good service delivery leads to happy customers and employee satisfaction for a job well done” (Mthembu 2016, p.36).

Nurses have engaged with and cared for individuals from different cultural groups since the beginning of the nursing discipline (Degazon & Perdue 2016, p.140; Degazon 2014, p.69). Therefore, it is essential that nurses understand different cultures and the meaning culture has for the health of the individual. In this sense, nurses need to be sensitive enough to behaviours that portray cultural differences. Culturally skillful nurses view each individual as a unique human being with differences that should be respected while meeting mutual goals of promoting the culture of health (Degazon & Perdue 2016, pp.141, 155; Kulbok & Botchwey 2016, p.378; Clark 2015, pp.104-109; Oakley 2013, p.99, Stuart 2013, p.139; Hattingh et al. 2012, pp.30-33).

## **b) Actions**

### **Nurses in the primary health care services:**

- Ask critical questions to collect thorough history or information from the widow and consider it in the light of theoretical nursing knowledge.
- Conduct a physical examination of the widow to identify the physical health support needs and intervene accordingly.
- Conduct a mental health assessment of the widow to identify the cognitive, emotional and the spiritual health-support needs and intervene accordingly.
- Acknowledge the experiences of widows and provide person-centred holistic care to widows based on their identified health-support needs.
- Acknowledge that the widow's needs differ and change with time and should be screened continuously.
- Acknowledge cultural and traditional beliefs of the widow that influence the management of the health of the widow.
- Display sensitivity towards the cultural beliefs of the widow and provide health support as needed.

**Guideline 2:** Nurses in the primary health care services create a therapeutic relationship with the widow in a therapeutic environment **through application of verbal and non-verbal therapeutic communication techniques, while portraying a culturally sensitive attitude to providing counselling and emotional support while the widow is adjusting to her situation.**

## **a) Rationale**

Communication is the means used to establish a therapeutic relationship in all spheres of life. The process of communication between individuals could take place on two levels – verbal or non-verbal (Stuart 2013, p.21), which are both acquired through one's culture (Degazon & Perdue 2016, p.145). Communication is the mode by which individuals influence the manner in

which one behaves, leading to either successful or unsuccessful outcomes of the relationship. In therapeutic communication, verbal or non-verbal communication attempts to maintain the self-respect and the dignity of both the nurse and the client (Degazon & Perdue 2016, p.145; Stuart 2013, pp.21-25). In this study, widows described both positive and negative encounters with the nurses who treated them at the local clinics. An emotional climate is created by the attitude of individuals who are involved in the communication process. Individuals seek meaning in everything the other person says or does (Uys & Middleton 2014, p.258; Hattingh et al. 2012, p.265). Nonetheless, nurses need to have sensitive awareness and understanding of culturally diverse meanings of health, illness, caring and healing practices to create a successful-therapeutic relationship with the client at all times (Blais, Hayes, Kozier & Erb 2006, p.373).

Health care professionals should establish adequate rapport to gain the trust of the individual. In a nurse-client relationship the nurse engages in the process of “the therapeutic use of self” in working with the client to instill insight and positive behavioural change. The important task of the nurse is to listen to the client (Stuart 2013, pp.13-14, 25; Hattingh et al. 2012, p.72). In this study, some of the widows indicated that nurses who worked at the local clinics listened and empathised with them while others felt that nurses lacked a caring and nurturing attitude. All in all, widows valued the caring and nurturing approach portrayed by some of the health professionals during the management they received at the primary health care services. It is clear that listening in a therapeutic sense requires the nurse to remain patient; to “be there” to observe and listen intently to what the individual might be saying both verbally and non-verbally. In doing so, attentive listening creates a climate in which individuals can communicate positively by displaying a sense of acceptance of one another (Townsend 2015, p.144; Uys & Middleton 2014, p.177; Hattingh et al. 2012, pp.265-267). The nurse should show interest in what the individual is conveying by being there for the individual without any disturbance while the person is talking (Uys & Middleton 2014, pp.177-178). However, the success of the nurse-client relationship depends on various factors, such as personality, previous experiences, and level of maturity, time they spent together, the objectives of the contact, situational factors and the meaning attached to the messages. A warm, caring environment should be part of every step-in the nurse-client interaction (Dorhout, Little & Rector 2014, p.321; Uys & Middleton 2014, p.185). In this study, Delphi experts acknowledged that not all nurses are familiar with the features of the therapeutic relationship and therapeutic environment, as it takes skills and experience to create a therapeutic relationship and therapeutic environment. As a result, it was recommended by the Delphi experts that experienced nurses should mentor the inexperienced nurses in this regard.



## **b) Actions**

### **Nurses in the primary health care services:**

- Take widows in their care to a private place where they can sit face to face to promote eye contact and interaction.
- Establish rapport with the widow by availing themselves to the widow, by “being there”, making time to listen to the widow’s concerns, and showing respect and trustworthiness.
- Utilise the verbal and non-verbal therapeutic communication techniques displaying a caring and nurturing attitude during interaction with the widow.
- Demonstrate interest and presence by maintaining eye contact while encouraging the widow to continue to talk and showing interest in what the individual is saying without interrupting.
- Acknowledge the cultural, traditional and social frame of reference of the widow that may impede her from disclosing factual information and feelings about herself.
- Display sensitivity towards the cultural or personal frame of reference of the widow by providing health support on her level.

**Guideline 3:** Nurses in the primary health care services utilise **continuous and participatory** health education as **one** of the strategies to offer support and disseminate information to widows to increase widows’ ability to accept and cope with their health problems **and increase their ability** to live a meaningful healthy life.

## **a) Rationale**

Having a reason to live gives people a sense of meaning, control and the feeling to rise and looking forward to the future (Townsend 2015, p.110). Educating the clients and providing them with relevant information to make informed decisions regarding their health is put first on the list of core activities by the primary health care services (Clark 2015, pp.20-21, 192). Interventions should be complementary as nurses and individual clients work together in a partnership, empowering each other and collaborating to improve the quality of care and health outcomes (Van Wyk et al. 2011, p.30). Clients are taking a more active role in decision making and it is the

health care provider's responsibility to find out what clients want, to help them find the right information, and to support them in the decision-making process (Krahn & Naglie 2008, p.437). Otherwise, the individual will not utilise the services and resources will be wasted. The primary health care approach should be adaptable and flexible to accommodate the needs of the client and the entire community. Primary health care nurses should educate individuals, families and communities regarding their health problems. Furthermore, individuals should be given information regarding different services available in the health facilities and be referred to relevant government sectors and non-government sectors for services other than those nurses can provide (Hattingh et al. 2012, pp.66, 71).

Nurses in the primary health care services should strive to promote the health of the individual through health education and health promotion activities. Health education is an essential component in the prevention of health problems and promotion of health (Ramkilowan 2016, pp.60-62). Health education is a participative process of facilitating learning that influences positive health-related behaviour at all three levels of care and prevention. The goal of giving health education is to empower people with relevant knowledge to influence their attitudes to make informed decisions about health (Pick & Dudley 2016, p.3; Ramkilowan 2016, pp.62-63; Clark 2015, pp.20, 266; WHO 2014, n.p.). The best approach is to consider the learning needs of people. The nurse should teach what people think they want to learn and in ways that facilitate their active learning. However, barriers to learning exist; for example, learner's motivation, lack of resources as well as lack of time or skill by the presenter. It is therefore important that during the planning phase appropriate strategies are put in place to minimise the barriers (Lancaster 2016, pp.356-357, 365; Ramkilowan 2016, pp.65-66; Lancaster 2014, p.192).

Health care professionals are the primary source of information regarding needs that include matters that are not health related, as they have the advantage of having access to information. As a result, health education should be determined by the needs of individuals and clients should be offered both verbal and written information based on their range of needs (Hattingh et al. 2012, p.66). Health education is an important tool to enhance individuals' capabilities and self-reliance so that individuals can take full responsibility for their optimal wellbeing (Setswe et al. 2011, p.24). All in all, it is important that nurses acquire basic skills in information technology to access necessary information about health issues. In doing so, nurses would be supporting evidence-based care by promoting the quality of care rendered to their clients (Ellis & Hartley 2012, p.127).

## b) Actions

### Nurses in the primary health care services:

- Assess the individual's readiness to learn or for health education, especially during early stages of mourning, as widows might not necessarily be able to concentrate and integrate facts. The individual's choice and willingness to receive health education should be taken into consideration.
- Ensure that they possess attributes of sensitivity and compassion in order to drive the intensity of the support to be offered.
- Ensure that health education is ongoing, culturally sensitive and participatory.
- Educate widows regarding their identified health problems and offer them both verbal and written information based on their health support needs.
  - o Information should be understandable to the listener or receiver.
- Help the widows to access the most appropriate information about their health-support needs and the different services available in the health facilities and support them in the decision-making process.
- Ensure that widows become active participants during the process of health education and give them adequate time to ask questions and express feelings or concerns as needed.

**Guideline 4:** Nurses in the primary health care services refer the widow to relevant interdisciplinary service providers **such as bereavement, psychotherapy and social services** in governmental and non-governmental **sectors** based on the widow's support needs **and consent**.

## a) Rationale

Widows in this study recommended that nurses working in the primary health care services should refer them to relevant services to help them with their special needs. The need for referral is in agreement with one of the basic principles of primary health care, outlining that an

effective referral system should be in place and be utilised by all role players in the primary health care services (Hattingh et al. 2012, p.71). Referral is the process of directing clients to relevant services or resources to meet their specific needs and improve the quality of care rendered (Clark 2015, p.21). Nurses need to collaborate with other healthcare providers in the area and mobilise relevant resources or systems of support for the optimal wellbeing of their clients. There are different reasons for a client to be referred to another institution or person. Most commonly, clients are referred to other services when they require assistance which the particular service or person is unable to render (Uys & Middleton 2014, p.78).

The nurse needs to be conversant with his or her scope of practice, outlining nursing responsibilities, accountabilities, acts, omissions and misconducts (South African Nursing Council, R2598, and R387 & R373). In doing so, the nurse would be able to accept his or her limitations and ask for assistance when the situation is beyond his or her level of expertise or knowledge (Ellis & Hartley 2012, p.127). It is therefore important to liaise with relevant stakeholders (government and non-government) in the area that is dealing with the issue under concern. In a South African context it is important not to exclude traditional healers (Reid 2016, p.27). In addition, involvement of all related sectors and non-governmental organisations is one of the basic principles of primary health care. An ideal primary health care approach should recognise the importance of integrated service delivery. In this instance; interdisciplinary, multi-professional and intersectoral collaborative teamwork should be promoted to ensure effective service delivery (Setswe et al. 2011, pp.7-8). Primary health care services should be in line with the beliefs of the community to be acceptable to the community (Hattingh et al. 2012, pp.71-72).

Uys and Middleton (2014, pp.282-284) assert that nurses should refer clients to relevant services based on their support needs. However, before referring a client to relevant services, nurses should conduct a situational analysis to assess the availability of the services, accessibility of the services, resources available and the effective programmes that are rendered in the service. Referral involves factors such as: (1) marketing the idea of the referral to the client; (2) dealing with the obstacles that might prevent the client from utilising the service; and (3) conferring with the service provider to deal with the obstacles. The aim of marketing the client to the service is to ensure that the service provider is determined to attain the ultimate needs of the client. However, Uys and Middleton (2014, pp.283-284) assert that there might be a series of obstacles against the use of the service that hinder the progress either in the client, in the service or both. The obstacles might include factors such as emotions, knowledge, skill or resources. These obstacles might be identified timeously to make realistic plans to deal with

them to lessen the clients' suffering in the process. It is important that the nurse stays in contact with either the client, service provider or both. In doing so, the nurse would be able to: (1) monitor if the clients use the services that they have been referred to; (2) ensure that the clients receive the expected services; and (3) monitor the client's progress in attaining his or her goals. Moreover, reasons for not utilising the services should be explored and be addressed to prevent further occurrences of the problem. In addition, the basic principles of primary health care outline that no primary health service can function efficiently without self-care and self-commitment by the individual (Hattingh et al. 2012, p.71).

## **b) Actions**

### **Nurses in the primary health care services:**

- Take into consideration that widows may sometimes require assistance with a particular service that the nurse is unable to deliver.
- Work in collaboration with inter-disciplinary healthcare providers including traditional healers in the area and refer widows to appropriate services based on widows' support needs for holistic well being.
- Assess the availability and accessibility of the services, resources available and effective programmes in the service and refer widows to relevant services based on their support needs.
- Explain the services to the widow to encourage the widow to utilise the services that she has been referred to.
  - o Widows should be well informed about the services and should give consent for the referral.
- Monitor the uses of the services that the widow has been referred to in order to ensure that the widow receives the expected services and monitor the progress as needed.

**Guideline 5:** Nurses in primary health care services need to mobilise support networks **and** outreach programmes offering support to widows and their dependants, especially during the first six weeks following the loss of a husband, as widows may struggle to seek help from **the primary health care services.**

#### **a) Rationale**

Widows in this study communicated that they were overwhelmed by challenges accompanying widowhood and acknowledged the fact that they sometimes doubted their own capacity to cope with the challenges. When facing challenges, individuals utilise personal coping strategies and environmental resources in attempting to cope with the situation (Uys & Middleton 2014, p.196). Coping strategies are effective or successful when they protect the individual from further harm and strengthen the individual's ability to resolve the problem (Townsend 2015, p.8). Health care providers need to assess the individual's ability to utilise coping strategies effectively and mobilise external protective resources, which could protect the individual against stress (Uys & Middleton 2014, p.196). The element of support is determined by the individual's efforts to reach out in helping others by strengthening their self-esteem. Support can be communicated to others by being available when needed, offering encouragement and reassurance while engaging with one another (Maree 2013, p.643).

People are social beings in need of others within their environment to value their being in the world. Most importantly, having a support system may enable the individual to cope better with the stressful situation. As a result, lack of adequate support networks or systems when facing a challenge might threaten the stability in one's life and lead to a possible crisis (Uys & Middleton 2014, pp.269-270). However, some individuals do better with a larger support system while others only need a smaller support system. All in all, giving and receiving support from others is a basic human need (Uys & Middleton 2014, p.270, Williams 2014, p.1).

In this study, some of the widows communicated that home visits by the nurse from the local clinic would have been much appreciated, especially during the first few weeks following the loss of a husband, as they lacked the energy to seek help from the clinic. Home visits as a strategy of care is an essential interconnection between clinical practice and comprehensive care, enabling a harmonious relationship between facility-based and community-based interventions (Reid 2016, p.20). Home visits by nurses are goal directed and designed to promote the well being of individuals and their families in their natural setting and allows the

nurse an opportunity to interact with the client and the family in their natural setting. Home visit enables the nurse to have a much richer understanding of the client's strengths and weaknesses. In this regard, the nurse would be able to assist widows to manage their challenges and reach out to relevant systems of support to address their identified needs. However, home visits as a strategy of care has both advantages and disadvantages (Clark 2015, pp.305-306; Uys & Middleton 2014, pp.302-303)

In the South African context, primary health care re-engineering introduced three streams of health care services focusing on: (1) implementation of ward-based primary health care outreach to improve performance of and access to those in need of health intervention; (2) strengthening of school health services; and (3) the establishment of district clinical specialist teams focusing on maternal and child health and chronic illnesses (Mthembu 2016, p.45). Community-based-or home-based models of care including case management are becoming embraced in the community health care system as a means of accessing community support and improving the quality of life. The primary intent of the community-based-or home-based care is to preserve the individual's sense of respect and self-worth and to promote independent living, as these are often lost in the inpatient settings. Moreover, patient-centred home care is a model of primary health care that delivers the core functions of primary health care (Sundeen 2013, p.208; Stuart 2013, pp. 654-657).

Stuart (2013, p.175) asserts that self-help groups are becoming more common in the communities as members come together to manage their own challenges. Members of the group go through similar experiences, join forces to achieve a common goal and empower one another to gain control over their lives. However, individuals who are unable to cope on their own seek professional help to receive appropriate and individualised recovery support. Recovery support could assist individual clients to recover from their challenges to lead satisfying and productive lives. While self-determination and self-directed actions are the catalysts of a successful recovery, individuals need to have a personal responsibility for their own self-care and journey to recovery (Sundeen, 2013, pp.199-200).

## **b) Actions**

### **Nurses in the primary health care services:**

- Ask critical questions to assess the widow's coping skills and identify concerns that signal the widow's ineffective skills to cope with widowhood challenges.

- Widow's need for support or coping skills may differ as time goes by; the first visit might be only for the need of comfort and the assurance of support.
- Assess the availability and the effectiveness of the support system and networks that widows rely on during stressful times.
- Work in collaboration with other healthcare providers to mobilise allocation of resources or support systems and networks for the optimal well-being of the widow.
- Initiate and utilise effective support programmes such as widows' (peer) support groups in the community based on the widows' support needs.
- Introduce the widow to the available support groups and services to encourage the widow to utilise the widows' support groups and services.
- Collaborate with ward-based community health workers to conduct home visits to widows who are unable to visit the local clinics as needed, especially during the first six weeks following widowhood and taking into consideration the widow's culture in relation to mourning practices.

## **5.5 VALIDITY OF THE GUIDELINES**

The five draft guidelines were based on the findings of the empirical data in phase 1 of this study. During the formulation of the preliminary guidelines, the researcher took into account what the widows wanted and valued and applicable literature findings. The preliminary guidelines were validated by a panel of experts who took part in a Delphi process. The panel of experts reviewed the guidelines according to the set criteria. These criteria were validity, reliability, applicability, clarity, relevance, and comprehensiveness. Other criteria were effectiveness, flexibility and acceptability to ensure reliable guidelines (Mahtani 2015; Agree Collaboration 2010; 2003-2013; Tan 2006; Institute of Medicine 1990). The Delphi panel of experts was chosen from different settings and geographical areas. Six participants were from governmental organisations while ten participants were from non-governmental organisations and had adequate knowledge to ensure that the draft guidelines represented the views of their intended users.



In this study, a valid and reliable 4-point Likert scale was used as an instrument appropriate to rate the guidelines (Rayens & Hahn 2000, p.309). The rating scale was explained and the descriptions of the criteria were provided to the Delphi experts as set out below.

**Table 5.3: Criteria and 4 point rating scale for validation of preliminary guidelines**

CRITERIA	RATING SCALE			
	Strongly disagree	Disagree	Agree	Strongly agree
	1	2	3	4
<b>Validity</b> The guideline produces the desired results based on the truth or facts. The guideline will facilitate the support rendered to widows by the primary health care nurses in the local clinics.				
<b>Reliability</b> Given the same circumstances the primary health care nurses in the local clinics would interpret and apply the guideline similarly.				
<b>Applicability</b> Target population is clearly stated: nurses working in the primary health care services caring for widows.				
<b>Clarity</b> The guideline is clear, easily understandable, unambiguous and logical.				
<b>Relevance</b> The guideline is related to the health-support needs of widows.				
<b>Comprehensiveness and effectiveness</b> The guideline shows the extensive understanding of the health-support needs of widows and enables the nurses in the primary health care services to render adequate and appropriate health support to widows.				
<b>Flexibility</b> The guideline will empower nurses in the local clinics to focus on a client-centred decision-making process and to implement changes as applicable.				
<b>Acceptability</b> The guideline is realistic and in line with the policies, mission and vision of the Department of Health.				

**Adapted from Mahtani 2015; Agree Collaboration 2010; 2003-2013; Tan 2006; Thompson & Dowding 2002; Institute of Medicine 1990.**

## **5.6 SUMMARY**

Chapter 5 covered phase 2 of this study; that is, the development and validation of guidelines for primary health care services to support widows in Tshwane, Gauteng Province, South Africa. The guiding attributes in the guideline development and validation were briefly explained. The structure and the content of the AGREE II (2010; 2003-2013) instrument as well as the Delphi technique that guided the development and validation of guidelines were presented. The five draft guidelines with the suggested changes made by the Delphi expert panel were also presented. The next chapter presents the conclusions from the findings and the validation and description of the guidelines with recommendations, limitations, implications and conclusions.

## CHAPTER 6

### CONCLUSION OF THE FINDINGS, VALIDATION AND DESCRIPTION OF THE GUIDELINES WITH RECOMMENDATIONS, LIMITATIONS, IMPLICATIONS AND CONCLUSIONS

#### 6.1 INTRODUCTION

In Chapter 1 the concept of widowhood, the background to and the rationale behind the problem, and the problem statement were presented. Also set out were the significance of the study, research questions, the purpose of the study, the research objectives, and a brief paradigmatic perspective of the study. A detailed discussion of the researcher's paradigmatic perspective together with the methodology of this research was dealt with in Chapter 2. In Chapter 3, the findings of phase 1 of this study on widows' health-support needs in the City of Tshwane were addressed. Chapter 4 presented literature synthesis in relation to the findings of this study integrated with the applicable theories. Chapter 5 of this study focused on the development, validation and the description of preliminary guidelines for primary health care services. The development and the validation of the guidelines were directed by the methodology developed by the researcher based on the AGREE II (2010) instrument: advancing guideline development, reporting and evaluation in healthcare, and AGREE II (2003-2013) instrument: appraisal of guidelines for research and evaluation combined with the Delphi technique. Chapter 6 delivers the conclusions from the findings and the validation and description of the guidelines with recommendations, limitations, implications and conclusions.

The aim of the study was to develop guidelines for the primary health care services to promote health support for widows in the City of Tshwane, Gauteng Province. The objectives in phase 1 were: (1) to explore and describe widows' experiences of widowhood, (2) to explore and describe the experiences of widows regarding the health support given by the primary health care services; and (3) to explore and describe the health-support needs of widows that can be addressed by primary health care services. In phase 2, the objective was to develop guidelines for the primary health care services that would promote health support for widows. The objectives of the study were met.

## **6.2 REVIEW AND SUMMARY OF MAIN FINDINGS**

In phase 1 of this study the findings were outlined in terms of: the essence of the experience of widowhood, widows' experiences of support; and the health support they required from primary health care services. The essence was identified and supported by its constituents (Chapter 3, 3.2).

### **6.2.1 Essence of widow's experiences**

The essence and constituents of widows' experiences is summarised as follows:

#### **6.2.1.1 Widowhood is an embodied experience**

Widows are conscious beings and experience the essence of widowhood through their bodies. The results of this study and the available literature made it evident that following widowhood, the body senses the discomfort and the changes that are taking place in the body. In this study, women experienced physical health problems such as general fatigue, lack of appetite, loss of weight, and disturbed sleeping patterns following widowhood. In addition, it was evident that the experience of widowhood added an additional level of vulnerability to physical health problems.

#### **6.2.1.2 Widowhood is an intense emotional experience**

Widows described their emotional reactions related to the experiences of widowhood. They experienced some changes with regard to their emotional wellbeing, such as feelings of loss, loneliness, anger, hurt, betrayal, worry, depression, anxiety and yearning.

#### **6.2.1.3 Widowhood has a cognitive impact**

Widows experienced negative effects with regard to their psychological well being. These effects included lack of concentration, forgetfulness, recurrent memories and suicidal ideation. It is evident that widows are active participants in the process of widowhood and that each widow experiences widowhood in a unique manner. Widows experience difficulty forgetting about their circumstances and have recurrent and intrusive memories of their widowhood experiences that make it difficult for them to adjust adequately to their circumstances. As a result, in this study widows readily recalled both the positive and negative experiences of widowhood. Widows verbalised their past experiences, their current support needs, and the health support they required from primary health care services.

#### **6.2.1.4 Widowhood is experienced on an existential level**

Widows experience an existential disruption arising from their circumstances, as they experience the loss as a disruption and ask themselves how they are going to face life's challenges. In addition, widows perceive that life itself is questioning them to understand the meaning of the spouse's death and may feel that external forces control their life events, which in turn increases symptoms of distress related to their spouse's death.

#### **6.2.1.5 Widowhood is a socially disruptive experience**

Widowhood is a social issue that is responsive to and influenced by what is happening in the society as a whole. It is clearly described in the findings of this study and the available literature that the culture of the family and the society expect appropriate grief reactions. Notably, traditional restrictions disrupt the widow's social level of functioning, as widows feel alienated, rejected, disrespected and uncomfortable around the community. Widows sometimes face threatening behaviours and social abuse, even within the circle of family or friends.

#### **6.2.1.6 Widows need to feel in control**

Widows need to feel in control of their lives and the feeling seems to stimulate the sense of positive self-concept. However, widow's self-esteem seems to be fluctuating during the adjustment to the major life stressor of spousal loss they experienced. Most of the widows perceived that they encountered different challenges that affected their well being on the physical, emotional, psychological, spiritual and social level of functioning and were immersed within their widowhood experiences. To survive the difficulties surrounding widowhood, most women had a confident belief in the truth. Women kept faith in their support systems, especially their spiritual support system. The women's trust in God kept them hopeful for a better future for them and their dependants. Moreover, finding balance as a process of learning to handle the difficult emotions, thoughts and activities of grief assisted widows in moving forward, feeling in control, and looking forward to the future.

#### **6.2.1.7 Widows need to accept what happened**

Most of the participants reflected on their experiences of widowhood. Widows question their circumstances to understand their past experiences, present situations and their future. Widows need to accept what happened through healing, peace and staying positive in life. The support that widows received from their external environment as they interacted with fellow widows and other systems of support enabled them to accept and adapt to their widowhood circumstances. Widows perceive that accepting the circumstances in one's life leads to a sense of healing.

Notably, a sense of peace and a positive outlook on life lead to less stress and uncomplicated grief. It is evident that the emotional acceptance of the loss is necessary to overcome the emotional pain. Overcoming the pain leads to a positive outlook on life.

#### **6.2.1.8 Widows need to resume a meaningful /normal life**

Widows need to adjust and resume a meaningful or normal life, living on a day-to-day basis and not feeling affected by their widowhood circumstances. The findings of this study and the available literature made it evident that widows use different coping strategies such as avoidance, distancing, emotional expression, seeking support, continuing bonds and reconstruction of life. Some of the widows resume their normal life, avoiding the past and being reluctant to talk about the past. They perceive that the events of the past were completed along with the death of the spouse. However, in an effort to resume a normal life and make meaning of their circumstances, some of the widows made cognitive or behavioural efforts to keep bonds with the deceased by looking back on their memories, having inner conversations with the deceased and living up to the wishes of the deceased. Widows who were able to accept spousal death could often search for meaning from the past to help them face the present and the future. Moreover, widows perceive that seeing other widows living meaningful or normal lives instilled a sense of hope for a better future and a positive outlook on life.

#### **6.2.2 Widows experiences of support**

In this study, widows belonged to the social environment and they interacted with other people within the environment, seeking meaningful support in order to survive the difficulties of widowhood. The importance of support from family and friends, employers, church, colleagues and other widows was emphasised by the majority of widows. The findings of this study and the available literature made it evident that widows sought emotional support, informational support, instrumental and social support from family, friends, church members, mental health professionals and from other widows. However, widows verbalised both negative and positive encounters related to their support systems. Irrespective of negative encounters with the social environment, widows still yearned to be with other people instead of being beside them.

In addition, most widows expressed the need for and the value of person-centred care. Widows experienced encounters with health providers as both positive and negative, as they experienced some challenges. Irrespective of dissatisfaction with the care rendered, health care providers such as nurses and psychologists were seen as components of an important support system necessary to render health care services.

### **6.2.3 Health support required by widows from the primary health care services**

Health support required by widows from the primary health care services included person-centred care, appropriate referral and peer support. In this study, widows expressed that health care providers, especially nurses at the primary health care services, should serve as role models by “being there” for widows in need of their support based on the individuality and the uniqueness of the widow. The need for appropriate referral to available support systems such as psychotherapy and psychological counselling is considered to have a valuable role in rendering support to widows. In addition, the need for support from other widows appears to be a general feeling and an important factor in freeing widows from their sense of rejection and enhancing the sense of acceptance, belonging and security. Widows perceive that seeing other widows living a meaningful or normal life instilled a sense of hope for a better future and a positive outlook on life.

### **6.3 DEVELOPMENT OF THE GUIDELINES**

In this study, the development of the draft guidelines in Chapter 5 was based on the empirical data that was given by the participants in phase 1 of this study (Chapter 3). The guidelines were drafted by the researcher in accordance with guiding attributes in the guideline development process (Chapter 5, 5.3.1). The researcher developed a framework based on some of the domains and items of AGREE II (2010) instrument: advancing guideline development, reporting and evaluation in healthcare, and AGREE II (2003-2013) instrument: appraisal of guidelines for research and evaluation. The Delphi technique was incorporated into the framework to establish consensus of experts to validate the preliminary guidelines in order to ensure reliable guidelines (Chapter 5, 5.3.2.3).

### **6.4 VALIDATION OF THE GUIDELINES**

The development and validation of the guidelines are outlined in Chapter 5. The criteria were developed from guiding attributes for guideline development, reporting and evaluation as set out in the literature, inclusive of the AGREE II (2010; 2003-2013) instrument (Chapter 5, 5.3.1). The attributes that guided the development of the guidelines were constructed into a checklist for rating the guidelines.

The participants who were involved in the validation process were experts from national-, international-, and governmental- and non-governmental organisations in the area of health

care, human behaviour, bereavement, research, policy and guideline development. The participants had adequate experience in the above-mentioned areas of expertise and were identified as being able to make valuable inputs. The rating scale was explained and the descriptions of the criteria were provided in the guideline instrument as outlined in Chapter 5 (Table 5.3). The ratings were as follows: strongly disagree = 1; disagree = 2; agree = 3 and strongly agree = 4.

Descriptive information of the participants is provided in Table 5.2 (Chapter 5). Sixteen respondents rated the guidelines, provided comments and outlined suggestions to improve the guidelines as requested. Table 6.1, 6.2 and 6.3 outline the ratings of each of the five draft guidelines in three Delphi rounds.



**Table 6.1: Rating of the guidelines in Delphi round 1 (16 panelists)**

CHECK LIST	Validity				Reliability				Applicability				Clarity				Relevance				Comprehensiveness and effectiveness				Flexibility				Acceptability			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
Guideline 1	0	1	3	12	0	3	5	8	0	3	3	10	0	2	3	11	0	0	4	12	0	2	6	8	0	1	4	11	0	1	4	11
Guideline 2	1	1	2	12	0	2	7	7	0	2	2	12	0	3	2	11	0	1	3	12	0	2	6	8	0	1	5	10	0	2	4	10
Guideline 3	0	0	1	15	0	1	6	9	0	0	1	15	0	1	1	14	0	0	6	10	0	3	5	8	0	2	5	9	0	0	8	8
Guideline 4	0	1	2	13	0	0	4	12	0	0	2	14	0	1	2	13	0	1	5	10	0	0	7	9	1	0	5	10	0	0	6	10
Guideline 5	0	3	1	12	0	1	5	10	0	2	1	13	0	1	1	14	0	1	4	11	0	2	4	10	0	1	6	9	0	1	4	11
<b>TOTAL SCORE</b>	<b>1</b>	<b>6</b>	<b>9</b>	<b>64</b>	<b>0</b>	<b>7</b>	<b>27</b>	<b>46</b>	<b>0</b>	<b>7</b>	<b>9</b>	<b>64</b>	<b>0</b>	<b>8</b>	<b>9</b>	<b>63</b>	<b>0</b>	<b>3</b>	<b>22</b>	<b>55</b>	<b>0</b>	<b>9</b>	<b>28</b>	<b>43</b>	<b>1</b>	<b>5</b>	<b>25</b>	<b>49</b>	<b>0</b>	<b>4</b>	<b>26</b>	<b>50</b>

**Table 6.2: Rating of the guidelines in Delphi round 2 (14 panelists)**

CHECK LIST	Validity				Reliability				Applicability				Clarity				Relevance				Comprehensiveness and effectiveness				Flexibility				Acceptability			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
Guideline 1	0	0	1	13	0	0	2	12	0	0	1	13	0	0	2	12	0	0	2	12	0	0	0	14	0	0	2	12	0	0	0	14
Guideline 2	0	0	1	13	0	0	1	13	0	0	1	13	0	0	1	13	0	0	1	13	0	0	0	14	0	0	2	12	0	1	1	12
Guideline 3	0	0	0	14	0	0	2	12	0	0	0	14	0	0	3	11	0	0	2	12	0	0	3	11	0	0	3	11	0	0	2	12
Guideline 4	0	0	1	13	0	0	4	10	0	0	1	13	0	0	1	13	0	0	2	12	0	0	2	12	0	0	1	13	0	0	3	11
Guideline 5	0	0	2	12	0	0	1	13	0	0	1	11	0	0	0	14	0	0	3	11	0	0	1	13	0	0	2	12	0	0	1	13
<b>TOTAL SCORE</b>	<b>0</b>	<b>0</b>	<b>5</b>	<b>65</b>	<b>0</b>	<b>0</b>	<b>10</b>	<b>60</b>	<b>0</b>	<b>0</b>	<b>4</b>	<b>64</b>	<b>0</b>	<b>0</b>	<b>7</b>	<b>63</b>	<b>0</b>	<b>0</b>	<b>10</b>	<b>60</b>	<b>0</b>	<b>0</b>	<b>6</b>	<b>64</b>	<b>0</b>	<b>0</b>	<b>10</b>	<b>60</b>	<b>0</b>	<b>1</b>	<b>7</b>	<b>62</b>

**TABLE 6.3: Rating of the guidelines in Delphi round 3 (14 panelists)**

CHECK LIST	Validity				Reliability				Applicability				Clarity				Relevance				Comprehensiveness and effectiveness				Flexibility				Acceptability							
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4				
Guideline 1	0	0	1	13	0	0	0	14	0	0	0	14	0	0	0	14	0	0	2	12	0	0	0	14	0	0	0	14	0	0	0	14	0	0	0	14
Guideline 2	0	0	1	13	0	0	1	13	0	0	1	13	0	0	0	14	0	0	0	14	0	0	0	14	0	0	1	13	0	0	1	13	0	0	1	13
Guideline 3	0	0	0	14	0	0	1	13	0	0	0	14	0	0	0	14	0	0	0	14	0	0	1	13	0	0	0	14	0	0	0	14	0	0	0	14
Guideline 4	0	0	1	13	0	0	0	14	0	0	0	14	0	0	0	14	0	0	0	14	0	0	0	14	0	0	0	14	0	0	0	14	0	0	0	14
Guideline 5	0	0	0	14	0	0	0	14	0	0	0	14	0	0	0	14	0	0	0	14	0	0	0	14	0	0	0	14	0	0	0	14	0	0	0	14
<b>TOTAL SCORE</b>	<b>0</b>	<b>0</b>	<b>3</b>	<b>67</b>	<b>0</b>	<b>0</b>	<b>2</b>	<b>68</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>69</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>70</b>	<b>0</b>	<b>0</b>	<b>2</b>	<b>68</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>69</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>69</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>69</b>				

## **6.5 DESCRIPTION OF THE FINAL GUIDELINES**

The five guidelines were developed and reformulated by the researcher based on the comments and recommendations outlined by the panel of experts in each of the Delphi rounds. A descriptive overview of the final guidelines is set out below:

### **6.5.1 Name of the guidelines**

**“GUIDELINES FOR THE PRIMARY HEALTH CARE SERVICES TO SUPPORT WIDOWS”**

### **6.5.2 Overall aim of the guidelines**

The overall aim of the guidelines was to enable the nurses in primary health care services to promote health support for widows.

### **6.5.3 The scope of the guidelines**

The guidelines in this study were developed for nurses in the primary health care services as the target users and widows using the primary health care services as the target recipients of appropriate health support.

### **6.5.4 Development of the guidelines**

The problem that initiated this study and led to the development of the guidelines for the primary health care services to support widows was outlined: During personal contact with the widows, the researcher observed that they appeared to be sad, complained of health problems and were reluctant to seek help from the primary health care services as they were not receiving the help that they needed. Through the phenomenological inquiry, supplemented by the literature synthesis in relation to the topic, the health-support needs of widows were identified. The health support needs guided and provided the rationale for the development of different guidelines. These guidelines were drawn up to provide direction and clarity to nurses in the primary health care services who provided health support to widows.

### **6.5.5 Methodology**

The research design and method used to explore and describe the experiences of widows regarding the health support given by the primary health care services were outlined. A qualitative, descriptive phenomenological, contextual design was employed in Phase 1. Phase 2 of the study was used to develop and refine the guidelines to promote adequate health support for widows from the primary health care services. The development of the guidelines was

grounded on the empirical data that was given by the participants in phase 1. The literature review was reflected in the rationale provided for each of the guidelines. In phase 2 of the study the structure and the content of the AGREE II (2010; 2003-2013) instrument, as well as the Delphi technique that guided the development and validation of guidelines were presented. The draft guidelines comprised the recommendations made by experts in the Delphi rounds.

#### **6.5.6 Guidelines development group**

The method used to select the members of the guideline development group was described. The descriptive information of the Delphi panel of experts who were involved in the development and validation of the guidelines reflect their qualifications, area of employment and experience as experts in the field of healthcare, human behavior, bereavement, research, policy and guideline development.

#### **6.5.7 Validation of the guidelines**

Guiding attributes in the guideline development and validation process are validity, reliability, applicability, clarity, relevance, comprehensiveness, effectiveness, flexibility, acceptability, documentation and scheduled review. The researcher validated the guidelines using Delphi rounds until the guidelines were considered valid and reliable by the panel of experts.

#### **6.5.8 Review and updating of the guidelines**

It is recommended that the guidelines in this study be reviewed and updated accordingly every three to five years after they have been implemented and tested in a nursing practice in the primary health care settings.

### **6.6 RECOMMENDATIONS**

The researcher made recommendations for: (1) the study's application to practice to ensure continued excellence in primary health care service delivery; (2) further research; (3) nursing education and training; and (4) nursing management as outlined below:

#### **6.6.1 Service delivery**

The following recommendations are made in terms of continued excellence in service delivery in the primary health care setting:

- Dedicated health care providers such as nurses, psychologists, counsellors and social workers in the primary health care services should be available for widows in need of support.
- Nurses should take more time to listen to their clients so that they can detect when health care needs are related to a loss or grieving process.
- Church pastors or ministers should be involved for the spiritual support of widows, especially during the early stages of widowhood since most widows indicated that this type of support helped them live through the challenges of widowhood. Primary health care nurses should refer widows for spiritual support of their choice.
- Nurses should be trained on how bereavement and loss may affect a person's health status and needs so that they are more sensitive to these needs.
- Nurses should also be made aware of the consequences of complicated bereavement as a health risk and a possible cause of ill-health, chronic illnesses and even a rise in mortality rates among widows.
- Nurses in the primary health care services should ensure that widows are provided with counselling, especially during the early stages of widowhood to help them cope with their loss and other psychological challenges of widowhood.
- Training should be provided to all primary health care providers with regard to the management of the widow.
  - o Nurses in primary health care services should be trained in the person-centred management approach. A person-centred management approach should be encouraged during the care and support of the widow based on the widow's support needs (Uys & Middleton 2014, pp.170-189)
  - o A person-centred management approach should include comprehensive health assessment and integrated screening of the widow to identify widows' health-support needs with regard to their physical, cognitive, emotional, spiritual and social well-being.

- Nurses in primary health care services should be trained in the “empathetic” and “therapeutic use of self” through application of effective communication skills during the care and support of widows since not all the nurses might be familiar with the approach (Uys & Middleton 2014, pp.170-189; Townsend 2015, pp.123-132).
- Primary health care nurses and mental health care nurses who are more experienced can provide support and guidance to nurses who are less experienced.
- Also advanced practitioners can provide supervision and guidance
- Continuous health education should be provided in order to conscientise widows about their potential health needs on a physical, emotional and psychological level of functioning and to empower widows on how to manage their health challenges.
  - Written information in a form of brochures should also be made available.
- Referral options and resources should be in place to enable the nurse to refer the widow to the appropriate professional person.
  - Nurses should utilise referral networks, including government and non-governmental sectors consisting of accessible and relevant services to the benefit of the widow.
  - A list of available professional resources or services with clear contact details should be easily accessible and be in writing as well.
- Peer support groups in the community and primary health care services should be encouraged and organised for widows since all widows in this study reflected that being with other widows increased their sense of belonging and seeing other widows cope instilled a sense of hope and a positive outlook in life. In addition, community ward-based primary health care outreach teams should be encouraged as this is one of the essential aspects in the Primary Health Care re-engineering (Mthembu 2016, p.45).

### **6.6.2 Research**

On the basis of the research findings, more qualitative and quantitative research with bigger populations is recommended. The studies could also observe gender differences and experiences of widowhood based on age differences and socio-economic status. The following recommendations are made in terms of future research topics:

- The views of widowers with regard to the health support provided by the primary health care services.
- The views of nurses with regard to the management of widows in the primary health care services.
- The views of widows with regard to the impact of peer support on the management of the well-being of widows.
- An assessment of the views of primary health care nurses regarding the implementation of the guidelines to support widows.
- Evaluation of the extent to which the guidelines to support widows have promoted a person-centred management approach for widows who use primary health care services.

### **6.6.3 Nursing education and training**

The following recommendations are made in terms of in-service training of nursing staff and education and training of student nurses in clinical nursing science, health assessment, treatment and care:

- Training programmes for nursing staff and nursing students should ensure that nurses receive appropriate training and guidance in health assessment, treatment and care of clients along physical, emotional, psychological, spiritual and social dimensions.
- Training programmes should be designed to promote a person-centred management approach, including comprehensive health assessment and integrated screening of the widows to identify their health-support needs with regard to their physical, cognitive, emotional, spiritual and social well-being.



- Training programmes should be designed to promote a holistic approach in the manner in which nurses work with clients during health assessment, treatment, caring and providing services to the client.
  - o Training programmes for nursing students should include a module about the empathetic and therapeutic use of self through application of effective communication skills (Uys & Middleton 2014, pp.170-189; Townsend 2015, pp.123-132).
  - o Training programmes for nursing students should include a module about the grieving process, loss, health risks related to bereavement, mortality risks related to bereavement and signs and symptoms of complicated or prolonged grief as well as the difficulties faced by families and the entire community as the result of the loss of the loved ones (Uys & Middleton 2014, pp.676-678; Townsend 2015, pp.284).
- Training programmes should be designed to produce quality nursing practitioners who are competent to identify vulnerable individuals such as widows in need of support, treat them, and refer them to relevant services in an appropriate and responsible way.

#### **6.6.4 Nursing management**

The following recommendations are made in terms of nursing management:

- Employee wellness programmes should be initiated and be given priority in every work place.
  - o An employee assistance officer should educate employers and employees about the grieving process and difficulties that employees face following the loss of the loved ones. In this sense, understanding the grieving process will help to change individuals' attitudes towards people in grief and mourning, especially widows. This change in attitude will enable the employer and fellow employees to be supportive to the grieving individuals in the workplace (Uys & Middleton 2014, pp.676-678; Townsend 2015, pp.284).

- Continuous in-service training programmes regarding work-related issues and life challenges such as grief and bereavement should be initiated and promoted in every workplace.
  - o Continuous in-service training on stress management and emotional intelligence could be introduced through role modelling of positive attitudes towards widows by those in management, including group training and mentoring of new employees by experienced employees.
- Employers need to recognise that they are valuable sources of support to their employees and should show interest in the well being of their employees.
- Nursing management should facilitate the conditions that will enable nurses to successfully implement the guidelines.
  - o Addressing critical issues such as the shortage of nurses in the primary health care setting. Guidelines could be successfully implemented when there are enough and trained nursing staff to render the services as required.
  - o Providing adequate space for consultation rooms to enable nurses to create a therapeutic environment that ensures privacy during consultations with clients such as widows.
  - o Making primary health care nurses aware of their responsibilities to provide holistic care based on responsible assessment and diagnosis.

## **6.7 IMPLICATIONS OF THE STUDY**

One clear implication of this study and the recommendations made by Delphi experts is that most of the primary health care facilities might not have resources to provide the desired therapeutic environment due to a shortage of nursing staff, and consulting rooms to provide privacy and even lack of nurses who are experienced on the therapeutic use of self. These situations might affect the service that nurses wish to render to widows. The study also has implications for continuous training of primary health care nurses. Nurses can be trained to use their therapeutic self as this forms the basis for all nursing interventions. Most activities in the guidelines can still be implemented by primary health care nurses and is part of their

responsibilities to provide holistic healthcare, for example referral does not need a special venue or much time. The findings of this study may be used to guide clinical practice and plan ongoing research in relation to the support for widows from the primary health care services in different cultural groups and geographical areas.

Considering the aspect of the primary health care re-engineering models currently being implemented and promoted in the primary health care settings (Mthembu 2016, p.45), it is increasingly important to recognise the effect the primary health care re-engineering models might have on the widows' health support given by the primary health care services.

## **6.8 LIMITATIONS OF THE STUDY**

Irrespective of the positive results obtained from this study, limitations of the study apply. The purposive sample in this study was limited to the City of Tshwane in Gauteng Province, which is one of the nine provinces in South Africa. As the result, the findings are limited to the setting involved.

The data were gathered from only 12 widows who met the selection criteria. The sample size was determined by data saturation. The sample size that has been used does not easily allow transferability of the results. Widows in this study belonged to Sepedi, Sotho and Tswana ethnic groups as these ethnic groups form a larger portion of the population in the City of Tshwane and share similar cultural beliefs, values and practices. Widows from different ethnic and cultural groups or geographic location may describe different contexts of widowhood. Therefore; the guidelines might only be transferable to settings similar to the study context. The guidelines may however be implemented, tested and adapted in other contexts.

Although the findings of this study advanced previous research on the experiences of widowhood, there are limiting factors that warrant further investigation; for example, it was clear that ethnicity, culture and religious traditions are integral to the widows' worldview and play an important role in shaping personal perspectives about widowhood. Additionally, further refinement on the plight of a widow and the person-centred management approach is required to enable the health care professionals to provide the most appropriate interventions for widows.

This study did not observe gender differences or experiences of widowhood based on age differences or socio-economic status. Therefore, widowers may have different health care needs since men and women, or even women within different age groups, may experience the

loss of the spouse differently based on the level of maturity, patterns of communication, expression of thoughts and emotions, and resources available for coping with the loss (Lee & Carr 2007, p.462; Daggett 2002, p.625). It would be interesting for future studies to continue to explore the experiences of males versus females, young widows versus elder widows regarding their health support needs. Similarly, taking into account the socio-economic status of the widows may also produce different results.

The available literature that specifically focuses on issues of widowhood and the health support by the primary health care services in South African context seems to be limited. There seem to be a need for similar studies.

The guidelines that have been developed in this study were validated by a panel of experts, however; the guidelines have not been applied and tested in any clinical setting. Therefore, it cannot be firmly concluded that the guidelines would achieve their intended purpose of promoting the support of widows by the primary health care services.

## **6.9 CONTRIBUTION TO THE BODY OF KNOWLEDGE**

The findings of this study made it clear that a holistic approach and person-centred management approach are necessary to enable the health care professionals to provide the most appropriate interventions for each widow. The study will enhance society's understanding of the health support needs of widows. Understanding the widows' health support needs may contribute to enhancing better and appropriate interventions offered by the primary health care services.

The study provided a unique picture of the experiences of widows from a phenomenological perspective. The embodied nature of experiences and the widows' recommendations for person-centred care have clear implications for primary health care nurses and contribute to the nursing body knowledge with regards to nurses' role in providing bereavement care and support for health care users experiencing loss and bereavement. It also contributes to mental health nursing in that the findings provide evidence for a client-centred approach. The guidelines provide the first attempt to guide primary health care nurses towards holistic care for bereaved individuals.

The findings of this study provide evidence that widowhood is a social issue and the need exists for adequate support from the primary health care services, to enable the widows to adjust to

the challenges that accompany widowhood. Additionally, the findings of this study made it clear that widows need to be continuously empowered with regard to their health needs in order to ease their suffering while finding their way through widowhood's challenges. Further research should advance our understanding and aid in clarifying the core meaning of widowhood and widows' health support needs.

## **6.10 CONCLUSION**

Phase 1 of this study explored the experiences of widows regarding the health support provided by the primary health care services. Unstructured, in-depth phenomenological interviews were used. Widows in this study verbalised their personal experiences. Participation was entirely voluntary and none of the 12 participants withdrew from the study. Three main findings were reported: essence of the widows' experiences supported by the constituents of the essence; widows' essential experiences of support and health support required by widows from the primary health care services.

This study provided knowledge and understanding of the widowhood experiences regarding the support given by different systems of support, including the health support given by primary health care services. The findings revealed that widowhood experiences of support are individualised, as widows verbalised both negative- and positive experiences with regard to their systems of support. Some of the findings of this study are comparable to the findings from previous research on widowhood experiences, which led the researcher to believe that the findings were likely to be applicable to a wide range of widows who make use of primary health care services.

The purpose of this study was to develop guidelines for the primary health care services to promote health support for widows in the City of Tshwane, Gauteng Province. The development of the five draft guidelines in phase 2 was grounded on the empirical data that was given by the participants in phase 1 of this study. The researcher followed specific steps to develop and validate the guidelines for the primary health care services to support widows. The researcher chose some of the domains and items of the AGREE II (2010; 2003-2013) instrument to develop the guidelines and combined them with the Delphi technique of guideline validation to establish consensus among experts on the topic to ensure reliable guidelines (5.3.2.3). The five guidelines were developed and reformulated by the researcher based on the comments and recommendations outlined by the panel of experts in each of the Delphi rounds. A descriptive

overview of the final guidelines was presented. Recommendations were formulated for service delivery, research, nursing education and training, and nursing management. Also set out were the implications and the limitations of the study.

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# ANNEXURES

**ANNEXURE A: APPROVAL FROM FACULTY OF HEALTH SCIENCES RESEARCH  
ETHICS COMMITTEE OF THE UNIVERSITY OF PRETORIA**

The Research Ethics Committee, Faculty Health Sciences, University of Pretoria complies with ICH-GCP guidelines and has US Federal wide Assurance.

- FWA 00002567, Approved dd 22 May 2002 and Expires 20 Oct 2016.
- IRB 0000 2235 IORG0001762 Approved dd 22/04/2014 and Expires 22/04/2017.



UNIVERSITEIT VAN PRETORIA  
UNIVERSITY OF PRETORIA  
YUNIBESITHI YA PRETORIA

Faculty of Health Sciences Research Ethics Committee

30/04/2015

**Approval Certificate  
New Application**

**Ethics Reference No.: 107/2015**

**Title:** DEVELOPMENT OF GUIDELINES FOR THE PRIMARY HEALTH CARE SERVICES TO SUPPORT WIDOWS IN TSHWANE, GAUTENG PROVINCE, SOUTH AFRICA

Dear Mrs Gopolang Sekgobela

The **New Application** as supported by documents specified in your cover letter dated 20/03/2015 for your research received on the 24/03/2015, was approved by the Faculty of Health Sciences Research Ethics Committee on its quorate meeting of 29/04/2015.

Please note the following about your ethics approval:

- Ethics Approval is valid for 4 years
- Please remember to use your protocol number (**107/2015**) on any documents or correspondence with the Research Ethics Committee regarding your research.
- Please note that the Research Ethics Committee may ask further questions, seek additional information, require further modification, or monitor the conduct of your research.

**Ethics approval is subject to the following:**

- The ethics approval is conditional on the receipt of 6 monthly written Progress Reports, and
- The ethics approval is conditional on the research being conducted as stipulated by the details of all documents submitted to the Committee. In the event that a further need arises to change who the investigators are, the methods or any other aspect, such changes must be submitted as an Amendment for approval by the Committee.

We wish you the best with your research.

Yours sincerely

**Dr R Sommers**; MBChB; MMed (Int); MPharMed.

**Deputy Chairperson** of the Faculty of Health Sciences Research Ethics Committee, University of Pretoria

*The Faculty of Health Sciences Research Ethics Committee complies with the SA National Act 61 of 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 and 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health).*

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✉ Private Bag X323, Arcadia, 0007 - 31 Bophelo Road, HW Snyman South Building, Level 2, Room 2.33, Gezina, Pretoria

**ANNEXURE B: (PICD 1) PARTICIPANT'S INFORMATION LEAFLET AND INFORMED  
CONSENT DOCUMENT (PHASE 1)**

**PARTICIPANT’S INFORMATION LEAFLET AND INFORMED CONSENT DOCUMENT (PHASE 1)**

**STUDY TITLE:** DEVELOPMENT OF GUIDELINES FOR PRIMARY HEALTH CARE

SERVICES TO SUPPORT WIDOWS IN TSHWANE, GAUTENG PROVINCE,  
SOUTH AFRICA.

**Principal Investigator:** Ms. Sekgobela G.L (20253967)

**Institution:** University of Pretoria

**DAYTIME AND AFTER HOURS TELEPHONE NUMBER(S)**

**Daytime numbers:** Tel no. 012 319 5668, Cell no. 078 904 7461

**After hour’s numbers:** Cell no. 078 904 7461

**DATE AND TIME OF FIRST INFORMED CONSENT DISCUSSION**

DAY	MONTH	YEAR	TIME

---

**Dear participant, Mrs..... Date of consent procedure: .....**

**1) INTRODUCTION**

You are invited to volunteer for a research study that forms part of a doctoral degree. This information leaflet is to help you to decide if you would like to participate. Before you agree to take part in this study you should fully understand what is involved. If you have any questions, which are not fully explained in this leaflet, do not hesitate to ask the investigator. You should not agree to take part unless you are completely happy about all procedures involved. In the best interests of your health, it is strongly recommended that you discuss with or inform your personal doctor/therapist of your possible participation in this study, wherever possible.

**2) THE NATURE AND PURPOSE OF THIS STUDY**

You are invited to take part in a research study. The aim of this study is to explore and describe the depth of the experiences of widows regarding the primary health care services. By doing so the investigator wishes to come to the better understanding of the health support needs of widows. The findings of this study will enable the investigator to develop guidelines for the primary health care nurses to support widows in Tshwane, Gauteng Province, South Africa.

### **3) EXPLANATION OF PROCEDURES TO BE FOLLOWED**

This study involves answering some questions with regard to your widowhood experiences regarding the support given by the primary health care services. Interviews will be conducted in English. One to one interview will be held with you at a place and time convenient to you, and will be tape recorded. The interview will last about thirty to forty five minutes or as deemed necessary.

### **4) RISK AND DISCOMFORT INVOLVED**

The only possible risk and discomfort the investigator anticipates is emotional discomfort. You will be reminded about the death of your spouse and might relive the traumatic experience. Your right to withdraw from the study at any given time will be respected by the investigator.

### **5) POSSIBLE BENEFITS OF THIS STUDY**

You will be given an opportunity to verbalise your experiences and views regarding the support that you received from the primary health care services (local clinics) following the death of your spouse in a safe environment without being judged. However, you will not receive a direct benefit as a result of participation. As a means of compensation for any fatigue, emotional distress or any inconvenience; the investigator will hold a debriefing session with you to provide counseling and emotional support as needed after the interview.

**6) I UNDERSTAND THAT IF I DO NOT WANT TO PARTICIPATE IN THIS STUDY, I WILL STILL RECEIVE EMOTIONAL SUPPORT AS NEEDED.**

**7) I MAY AT ANY TIME WITHDRAW FROM THIS STUDY**

**8) HAS THE STUDY RECEIVED ETHICAL APPROVAL?**

The Protocol was submitted to the Faculty of Health Sciences Research Ethics Committee, University of Pretoria, telephone numbers 012 354 1677/ 012 354 1330 for review, and a written approval was granted by the committee (Protocol 107/2015). The study has been structured in accordance with the Declaration of Helsinki (last update: October 2013), which deals with the recommendations guiding research involving human subjects. The copy of the Declaration may be obtained from the investigator should you wish to review it.

### **9) INFORMATION**

**If I have any questions concerning this study, I should contact:**

The investigator, Ms. GL Sekgobela, Tel no. (012) 319 5668 or cell no. 078 904 7461.

The supervisors, Prof. M.D. Peu and Dr. A.E. Van der Wath, Tel no. 012 354 2133 / 012 354 2274.

**10) CONFIDENTIALITY**

All records or other information obtained whilst in this study will be regarded as confidential. Results will be published or presented in such a way that participants remain unidentifiable.

**11) CONSENT TO PARTICIPATE IN THIS STUDY**

I have read or had read to me in a language that I understand the above information before signing this consent. The content and meaning of this information have been explained to me. I have been given opportunity to ask questions and I am satisfied that they have been answered satisfactorily. I understand that if I do not participate it will not alter my management in any way. I hereby volunteer to take part in this study.

I have received a signed copy of this informed consent agreement.

.....	.....
Participant name	Date
.....	.....
Participant signature	Date
.....	.....
Investigator's name	Date
.....	.....
Investigator's signature	Date
.....	.....
Witness name and signature	Date.....

**VERBAL PARTICIPANT INFORMED CONSENT**

I, the undersigned, Mr, Ms, Dr, Prof. ...., have read and have explained fully to the participant, named..... and her relative, the participant information leaflet, which has indicated the nature and purpose of the study in which I have asked the individual to participate. The explanation I have given has mentioned both the possible risks and benefits of the study. The participant indicated that she will be free to withdraw from the study at any given time for any reason and without jeopardising her health.

I hereby certify that the individual has agreed to participate in this study.

Participant's Name.....

(Print)

Participant's Signature.....

(or Right thumb print)

Date:.....

Investigator's Name .....

(Print)

Investigator's Signature:.....

Date:.....

Witness's Name:.....

Date:.....

Witness's signature.....



**ANNEXURE C: INTERVIEW GUIDE (PHASE 1) - PHENOMENOLOGICAL INQUIRY**

## **INTERVIEW GUIDE (PHASE 1) - PHENOMENOLOGICAL INQUIRY**

**STUDY TITLE:** DEVELOPMENT OF GUIDELINES FOR PRIMARY HEALTH CARE SERVICES TO SUPPORT WIDOWS IN TSHWANE, GAUTENG PROVINCE, SOUTH AFRICA

**Principal Investigator:** Sekgobela G.L, Student no. 20253967

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### **Grand tour question**

- Tell me about your experiences of widowhood following the death of your spouse.
  - The question requires the participant to describe series of events that she personally lived through following the death of her husband.
    - The participant needs to verbalize her perceptions of widowhood, her thoughts, attitudes emotions and understanding of her widowhood experiences. The participant could verbalize negative or positive statements regarding her widowhood experiences.
- What are your experiences regarding the support that you received from the primary health care services such as clinics following the death of your spouse?
  - The question requires the participant to describe her lived experiences regarding the assistance that she received from the primary health care services that gave her aid, encouragement and kept up her personal spirit in time of stress (following the death of her husband).
    - The participant needs to verbalise ways in which the primary healthcare services assisted her to cope, gaining control and making the pain of losing her husband bearable. The participant could verbalize negative or positive statements regarding the support and/or care that she received.

### **Examples of sub – questions or follow up questions**

- What are your health support needs?
  - The question requires the participant to describe her health support requirements which are determined by the presenting health problems or concerns.
    - The participant needs to verbalise her awareness of change in her health status and the effects it has on her life following the death of her husband.

- Whom do you rely on for support?
  - The question requires the participant to describe whom does she depend on in times of stress or whom she trusts confidently to discuss her concerns and who is available when she usually seek assistance in time of need to help with health concerns.
    - The participant needs to verbalise her awareness of the resources available in her life (family, friends, etc.) and within the community from which she can receive assistance and support. This would indicate if the participant has information regarding the resources available e.g. support groups from which she can participate or seek assistance in dealing with health and/or psychosocial issues she might be experiencing.
  
- How do you feel regarding the support that you received from the primary health care services?
  - The question requires the participant to express personal feelings regarding the assistance or care that is available, which she received from the primary health care services addressing her health needs.
    - The participant needs to express her personal satisfaction or dissatisfaction regarding the support that she received from the primary health care services. She needs to describe if the care and/or support received from the primary health care services addressed her health needs and made her feel better as a widow or not.
  
- How do you think the primary health care services could support widows to meet their health support needs?
  - The question requires the participant to describe her expectations regarding the support that primary health care services could render to widows in order to address their health needs.
    - The participant needs to verbalise her recommendations and/or ways in which she thinks the primary health care services could improve or enhance the level of care and/or assistance rendered to widows. The participant needs to verbalise how hopeful she is about obtaining a better degree of health care from the primary health care services.
  
- How would you have liked the primary health care services to support you following the death of your spouse?
  - The question requires the participant to describe the strengths and/or weaknesses of the support rendered by the primary health care services following the death of her husband.

○ The participant needs to verbalise her likes (preferences) and dislikes of the care and/or support rendered by the primary health care services.

- **Communication skills such as paraphrasing, clarification, probing, exploration and reflecting will be used as needed to facilitate the interview process.**

Principal Investigator's Signature: ----- Date -----

**ANNEXURE D: EXAMPLE OF A TRANSCRIBED UNSTRUCTURED  
PHENOMENOLOGICAL INTERVIEW (PHASE 1)**

## EXAMPLE OF A TRANSCRIBED UNSTRUCTURED PHENOMENOLOGICAL INTERVIEW (PHASE 1)

**STUDY TITLE: DEVELOPMENT OF GUIDELINES FOR PRIMARY HEALTH CARE SERVICES TO SUPPORT WIDOWS IN TSHWANE, GAUTENG PROVINCE, SOUTH AFRICA.**

**Date of the interview: 18 July 2016**

### INTERVIEW PROCESS:

**Researcher:** Good afternoon Mam!

**Participant:** Good afternoon sister!

**Researcher:** Mam, as I have introduced myself to you during our last meeting, my name is Gopolang Sekgobela; I am a doctoral student at The University of Pretoria. One of the requirements of my studies is that I conduct a research. Today I am here with you to conduct research.

**Participant:** Mmm

**Researcher:** Mam be rest assured that this research has been approved by the University as I have already shown you the approval certificate and the process have been explained to you during our first meeting.

**Participant:** Ok sister,

**Researcher:** So today I would like to welcome you to this interview and to thank you for agreeing to participate in this research interview and for honouring the appointment. As I have already explained to you regarding the interview, I will be asking you few questions and I would like you to relax, take your time when answering the questions and feel free to ask for clarification where you do not understand.

**Participant:** Ok Mam,

**Researcher:** Mam please be rest assured that there is no wrong answer to the questions asked and feel free to say your experiences as detailed as possible. As I have already explained to you that our conversation will be audio taped, so that we capture all the information and again I would like to thank you for allowing me to record this interview.

**Participant:** Is fine Mam.

**Researcher:** Mam kindly take note that the recorded interview will be transcribed, meaning it will be written down by myself and your name will remain anonymous from others and the records of this

interview will not be linked to your name. The documents of this interview will be only used for the purpose of the research.

**Participant:** Ok Mam.

**Researcher:** Mam again take note that during this interview I will be writing some notes on my note book...don't worry about that...just continue talking. I will be writing key points just to remind me of what we have spoken about. You just continue and don't worry about it. Is that ok Mam?

**Participant:** Yes sister.

**Researcher:** Ok, Mam; is there anything else you would like to ask before we start with the interview?

**Participant:** No.

**Researcher:** Ok Mam in that case can we start with the interview when you are ready?

**Participant:** Yes you can start sister.

**Q1. Researcher:** In that case Mam may you kindly **tell me about your experiences of widowhood. I mean your experiences as a widow.**

**Participant:** Ehhh...the death of my husband was quite a shock to me. When I got back home my husband was not there...it was just two days after his birthday. I still remember that day very well ....he left for work in the morning...he looked ok...little was I know...little did I know was that I was not going to see him again...How I survived till this day is unbelievable!

**Researcher:** Mmm, Mam I hear you say "how you survived till this day is unbelievable" can you tell me what you mean by that?

**Participant:** ...months after my husband's death, I stayed home as expected...I could not stand to see anyone. I only wanted to be left alone.... I did not see the need to listen to people telling me things would be ok....because I know that things could never be the same...not without Peter...I just stayed in my bedroom most of the time, not wanting to see anyone, doing no cooking, no cleaning and no eating...I was so caught up in my pain. I just wanted to be alone and understand what I was feeling. I was hurt...very hurt.

**Researcher:** I can see from your facial expression that you were hurting a lot, is there anything else you would like to say about your widowhood experiences?

**Participant:** No sister.

**Researcher:** Mam if I can just take you back to what you said earlier; I heard you say that you were caught up to your pain, can you tell me how was it like for you being caught up in your pain?

**Participant:** ...nothing else mattered! Accepting my husband's death was hard for me...life meant nothing. I felt so empty...I often cried for hours and stayed in my bedroom for days. I just wanted to be left alone with my pain...thinking that maybe I would understand what was really going on...I needed to make sense of what was going on... my children are so young to be losing their father. What will we be without their father? How are we going to cope with life? ... I worried a lot about my children...what kind of a future they will have without their father. Will I cope raising them alone? Everything was just too much for me. I don't sleep at night thinking of them!

**Researcher:** It sounds as if you worry a lot about the future of your children. Mam is there anything else you would like to say about that?

**Participant:** I need to be there for them...who will take care of them if something bad had happened to me. I am not sure anymore because what happened was unexpectedly these days. I can't let anything separate me from my children.

**Researcher:** You can't let anything separate you from your children; is there anything else you still need to say regarding that?

**Participant:** No sister

**Researcher:** Is fine Mam...Mam, if I can take you back; earlier on you said that following your husband's death you stayed in your room most of the time and you cried most of the time; can you tell me more about it.

**Participant:** No sister you know really is too painful to talk about it.

**Researcher:** ...is too painful to talk about it, is ok Mam; you don't have to say anything that you are not comfortable with, in that case Mam is there anything else you would like to add regarding your experiences as a widow?

**Participant:** No sister.

**Q2. Researcher:** Ok Mam, in that case can you tell me what are your experiences regarding the support that you received from the primary health care services such as clinics following the death of your husband?



**Participant:** Mmmh,..My mother and my sister insisted that I get help from the clinic...I did not want to go to the clinic...so I called my friend from church...she is a nurse. She came to see me at home...I was not in the mood to see people...let alone going to the clinic.

**Researcher:** mmmh...can you tell me more about that?

**Participant:** Hhhh...She spoke to me but still insisted that I went to the doctor or to the clinic for the purpose...for the proper treatment...to get medication...All she kept saying was that I should go to the clinic. I wondered how the clinic would help me. I went to the clinic...After talking to the sister about my troubles she said I was depressed...and she told me that I should take it easy...to move on and to focus on myself...take care of myself so that I can be there for my children...At that time I realised that I needed to accept my situation...to get better...The sister gave me medication...and I was taken to the clinic...and I was taken to the clinical psychologist who spoke to me for hours.

**Researcher:** mmmh...is there anything else you would like to say regarding that?

**Participant: (throat clearing)**...The sister told me that it would be ok, as long as I take my medicine and come to the clinic every month for medication. They all listened to me...the sister and the psychologist...they were understanding.... and what they said to me made sense...it was as if they were reading my mind...what I was thinking.

**Researcher:** It was as if they were reading your mind, I wonder how that made you feel?

**Participant: (laughing)**...it made me feel better...they really gave me hope that I will be better with time. It was quite a relive because I thought I was going mad **(laughing)**...and I will never going...I was never going to feel better but I was wrong. I felt much better, the medication made me feel better and talking about my problems made me feel better. They helped me a lot...listening to...to me helped me a lot

**Researcher:** Mam, I hear you say the medication and talking about it made you feel better; is there anything else you would like to say regarding the support that you received from the clinic?

**Participants:** No sister!

**Q3. Researcher: Ok Mam, how about you tell me about your health support needs?**

**Participant:** I need to feel better again, to be hopeful and spent each day without feeling hopeless and be prepared for the day...I don't need to deny my pain and I need to know that whatever the problem I am facing will not last forever but will come to pass. I need to accept what happened to my husband and move on with my life.

**Researcher:** It seems as if you need to be reassured that things will be ok with you, can you explain more about it?

**Participant:** I need to be there for my children...to be strong for them. They need me. I must take care of them. They mean a lot to me.

**Researcher:** Your children mean a lot to you; is there anything else you would like to say regarding your health support needs?

**Participant:** No

**Researcher:** Mam...If I can take you back; earlier on you said that talking to the sisters and the psychologist made you feel better, can you tell me what did that mean to you?

**Participant:** Ehhh...They gave me attention I needed and I have learnt a lot from them. They brought my smile back and motivated me...I lacked energy and I was always avoiding people. I thought I could deal with my problems all by myself but I was wrong. I needed proper ehh...treatment for my problems...the right medication and correct advices. They motivated me and gave me hope.

**Researcher:** ...they brought your smile back; I can see from your face right now that you are happy that they gave you the help that you needed. Is there anything else you would like to say about it?

**Participant:** No sister.

**Researcher:** Mam you mentioned that the sisters at the clinic listened to you...they were all understanding; and gave you hope; is there anything else you would like to add?

**Participant:** No that's not correct sister.

**Researcher:** Mam...you mentioned to me that the sisters at the clinic listened to you...they were all understanding; and gave you hope...

**Participant:** No that's correct sister.

**Researcher:**...I thought you said that's not correct sister!

**Participant:** (laughing)....

**Researcher:** **No is fine**, can we continue with the interview?

**Participant:** Yes we can.

**Q4. Researcher: Mam, with all the challenges that you went through as a widow, can you tell me who do you rely on for support? Who supports you?**

**Participant:** My friends and family support me. They are good to me...They...they are there when I need them. Things are tough for me at times and they are always there to listen to me. They keep me busy so that I keep my mind...I keep my mind occupied and not think about my problems. They always invite me to spend time with them...talking and laughing about things. That really helps...I learnt to talk and laugh about things irrespective of my situation...because I cannot change what happened to my husband. Laughing about them makes it easy for me to accept my situation and be comfortable talking about them.

**Researcher:** Mmm...I wonder how that feels for you.

**Participant:** I feel happy (**laughing**) because it made me realize that my misery is optional...I choose to be happy most of the time. I socialize with positive people...people who motivate me...that keep me going. My friends and family do that for me. They always bring me motivational books and that empowers me a lot. I handle my situations much better now and it makes me happy.

**Q5. Researcher: ...being motivated makes you happy, Mam can you tell me how you feel regarding the support that you received from the primary health care services such as clinics?**

**Participant:** Mmmh...I am happy with the support. During the time when I was frustrated and I started thinking about suicide; I became a burden to myself and I did not know how to handle it...I was for no help to myself but they helped me at the clinics. The sisters helped me; they were all giving themselves time for me. They listened...they listened to me and their advice helped me...they motivated me a lot. I am grateful for their support. Today I motivate other widows in the community.

**Researcher:** Today you motivate other widows in the community; can you tell me what that means to you?

**Participant:** It means that I choose to turn my life around and use my negative situation to do something positive for others. My own pain is helping others today...I am hurt about my husband's death but at least something positive came out of it. Today I am a better person than I was three years ago...I know how to pray...how to love and be there for others and that is enough for me. I am happy about it.

**Researcher:** ...your facial expression says it all. Mam is there anything else you would like to say regarding the support that you received from the clinic?

**Participant:** Mmmm...Yes Mam. I am happy that I am using my negative situation to do something positive by helping others...that makes me happy.

**Q6. Researcher:** Mam I heard you say that you are happy with the support that you received from the clinic. However; **Mam, can you tell me on an ideal situation; can you tell me how would you have liked the primary health care services to support you or to support widows in general following the death of the husband?**

**Participant:** I would have liked the nurses to do home visits to clients including widows.

**Researcher:** Mam...how about you explain more about that?

**Participant: (throat clearing)**...The death of my husband was painful for me...I did not like...I did not feel like going out...I just wanted to stay in bed...I sometimes wished I could talk to someone...a professional...someone who can tell me things will be ok...but I did not have the energy to go to the clinic. Home visits by a nurse could have helped me a lot.

**Researcher:** ...you say home visits by a nurse could have helped you a lot; can you explain more about it?

**Participant:** Talking to my friend who is a nurse helped me a lot...I called her to visit me at home...as a friend and that helped me a lot...

**Researcher:** Can you tell me how was it is like for you feeling helped?

**Participant:** I was not ready to face the world...I did not want to see a lot of people...and I was comfortable being at home...but I still needed someone to be there for me...to allow me to say what I was feeling...But the sisters don't do home visits to listen to clients anymore...they used to visit patients who cannot come to the clinic but this days...not anymore.

**Researcher:** ...this days not anymore; it sounds as if you would like the nurses to start visiting clients or widows at their homes following the death of the husband, how about you tell me more about it?

**Participant:** ...getting visits from the nurses would help me a lot...especially during the first weeks...when one does not know where to start...when one is still in shock...Like...like I already said that it was hard for me...I often cried for my husband and wanted to understand what was wrong with me...but could not get myself to go out to look for help.

**Researcher:** I hear you say that you often...you often cried, can you tell me more about it?

**Participant:** ...like I already said that it was hard for me... I often cried for hours and wanted to understand what was wrong with me...but could not get myself to go out to look for help.

**Researcher:** ...but could not get yourself to go out to look for help, Mam I wonder how that felt for you?

**Participant:** I felt helpless but my family was there for me and that gave me hope that I was not alone. Having them around helped me a lot.

**Researcher:** Mam, I hear you say having your family helps you a lot; is there anything else you would like to talk about regarding the support that you would like to receive from the primary health care services such as clinics?

**Participant:** No

**Researcher:** Ok is fine Mam, it sounded as if you think that getting home visits from the clinic would have made a difference for you following the death of the husband. Mam, is there anything else you would like say regarding that or regarding your experiences as a widow?

**Participant:** No Mam.

**Researcher:** Ok, Mam in that case can I remind you of what we spoke about.

**Participant:** Mmmh...

**Researcher:** You said that your husband's death was hard for you and you often cried for hours, you wanted to understand what was going on. It sounded as if you were worried about your children and that affected your sleep and did not eat well. The sister at the clinic said you were depressed and gave you medication and advised you to take it easy. Is that correct Mam?

**Participant:** Mmmh...Yes sister.

**Researcher:** You also verbalized that you I learnt to talk and laugh about things irrespective of your circumstances and indicated that your family support you. However, you were still caught up in your pain. You needed to feel better again, to be hopeful and you felt that home visits from the clinic would have made a difference and your situation made you want to be there for others, motivate and supports other widows. Is there anything else you would like to add?

**Participant:** No

**Researcher:** Ok Mam, how about you take a moment and think about it...think about anything that you still need to say.

**Participant:** Mmm...No is fine! **(Laughing)**

**Researcher:** Ok in that case Mam... I would really like to thank you for agreeing to participate in this study and for sharing your experiences and for your time. Mam as I have already said; kindly be rest

assured that your name will not be linked to any of your experiences and feel free to ask any question regarding the interview or indicate if you need counselling or any support after this interview. I am just a phone call away or I can even refer you to the service of your choice if needed. Is that fine with you Mam?

**Participant:** Mmmh... I am ok sister and I don't...I don't have questions anymore.

**Researcher:** Ok Mam, if there is no any question and there is nothing else you would like to add or to clarify regarding what we have just spoken about ; may I take this opportunity to thank you for your time. Thank you Mam!

**Participant:** Thank you!

**THE END**

**ANNEXURE E: EXPERT PARTICIPANT'S INFORMATION LEAFLET AND INFORMED  
CONSENT DOCUMENT (PHASE 2)**

**EXPERT PARTICIPANT'S INFORMATION LEAFLET AND INFORMED CONSENT DOCUMENT  
(PHASE 2)**

**STUDY TITLE:** DEVELOPMENT OF GUIDELINES FOR PRIMARY HEALTH CARE SERVICES TO SUPPORT WIDOWS IN TSHWANE, GAUTENG PROVINCE, SOUTH AFRICA.

**SPONSOR:** NONE

**Principal Investigator:** Ms. Sekgobela G.L (20253967)

**Institution:** University of Pretoria

**DAYTIME AND AFTER HOURS TELEPHONE NUMBER(S)**

**Daytime numbers:** Tel no. 012 319 5668, Cell no. 078 904 7461

**After hour's numbers:** Cell no. 078 904 7461

**DATE AND TIME OF INFORMED CONSENT**

DAY	MONTH	YEAR	TIME

-----  
**Dear Expert participant,**

**1) INTRODUCTION**

For the fulfillment of my doctoral degree at Pretoria University, I am expected to conduct a research. As part of my research, I am expected to develop guidelines for the primary health care services to promote health support for widows. As an expert; you are invited to participate in phase 2 of this study: Development and validation of guidelines for the primary health care services to promote health support for widows. The development of the preliminary guidelines by the researcher was based on the empirical data collected in phase 1 and was supported with sufficient literature sources.

**2) WHO IS AN EXPERT?**

An expert is any individual who is qualified and who has tremendous knowledge and understanding in areas of human behavior, bereavement, policy and guideline development such as academic researchers, mental health nurses, psychiatrist, psychologists, social workers and church ministers.

**3) EXPLANATION OF PROCEDURES TO BE FOLLOWED**

The development and validation of guidelines will be done using the Delphi technique to ensure guidelines of high quality. The most important aspect of Delphi technique is choosing appropriate group of experts who will address the issues more appropriately. It is expected that not more than three rounds of



the Delphi will be sufficient to obtain consensus on the content of the guidelines. The researcher is the facilitator of the Delphi rounds while expert participants remain anonymous to each other.

#### **4) WHAT WILL BE EXPECTED OF YOU?**

As a participant, you will be provided with the drafted preliminary guidelines by the researcher. You will be expected to read through the guideline then rate the guideline and write comments. Your ratings and comments will be compared with the work done by fellow experts. The controlled feedback session will be given to each participant by the researcher. This feedback will consist of a well organized summary of prior iterations which will be distributed to the panelists. This will give each participant an opportunity to generate additional insights and one can change her decisions in later iterations. The Delphi process will take at least two rounds; you will be expected to respond within a period of 1-2 weeks in each round. **You are expected to scan the last signed page of the consent and return it to the researcher by email with the rated guidelines.**

#### **5) POSSIBLE BENEFITS THAT MAY COME FROM YOUR PARTICIPATION**

You will contribute to the development of effective interventions and guidelines for the primary health care services to promote health support for widows. However; there will not be any monetary benefits but you will gain more knowledge and insight into guideline development as you will learn from other experts and this could promote your personal and professional growth.

#### **6) HAS THE STUDY RECEIVED ETHICAL APPROVAL?**

The Protocol was submitted to the Faculty of Health Sciences Research Ethics Committee, University of Pretoria, telephone numbers 012 354 1677/ 012 354 1330 for review, and a written approval has been granted by the committee (Protocol 107/2015). The study has been structured in accordance with the Declaration of Helsinki (last update: October 2013), which deals with the recommendations guiding research involving human subjects. The copy of the Declaration may be obtained from the investigator should you wish to review it.

#### **7) WHO CAN YOU CONTACT FOR ADDITIONAL INFORMATION REGARDING THE STUDY?**

The researcher, Mrs. GL Sekgobela can be contacted during office hours at Tel (012) 319 5668 or cell no. 078 904 7461. The supervisors, Prof. M.D. Peu and Dr. A.E. Van der Wath can be contacted during office hours at 012 354 2133 / 012 354 2274

**Kindly note that your participation will be highly appreciated!**

**EXPERT PARTICIPANT INFORMED CONSENT**

I, the undersigned, Prof., Dr., Mr., Mrs.....have read the expert participant information leaflet, which has indicated the nature and purpose of the study, my responsibilities as an expert participant and the benefits of participating in the validation of the guidelines for the primary health care services to support widows in Tshwane, Gauteng Province, South Africa. I hereby certify that I agreed to participate in the Delphi process as needed.

Participant's Name:.....

(Print)

Participant's Signature:.....

Date:.....

Investigator's Name: .....

(Print)

Investigator's Signature:.....

Date:.....

Witness's Name:.....

Witness's signature.....

Date:.....

**ANNEXURE F: LETTER OF INVITATION TO EXPERT MEMBER OF THE DELPHI PANEL  
(ROUND 1)**

## **LETTER OF INVITATION TO EXPERT MEMBER OF THE DELPHI PANEL (ROUND 1)**

Dear Expert participant,

### **INVITATION TO PARTICIPATE IN THE VALIDATION OF GUIDELINES FOR THE PRIMARY HEALTH CARE SERVICES TO SUPPORT WIDOWS IN TSHWANE, GAUTENG PROVINCE, SOUTH AFRICA**

I am a PhD student in the Department of Nursing Science, Faculty of Health Sciences at the University of Pretoria. I am conducting a study on “**DEVELOPMENT OF GUIDELINES FOR THE PRIMARY HEALTH CARE SERVICES TO SUPPORT WIDOWS IN TSHWANE, GAUTENG PROVINCE, SOUTH AFRICA**” under the supervision of Professor. Mmapheko Doriccah Peu and Dr. Anna Elizabeth Van der Wath.

The specific objectives that formed the basis of this study were the following according to the two study phases:

#### **Phase 1**

- To explore and describe widow’s experiences of widowhood in Gauteng Province in the City of Tshwane.
- To explore and describe the experiences of widows regarding the health support by the primary health care services in Gauteng Province in the City of Tshwane.
- To explore and describe the health support needs of widows that can be addressed by the primary health care services in Gauteng Province in the City of Tshwane.

#### **Phase 2**

- To develop guidelines for the primary health care services to promote health support for widows in Gauteng Province in the City of Tshwane.

In phase 1 of the study a descriptive phenomenological approach was used to explore and describe the experiences of widows with regards to the health support by the primary health care services in the City of Tshwane. Data were collected through in-depth interviews with widows residing within the City of Tshwane Metropolitan Municipality. The findings revealed the essence of widow’s experiences, widow’s experiences of support and the health support required by widows from the primary health care services.

The essence of the widows’ experience is that widowhood is an intense emotional experience that affects women on a physical, cognitive, emotional, existential and social level. Women described embodied experiences, intense emotions, cognitive and social disruptions as part of their experiences. Widows

received their support from different sources, namely: family members, friends, colleagues, peer group members, employers, spiritual counsellors and health care providers. The experience of support from others was significant for all the participants and was considered to play a valuable role in the emotional, spiritual and physical functioning of all the widows.

In phase 2 of the study the researcher developed draft guidelines for the primary health care services to support widows in Tshwane, Gauteng province, South Africa. The preliminary guidelines were drafted and formulated based on the empirical data (Phase I) and an extensive literature synthesis. Appropriate statements were selected from the empirical data to formulate the preliminary guidelines. In addition, the researcher took into account what the widows want and value. As the result, recommendations by widows were integrated into clinical decisions. The aim of the guidelines is to assist the primary health care services particularly community nurses to promote health support for widows in the City of Tshwane.

You are invited to participate in the validation of the guidelines. The Delphi technique has been chosen as the preferred method for the validation process. A minimum of 10 national and international experts, in government and nongovernmental organizations in the field of human behavior, bereavement, research, policy and guideline development are expected to participate in the process. It is expected that not more than three rounds of the Delphi will be sufficient to obtain consensus on the content of the guidelines.

There are five preliminary guidelines for the primary health care services to support widows.

- You will be expected to read through the guideline then rate the guideline in accordance with the given criteria and write comments on the space provided at the end of each section. Your ratings and comments will be compared with the work done by fellow experts.
- You are expected to scan the last signed page of the consent and return it to the researcher per e-mail with the rated guidelines.

Please complete the biographical information in the first section of the instrument by providing descriptive information on your professional and academic experience. This will enable the researcher to describe the sample. No names or identities will be mentioned in the research report or publications. The validation process should take approximately 1 hour to complete. The Delphi process will take at least two rounds; you will be expected to respond within a period of 1-2 weeks in each round. Your participation and comments will be highly appreciated. Comments received in round one will be collated and analysed for further validation in round two. Attached is a consent form that should be returned with the guidelines should you agree to participate in the study. For any clarification that may be required please contact me or my supervisors on the following:

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**ANNEXURE G: EXAMPLE OF THE INSTRUMENT OF BIOGRAPHICAL INFORMATION  
REQUIRED FROM DELPHI EXPERTS (ROUND 1)**

**EXAMPLE OF THE INSTRUMENT OF BIOGRAPHICAL INFORMATION REQUIRED FROM DELPHI EXPERTS (ROUND 1)**

Dear Delphi Expert,

Please complete the biographical information by providing descriptive information on your professional and academic experience. This will enable the researcher to describe the Delphi sample.

NO.	PROFESSIONAL QUALIFICATIONS	OCCUPATION	EMPLOYER	EXPERIENCE IN THE FIELD OF HEALTH CARE/ HUMAN BEHAVIOUR /SOCIAL SUPPORT/ BEREAVEMENT, RESEARCH/ POLICY AND GUIDELINE DEVELOPMENT
1.				
2.				



**ANNEXURE H: COPY OF THE INITIAL FIVE PRELIMINARY GUIDELINES BY THE RESEARCHER**

**COPY OF THE INITIAL FIVE PRELIMINARY GUIDELINES BY THE RESEARCHER**

**ANNEXURE I: EXAMPLE OF THE DELPHI INSTRUMENT - RATING SCALE OF THE  
GUIDELINES - GUIDELINE 1 (ROUND 1)**

**EXAMPLE OF THE RATING SCALE OF GUIDELINES SEND TO DELPHI EXPERTS -  
GUIDELINE 1 (ROUND 1)**

**ANNEXURE J: EXAMPLE OF THE INSTRUMENT FROM DELPHI RESPONSE –  
GUIDELINE 1 (ROUND 1)**

**EXAMPLE OF THE INSTRUMENT FROM DELPHI RESPONSE – GUIDELINE 1 (ROUND 1)**

**ANNEXURE K: EXAMPLE OF THE FINAL GUIDELINES INCORPORATING INPUTS AND RECOMMENDATIONS BY THE DELPHI PANEL OF EXPERTS - GUIDELINE 1**

**EXAMPLE OF THE FINAL GUIDELINES INCORPORATING INPUTS AND  
RECOMMENDATIONS BY THE DELPHI PANEL OF EXPERTS**