

**THE VIEWS OF FEMALE RAPE SURVIVORS REGARDING THE  
MANAGEMENT RECEIVED AT AN EMERGENCY UNIT IN THE  
NORTH WEST PROVINCE**

by

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## Declaration

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I, **Koonyatse Maureen Mosang**, declare that **THE VIEWS OF FEMALE RAPE SURVIVORS REGARDING THE MANAGEMENT RECEIVED IN AN EMERGENCY UNIT IN THE NORTH WEST PROVINCE** is my own work and that all sources that have been used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted for any other degree at any other institution.

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**Koonyatse Maureen Mosang**

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**Date**

## Dedication

This study is dedicated to my late mother, **Phemelo Motlhabane** who passed away while I was a teenager and before she could enjoy the fruits of her labour.

Thank you very much mom for ensuring that I get the education you could afford with your hard work.

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**Abstract**

Sexual assault is a global public health and human rights challenge which cuts across all social classes. According to a literature review based on 50 studies from around the world, between 10% and 50% of women have experienced some act of physical violence while one in every four women experience sexual violence by an intimate partner at some point in their lives. In an emergency unit in the North West, South Africa there are policies, guidelines and procedures in place with regard to the management of the rape survivors after the incident which focus on a medical orientated approach. The views of female rape survivors on their management are neglected; therefore management is not patient-centred. The main objective of the study was to explore and describe the views of the female rape survivors regarding the management they received in emergency unit to enable the health care professionals to move towards a more patient-centred approach in the management these patients.

Appreciative Inquiry was used a research methodology. A qualitative design using purposive sampling was used to select the participants. Unstructured interviews were conducted with 10 female rape survivors and Tesch steps were used to analyse the data.

Three main themes were identified, namely 1) therapeutic environment, 2) optimal healthcare received and 3) excellence in service delivery. With regard to the disease orientated management received the female rape survivors found it to be good. The participants voiced that it is important that female rape survivors should have an opportunity to attend group therapy following the rape incident so that they are able to support each other.

**Key words:** Female rape survivor, health care professionals, emergency unit, patient centred approach.

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## List of abbreviations

AI	Appreciative Inquiry
AIDS	Acquired Immune Deficiency Syndrome
ANCCMH	American Nurses Credential centre Magnet Hospital
CHOP	Children's Hospital of Philadelphia
DoH	Department of Health
HIV	Human Immunodeficiency Virus
NGO	Non Governmental organisation
POWA	People Opposing Women Abuse
UK	United Kingdom
VAW	Violence Against Women
SANE	Sexual Assault Nurse Examiner
SOAR	Strengths, Opportunities, Aspirations and Threats
SWOT	Strengths, Weaknesses, Opportunities and Threats

For the purpose of **anonymity**, the hospital in which the study was conducted will be referred to as **the hospital**, in both text and referencing.

# 1 ORIENTATION TO THE STUDY

## 1.1 INTRODUCTION

Rape is an act of sexual violence that shatters the victim's life. Rape survivors suffer incalculable pain and loss; the physical and mental health effects of such violence can last years beyond the initial abuse. The overwhelming majority of those directly experiencing sexual violence, including rape, are women (Smith et al. 2013: 2; World Health Organization [WHO] 2010: 1). Rape occurs in every culture and at every level of society without exception (WHO 2010: 1). Greeson and Campbell (2012: 83) confirm that "*in a recent study conducted in the United States, it was concluded that 1.3 million adult women are raped annually*". According to a literature review based on 50 studies from around the world, between 10% and 50% of women have experienced some act of physical violence while one in every four women experience sexual violence by an intimate partner at some point in their lives (Smith et al. 2013: 2; WHO 2003: 5).

The Federal Bureau of Justice estimates that 72 out of every 100 000 females were raped in 2009 in South Africa (Rape Statistics – South Africa and Worldwide 2010: [1]). Statistics about rape vary because of a diversity of factors such as how rape is defined in a specific country, how the data is collected, where the data comes from, and the methods that are used to report this crime. However, rape is one of the most underreported of all crimes (Gokdogan & Bafra 2009: 285; Jina et al. 2010: 86) because only a small proportion of cases are reported. For example, a Latin American study estimated that only around 5% of adult victims of sexual violence reported the incident to the police (WHO 2012: 1).

In South Africa the Department of Health's (DoH's) National Management Guidelines for Sexual Assault (DoH 2005: 5) provides guidelines for healthcare professionals on how to respond to the health needs of female rape survivors. These guidelines provide instructions and information related to the care of physical injuries

(immediate as well as long-term), psychological support and counselling, social support, pregnancy prevention, and preventative strategies pertaining to possible infection with the human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS).

In an emergency unit of a public level II hospital in North West, one of the nine provinces in South Africa, the management of female rape survivors primarily focuses on medical interventions. The interventions include the immediate management of physical injuries, collection of forensic evidence, counselling regarding the possibility to contract HIV following the incident, pregnancy prevention, and strategies to prevent HIV/AIDS. The predominant management strategy used is a disease-orientated approach with very little attention given to the other specific needs of the female rape survivor as prescribed by the DoH (2005: 5). In a study conducted by Garbett and McCormack (2004: 17) in the United Kingdom (UK), it was found that the management of patients in general mainly focused on a disease-orientated rather than a patient-centred approach.

Crucial in the management of female rape survivors is to re-focus care towards a patient-centred approach so that the female rape survivors can cope with what has happened to them, come to terms with it, and then focus on their future (Frampton et al. 2008: 4; Luxford 2010: 14). One of the rape survivors with whom the researcher had an informal conversation before this study was conducted shared that in her view what the female rape survivors really needed in order for them to cope with what has happened, was their own therapy group. Healthcare professionals should allow rape survivors to form their own therapy group in which they can counsel each other *but* with the assistance of nurses and medical doctors. This rape survivor's opinion is indicative of the necessity for practice to be evaluated and tailored to incorporate the specific needs of female rape survivors to move towards a patient-centred management approach.

The evaluation of practice remains locked into "*problems*" within practice, focusing on "*what is not working*" or "*what is wrong*" (Cram 2010: 1). Using such problem-solving, deficit-based approaches have a negative effect on the people involved in

organisations that deliver services (McKenzy 2003: 37). In contrast, Appreciative Inquiry (AI) can be used effectively as a practice evaluation approach for organisational improvement; AI focuses on achievements and collective power adding value to organisations and not problems (Cooperrider, Whitney & Stavros 2003: 5; Whitney & Trosten-Bloom 2010: 268).

In this study, AI was used as an approach to evaluate practice relating to the management of the female rape survivors. Through AI dialogue current practice relating to the management of female rape survivors was appraised and female rape survivors were provided an opportunity to voice their views on the challenges they experienced during their management in an emergency unit in North West, a province in South Africa.

## 1.2 BACKGROUND AND RATIONALE

Sexual assault is a global public health and human rights challenge which cuts across all social classes. Lutwak (2012: 209) ascertains it is a fact that “*violence against women is a worldwide problem*”. Rape is a universal phenomenon that persists in all countries of the world, and whether the incidence of rape in any country is documented as high or low, it is a major contributor to the ill health of women. The prevalence shows that between 6% and 59% of women have experienced sexual assault in their life (Smith et al. 2013: 2). The consequences of rape is devastating and includes physical injury, unwanted pregnancy, sexually transmitted infections (STIs), becoming infected with HIV, depression, and other psychological problems (Reyes et al. 2012: 83).

A United Nations (UN) survey conducted globally showed that out of all the countries in the world, South Africa has the highest sexual assault rate with women between 17 and 48 affected the most (Anguita 2012: 491; Arend et al. 2013: 155). Anguita (2012: 489) adds that gender-based violence is a widespread problem in South Africa. According to this author, rape is a “*hate crime*” whereby a woman is raped because of her sexual orientation and/or gender identity; a woman is made to suffer simply because of her gender. In a study done by Tonnessen (2012: 4) in the



Sudan, for example, it was revealed that the Sudanese authorities had stopped female support programmes and closed down health service facilities in locations in Darfur that were run by one of the non-governmental organisations (NGOs). These actions had been carried out due to the NGO's report that approximately 500 rape survivors had been treated over a four-month period; the government also accused the NGO of having given a false report and subsequently it was closed down and two staff members were arrested.

The management of rape survivors in South Africa is done in the public sector at primary healthcare level and after-rape care here should be provided by trained nurses and medical doctors (Jina et al. 2013: 3). But, as Suffla, Sedat and Nascimento (2002: 1) note, the management of rape survivors in hospitals in the country leaves a lot to be desired and can be described as "*tragically inadequate*". In some healthcare services not even the minimum standards for the management of female rape survivors are being met. This statement is validated by Kim et al. (2007: 1) who reported in their study findings that the unmet needs of rape survivors are receiving increased attention. While these authors are of the opinion that emerging best practice guidelines suggest that existing health interventions may play a critical role in meeting some of these needs, the actual implementation and coordination of these services present a significant challenge.

There are challenges that discourage or prevent rape survivors from accessing appropriate after-rape care. These challenges include, amongst others, the "*incompetent documentation of medico-legal evidence, lack of resources, insufficient and inadequate training of the health care providers who handle these cases, disparities across clinics, and weak intersectoral collaboration between the government and the private sector*" (Suffla 2004: 41). Although Kim et al. (2007: 1) confirm that these factors influence the quality of care that is available to the survivors of rape these authors also recognise that the unmet needs of rape survivors are receiving increasing attention in South Africa. According to Roland et al. (2011: 991), South African healthcare providers lack the training to provide quality care for rape survivors in that the providers' attitude may be negative while the delivery of care is also uncoordinated. Furthermore, these authors found that of the

124 nurses and medical doctors involved in the management of female rape survivors a third did not view rape as a serious medical condition and less than a third had ever been trained in caring for rape survivors.

At the time this study was done female rape survivors at a public level II hospital in North West were managed in the emergency unit. In the emergency unit here was only one nurse who had been trained as a sexual nurse examiner and three medical doctors trained to care for rape survivors. From June 2011 to December 2011 a total of 228 rape survivors had been admitted to the emergency unit where the current study was conducted (The Hospital: emergency unit statistics 2011). (View Section 1.6.2 for further information regarding the research setting).

The current practice followed during the management of female rape survivors in the emergency unit focused on a predominantly disease-centred approach. This is in contrast to the WHO's (2003) guidelines pertaining to medico-legal care for female rape survivors which states that care should be patient-centred. Ferguson et al. (2013: 283) emphasise that, regardless of the setting and location of a healthcare institution, the care of a female rape victim should be in accordance with the WHO's specification that *"care should be ethical, compassionate, objective and above all, patient-centred"* (WHO 2003: 18).

By using AI as the research methodology in this study, it was possible to re-look the current management in the emergency unit of female rape survivors from the perspectives of the female rape survivors. Through incorporating their views, recommendations were made to enhance the management of female rape survivors towards a patient-centred approach in the future. In this study AI dialogue was used to give female rape survivors an opportunity to provide inputs regarding their specific needs, thereby contributing positively to the development of a patient-centred approach during the management of female rape survivors in the emergency unit.

### 1.3 PROBLEM STATEMENT

Sexual assault is a worldwide public health concern that can place female rape survivors at risk for an unplanned pregnancy, psychological instability and STIs (Chacko et al. 2012: 335). Greeson and Campbell (2012: 83) found in the USA rape was a widespread problem with about 1.3 million adult women being raped annually in that country. In a study that was done in Thailand by Teerapong et al. (2009: 888) it was found that at least 20% of women have been physically or sexually assaulted in their lifetime. In a multicountry study conducted by the WHO on women's health and domestic violence against women, 24 000 women across 10 countries were included. The results showed that domestic violence is widespread and sexual violence by an intimate partner ranged from 10% to 50% (Husain & Khan 2008: 468).

Female rape survivors were managed in the emergency unit of a public level II hospital in North West on a daily basis using a predominantly disease-centred approach. Although the components of the disease-centred approach used are vital and should not be discarded, the voice of the female rape survivors regarding their views of the management they received in the emergency unit remained silent and unheard. Involving female rape survivors to express their views of the management they received is important if the healthcare professionals' future aim is to enhance patient-centred approach where the patient is the focus of the care (Ferguson et al. 2013: 283).

Ekman et al. (2011: 1) depict that transferring a patient-centred approach into clinical practice is a challenge even though it has been shown to improve outcomes and increase patient satisfaction. In 2005 the WHO conducted a multistudy on women's health and domestic violence against women (Garcia-Moreno et al. 2005: 12). Data were collected in 10 countries through individual interviews from survivors of violence, including sexual abuse and rape. The women's strategies they used to cope as well as their needs were documented (Garcia-Moreno et al. 2005: 12).

Currently, female rape survivors at the emergency unit of the hospital are managed using the National Department of Health's guidelines which are not patient-centred,

but disease oriented (DoH 2005: 5). It was envisaged by the researcher that by listening to the female rape survivors when they share their views of the management they received through AI dialogue healthcare professionals at the hospital and in the whole country would gain insight into “*what is*” (what works well), “*what could be*” (what can be addressed to move towards a patient-centred approach) and “*what should be*” (suggest strategies to move towards a patient-centred approach).

According to Barry and Edgman-Livitan (2012: 780), if disease-oriented care is given to the patient (in the current study the female rape survivors) it can result in a situation where the healthcare environment excludes the patients and their families from important discussions. In the setting of this study the current management (which is disease-oriented) of the female rape survivors does not allow them to be involved in their own care. For example, there are no support groups which were mentioned as one of the female rape survivors’ wishes for their future management. The researcher is a registered nurse who delivers disease-oriented care in the study setting. As a researcher, she observed that the management of female rape survivors have not been explored after she had had an informal conversation with a female rape survivor who shared that what would help female rape survivors to cope with what has happened to them, was their own therapy group. This aroused her interest to conduct a study and explore the female rape survivors’ experience of their post-rape management.

In South Africa the National Department of Health’s (NDoH) National Core Standards for Health Establishments (NCS) “*have been created as a statement of what is expected and required to deliver decent safe quality care*” (NCS 2011: 6). The NCS (2011: 9) require that quality should be effective, efficient, accessible, acceptable (patient-centred), equitable and safe. According to a 2010 (give full name and (POWA) in brackets) (2010: 5) report, violence against women contravenes the constitutional rights of women and, in addition, “*the right to equal benefit and protection of the law*”. The POWA report further states that “*protection against women abuse is limited while perpetrators enjoy a widespread impunity*” (POWA 2010: 5).

The NCS consist of seven domains. The patients' rights domain is concerned with patient safety, clinical governance and clinical care and requires that healthcare professionals must respect the rights of patients and make sure that the latter have access to "*much needed care*" in accordance with the Batho Pele Principles and the Patients Right Charter (NCS 2011: 11). Accordingly, female rape survivors must be respected and their rights be upheld such as be given a chance to form a support group, which they mentioned during the female rape survivors one-on-one interview, and to be assisted by the health care professionals and the counsellors as it is one of the participants wishes for future management of female rape survivors.

## 1.4 RESEARCH QUESTION

The research question developed for this study was as follows:

*What are the views of female rape survivors regarding the management they received at an emergency unit in the North West province?*

## 1.5 AIM AND OBJECTIVES

The overall aim of this study was to explore the views of female rape survivors regarding the management received at an emergency unit in North West, one of the nine provinces in South Africa.

In accordance with the overall aim noted above, the study objectives were to:

- explore and describe the views of female rape survivors regarding the management they received at the emergency unit
- make recommendations to healthcare professionals responsible for managing the rape survivors in the emergency unit to promote patient-centred management.

## 1.6 RESEARCHER'S FRAME OF REFERENCE

The frame of reference is discussed in terms of the role of the researcher, setting, relevant paradigm, assumptions and key concepts.

### 1.6.1 Role of the researcher

The researcher is a trauma and emergency nurse practitioner and has 24 years' experience as a registered nurse of which nine years were in the emergency unit of the hospital in North West where the study was conducted. At the time when the study was conducted the researcher was, and still is, the operational manager of the emergency unit. The unit is divided into two areas where female rape survivors are admitted, managed and followed up following sexual violence: Area 1 (trauma and emergency) and Area 2 (crisis centre) (view Section 1.6.2).

The four elements that identify the researcher's role (Creswell 2003: 164) and their application to this study are set out next.

- Firstly, the adult female rape survivors' statements included information on their past experiences that provided background data to better understand the topic, the setting and their experiences. (View Section 1.6.2).
- Secondly, due to her working experience the researcher had access to the setting. Therefore, she was able to obtain permission to interview the female rape survivors in collaboration with the counsellor (View Section 3.4.4).
- Thirdly, the comments on the connection between the researcher and the female rape survivors relating to the research setting were indicated. (View Annexure B; Figure 3.1).
- In the fourth instance any comments as concerns sensitive ethical issues that could arise during the research process were duly documented. (View Section 1.9.1.1).

### 1.6.2 Setting

The emergency unit is located in a public level II hospital in North West province, South Africa. When the study was conducted the emergency unit was staffed with the following basic specialities: surgery, medicine, orthopaedics, paediatrics, obstetrics gynaecology, diagnostic radiology and anaesthetics. It is a referring hospital to which district hospitals and community health centres refer patients for further management.

The emergency unit consists of two separate areas where patients are managed. In Area 1 (trauma and emergency) all the injured and ill patients as well as survivors of sexual abuse are admitted to and managed, but the latter is only admitted after 19h00. In Area 2 (crisis centre) sexually violated patients (including female rape survivors) are admitted and managed on a daily basis between 07h00 and 19h00. If a sexually violated patient has to be admitted and managed between 19h00 and 07h00, the patient will be admitted to and managed in Area 1. From 1 June 2011 to 31 December 2011 a total of 288 adult female rape survivors were admitted and managed in both Areas 1 and 2 of the emergency unit.

Healthcare professionals are allocated to one of two shifts: from 07h00 to 19h00 or from 19h00 to 07h00. Generally a total of eleven (11) professional nurses, three (3) enrolled nurses, and two (2) medical doctors are allocated to Area 1. The healthcare professionals normally working in Area 2 consist of two (2) professional nurses, a psychologist, a social worker, four (4) professional counsellors, two (2) police officers, and 2 medical doctors. Importantly, the two (2) medical doctors have to cover both Area 1 and Area 2 during their shifts.

### 1.6.3 Relevant paradigm

In this study an interpretive paradigm was followed. According to Polit and Beck (2010: 14), a paradigm is “*a worldview or general perspective on the complexities of the real world*”. These authors identified two main paradigms, namely a positive paradigm and a naturalistic paradigm, also referred to as the constructivist paradigm

(Polit & Beck 2008: 14). Polit and Beck (2008: 15) further state: “*The voices and interpretations of those under study are crucial to understanding the phenomena of interest*”. In the current study, interpretivism emphasised the importance of the insiders’ (in this study the female rape survivors) views on understanding the reality (in this study the management received in the emergency unit). Knowledge could therefore be generated by exploring the views of female rape survivors pertaining to the management they received in the emergency unit.

Using interpretivism in this study would give the female rape survivors the opportunity to share their experiences of their management with the researcher. According to Polit and Beck (2008: 15), findings from the naturalistic inquiry are the result of the “*interaction between the inquirer and the participants*”. In the case of the current study the “*inquirer*” was the researcher and the “*participants*” referred to the adult female rape survivors. It was the researcher’s belief that based on the findings, she would be more informed and enabled to plan strategies to increase patient-centred approach towards the management of female rape survivors.

### **1.6.3.1 Assumptions**

Interpretivism is described as a “*belief that the subject matter is fundamentally different from that of natural sciences, and that a different kind of methodology is required to make an interpretation of understanding and explanation*” that will enable the researcher to appreciate the subject meaning (de Vos et al. 2011: 309). Polit and Beck (2010: 14) define an assumption as “*a basic principle that is believed to be true without proof or verification*”.

The assumptions on which this study was based were derived from the interpretative paradigm as well as from the AI approach that was used as the research methodology. As prescribed by Cooperrider, Whitney and Stavros (2008: 41) this study was guided by including “*deliberate positive assumptions made about people, organisations and relationships and leaving deficit-orientated approaches behind*”.



The combined AI assumptions of Hammond (1998: 21-22), Davis (2007: 1) and Reed (2007: 28) were used to guide the study. The earlier assumptions of Hammond (1998: 21-22) are stated with extrapolations by Davis (2007: 1) and Reed (2007: 28) where noted.

- In every organisation, something works.
- Looking for “*what works well*” is more motivating and effective than looking for “*what does not work*”.
- What we focus on becomes our reality and there are “*multiple realities*”. Appreciative Inquiry focuses on drawing these multiple positive realities from the stakeholders and building the future of the organisation on them (Davis 2007: 1; Reed 2007: 28).
- The act of asking questions begins the change and influences the group in some way. No matter what challenges are facing us in this complex world, asking positive questions will positively influence us in some way (Reed 2007: 27).
- We have more confidence and comfort to journey into the future (the unknown) when we bring forward parts of the past (the known); thus, by linking unknown future plans to the currently known positives gives people more confidence and they feel more comfortable to move forward (Reed 2007: 28).
- If we bring parts of the past forward, they should be “*what is best*” about the past. In other words, only the positive (“*best*”) parts must be brought forward (Reed 2007: 28).
- The words we use to anticipate and describe reality therefore create a reality. We should thus strive to talk about what is right and positive even if some negativity exists; if negativity does exist, we should talk positively about this seeming negativity because positive words result in positive actions.
- Reed (2007: 28) adds that it is “*important to value differences*” because it is the different viewpoints that people bring and share that result in positive change.

⇒ **Interpretive assumptions**

In the interpretive paradigm *“the role of the researcher as a co-creator of the meaning becomes important when the insider’s story is captured”* (Henning 2004: 25). According to Henning (2004: 25), interpretive assumption is described as knowledge gained or *“filtered”* through social constructions such as language, shared meaning documents and other artefacts. Interpretive assumption is therefore an attempt to understand phenomena through meanings people assign to them.

The interpretive assumptions according to Henning’s (2004: page?) are noted next.

- Individuals are not considered to be passive vehicles of social and historical affairs, but have inner capabilities allowing individual judgement and decision making.
- The belief that any event or action is explainable in terms of events and processes.
- There is extreme difficulty in completing objectives, especially observing human subjects.
- The view that the aim of inquiry is to develop an understanding of individual cases rather than predictive generalisation.
- The world is made up of multifaceted realities that are best studied as a whole.
- Recognition that inquiry is always value laden and such values influence the framing, focusing and conducting of a research study

#### **1.6.4 Key concepts**

The key concepts used in the study were identified and are described to enhance the simplicity and consistency of the use thereof throughout the study.

#### 1.6.4.1 Adult female rape survivor

According to the Criminal Law (Sexual Offences and Related Matters) Amendment Act (2007: 22), an **adult** is a person who is 16 years or older. This is the legal definition in South Africa.

**Rape** is broadly defined by the WHO (2003: 6) as:

*any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic or otherwise directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work.*

The Criminal Law (Sexual Offences and Related Matters) Amendment Act (2007: 11) defines **rape** as when any “person (“A”) who unlawfully and intentionally commits an act of sexual penetration with a complainant (“B”) without the consent of the complainant (“B”). The latter definition was adopted for the purpose of this study. Garcia-Moreno et al. (2005: 14) refine this definition by detailing the act of rape as that when a woman is “*physically forced to have sexual intercourse*” when she does not want to, or because she is afraid of “*what her partner might do*”, or she is forced to do something sexual that she finds “*degrading or humiliating*”.

A **survivor** is someone who “*manages to live normally in spite of many problems, accidents or illness*” (Longman dictionary of contemporary English 2009).

For the purpose of this study a **female rape survivor** referred to a person of the female gender, 18 years and older (an adult) who had been raped and had been admitted to the designated hospital where she was managed in an emergency unit following the incident.

#### 1.6.4.2 Patient-centred approach

A **patient-centred approach** can be described as “*individualised care that recognises the uniqueness of each patient’s preferences, needs and condition as well as involving them in discussions and decisions about their health care*” (Ferguson et al. 2013: 284). This view is supported by Kelly-Heidenthal (2003: 257). Urden, Stacy and Lough (2006: 6-7) state physiological illness is usually much better understood and more predictable than the effect of psychosocial influences on the healing process of the body and mind. Reuben and Tinetti (2012: 777) and Barry and Edgman-Levitan (2012: 780) are in agreement that a patient-centred approach means to be respective of and respectful to individual patient preferences, needs and values and to ensure that patient values guide all clinical decisions.

In the context of this study **patient-centred approach** related to exploring the unique needs that arose from the views of female rape survivors and deriving from them their wishes for the future management of female rape survivors in the emergency unit in order to enhance current practice and move towards a patient-centred approach.

#### 1.6.4.3 Healthcare professionals

For the purpose of this study, a **healthcare professional** indicated a medical officer (doctor), a counsellor or a nurse who was involved in the management of female rape survivors in Area 1 and Area 2 (Or only one area??? Specify and make it clear!!!) in an emergency unit of a public level II hospital in North West.

### 1.7 SIGNIFICANCE OF THE STUDY

According to Hofstee (2009: 89), the significance of a research study should be both theoretical and practical. The current study might have considerable advantages for female rape survivors admitted and managed in the emergency unit. The current practice relating to the management of female rape survivors focuses on a disease-

oriented approach and thus does not acknowledge the voice of the female rape survivor.

Through AI dialogue healthcare professionals were made aware of how female rape survivors view the management they currently receive; they were also made aware of what suggestions the female rape survivors made in order to move towards a more patient-centred approach practice. For example, although the female rape survivors viewed the current practice as “good” their suggestions were implemented to move the management of female rape survivors towards an “excellent” practice through focusing on a patient-centred approach. Based on the data collected, the healthcare professionals were afforded the opportunity to implement the suggestions made by the female rape survivors and move the current disease-centred practice towards a patient-centred approach.

## 1.8 RESEARCH METHODOLOGY

The research methodology refers to the way in which a study is structured. It includes the manner in which the sample is obtained and the techniques used to gather the data and analyse it systematically (Polit & Beck 2012: 741). In this study the AI approach was used to guide the research methodology.

Appreciative Inquiry was used because it challenges traditional problem-solving models by encouraging participants to reflect on and share their personal experiences of achievements within the organisation (Martin & Calabrese 2011: 112). Appreciative Inquiry is a strength-based approach that motivates people and organisations to take the “*what is best*” (positive) from the past and move forward towards a better future (Reed 2007: 28). The strength of AI lies therein that asking positive questions and sharing positive thoughts influence the self and others towards positive growth. In spite of what is negative, a positive reality is created by asking questions such as “*what is working*”, what “*has gone well*” and “*what does not need to be fixed*” thus focusing on “*what could be*” rather than “*what was*” (Cooperrider et al. 2008: 3; van Vuuren & Crous 2005: 403; Watkins & Mohr 2011: n.p.).

Using AI to guide the research methodology, this study provided insight into the female rape survivors' views of the management they received in the emergency unit by including both "*what is working*" and "*what could be changed*". It was perceived that, by recognising the views of the female rape survivors, the healthcare professionals would be able to identify and understand the strengths, opportunities as well as the female rape survivors' hopes for the future management of such women in the emergency unit (Cooperrider et al. 2008: 190).

Through AI the female rape survivors were given the opportunity to challenge the status quo and build upon or expand potential for future management of female rape survivors. The stakeholders (nurses, medical doctors, counsellors, social workers and psychologists) would thus be able to envision what the future management of female rape survivors should encompass as suggested by Cooperrider et al. (2008: 137). An in-depth discussion of AI is presented in Chapter 2.

The research methodology guided the research design and methods used in the study.

### **1.8.1 Research design and methods**

The research design and method is the overall plan for collecting and analysing data. The research design specifically refers to "*the overall plan for obtaining answers to questions being studied and for handling some of the difficulties encountered during the research process*" (Polit & Beck 2008: 66).

For the purpose of this study a qualitative, explorative and descriptive design was used to conduct the study. The research methods included "*the technique used to structure the study and to gather and analyse information in a systematic fashion*" (Polit & Beck 2008: 765).

The research methods used are summarised in Table 1.1.

**Table 1.1: Summary of the research methods**

Population	Sampling	Data collection	Data analysis	Trusworthiness
Female rape survivors managed in an emergency unit in North West province	<u>Sampling:</u> Purposive  <u>Sample size</u> 10	Appreciative interview  One-to-one	Content analysis	Based on Guba's model of trustworthiness, using four strategies: <ul style="list-style-type: none"> <li>• credibility</li> <li>• transferability</li> <li>• dependability</li> <li>• confirmability including</li> <li>• authenticity</li> </ul>

A detailed, more in-depth discussion of the research design, methods and strategies to enhance trustworthiness are discussed in Chapter 3.

## 1.9 ETHICAL CONSIDERATIONS

Polit and Beck (2012: 139) state ethical considerations are “*essential factors in any research project*”; it is the responsibility of the researcher to ensure that the participants' rights are identified and also protected. According to Streubert Speziale and Carpenter (2007: 60), ethical considerations consist of a set of values and imperatives that researchers are obliged to adhere to when conducting a research study. The WHO (2001: 373) states the following with regard to the ethical conduct of a research study:

*“Ethics is the science criteria, norms and values for human action and conduct. It is engaged in reflection and analysis of morals concerning whether an act is good or bad and how it influences our basic quest for meaning. Its intention is to safeguard human dignity and to promote justice, truth and trust”.*

In this study the protection of human rights was especially important. The study dealt with a very sensitive issue, namely females who had survived a rape incident. It was plausible that some, or all, participants might need counselling during or after their one-to-one interviews. It was therefore crucial for the Research Ethics Committee of

the University of Pretoria to make certain that the researcher would exercise great care to conduct this study in an ethically sound manner (Polit & Beck 2008: 184).

The researcher's proposal for this study was reviewed and approved by the Research Ethics Committee of the Faculty of Health Science at the University of Pretoria. The approval (view Annexure A) of the committee endorsed that the study would be conducted with a high degree of integrity and honesty and that the participants' human rights would be protected during the research process (Polit & Beck 2008: 184). Permission to conduct this study was also sought and granted from the North West Department of Health and the hospital where this study was conducted (View Annexures A).

This study was guided by the three primary ethical principles as articulated in the Belmont Report, namely, beneficence, respect for human dignity and justice (Polit & Beck 2008: 170).

### **1.9.1 The principle of beneficence**

This principle involves all efforts to secure the safety and well-being of persons. Polit and Beck (2012: 152) state a researcher should minimise harm and, above all, do good. Preventing harm and discomfort includes emotional, physical, and psychological harm and discomfort (Brink, van der Walt & van Rensburg 2010: 32). According to Holloway and Wheeler (2010: 55), the benefits should "*outweigh the risks for the individual*".

#### **1.9.1.1 Right to protection from harm and discomfort**

Polit and Beck (2012: 152) and de Vos et al. (2011: 115) emphasise that the researcher has an obligation to avoid or prevent subjecting participants to unnecessary harm or discomfort. Aware that this study was concerned with a sensitive issue that necessitated invading people's privacy, the researcher assured the participants that they were at liberty to decline participation. She emphasised that, if they agreed to participate but felt they could not continue for any reason



whatsoever (such as emotionally stressed or discomfort) it was within their right to withdraw from the study any time without prejudice (Oliver 2010: 49). In addition, a counsellor was pre-arranged to be on standby for counselling at all times and whenever the interviews were conducted.

### **1.9.1.2 Right to protection from exploitation**

The participants were fully informed beforehand of the purpose of the study and the process that would be followed (Oliver 2010: 31). The researcher also informed them that they would not receive any remuneration for participation, but that their participation would yield information that would form the basis for recommendations to healthcare professionals responsible for managing the rape survivors in the emergency unit to promote patient-centred management. All participants were adults (18 years and older); vulnerable groups of people such as children, mentally ill, disabled or elderly females were excluded in this study (Oliver 2010: 37).

## **1.9.2 The principle of respect for human dignity**

The steps that were taken to protect the participants' human rights, namely the right to self-determination and the right to self-disclosure and informed consent, are discussed next.

### **1.9.2.1 Right to self-determination**

Polit and Beck (2012: 154) hold that prospective participants' autonomy must be upheld; they must be fully informed of the study so that they can make an informed decision to participate or decline participation. The participants in this study were assured that their participation was their own decision; they were not coerced or forced to participate in any way. It was stressed by the researcher that their participation was voluntary and that they could, at any stage, withdraw from the study without penalty (Burns & Grove 2009: 154).

### 1.9.2.2 Right to self-disclosure and informed consent

De Vos et al. (2011: 117) and Polit and Beck (2012: 158) are in agreement that prospective participants must be provided with accurate and complete information so that they fully comprehend the details of the investigation. The researcher described the nature of the current study in detail so that the participants could make an informed and voluntary decision on whether to participate or not. The benefits as well as the risks of participation were explained to each participant. According to Oliver (2010: 29), the most important feature is that *“participants should be fully informed about a research project before they accept to taking part”*. The researcher disclosed all the aforementioned information during a telephonic conversation with every participant when she invited them to participate.

The documentation requesting their informed consent was delivered to the participants via the counsellors. The documents contained complete and full information of the details of the proposed study: the aims and objectives, why conducting this study was important, the informed consent form to be signed if they willingly agreed to participate as well as a list of the questions that would be asked during the interviews. Lastly, the contact details of the researcher were given to every participant after her individual interview. This was done so that the participant could contact the researcher if she had any questions. The participants in this study participated voluntarily after being informed about the expectation regarding participation in the study (Holloway & Wheeler 2010: 59)

### 1.9.3 Principle of justice

The principle of justice implies that the research is fair and just to the participants (Holloway & Wheeler 2010: 54). According to Polit and Beck (2012: 155) and Brink et al. (2010: 33), this principle includes the right to fair treatment and the right to privacy. The participants remained anonymous and the researcher was not judgemental or biased during the unstructured interview.

### 1.9.3.1 Right to fair selection and treatment

Participation in this study was voluntary. The selection of participants was fair and just as the participants were selected according to the inclusive criteria as indicated in Section 3.4.1.1. The dignity, rights, safety and well-being of the participants were protected throughout the study (Holloway & Wheeler 2010: 54). Benefits and risks of the study were distributed fairly; there were no researcher bias. The researcher respected the culture and lifestyles of all the participants. Only the participants who conformed to the specified criteria were contacted and invited to participate. The interviews were done until data saturation was reached and no new themes or data emerged (Polit & Beck 2012:91).

### 1.9.3.2 Right to privacy and confidentiality

The individuals who agreed to participate have a right to expect that the information collected from them will remain private (Brink et al. 2010: 33; de Vos et al. 2011: 119; Polit & Beck 2008: 170). Privacy in this study was enhanced by maintaining anonymity. The participants' names were not disclosed to anybody and pseudonyms were used throughout the study. Only their pseudonyms were written on the transcribed data that were presented to the independent co-coder for coding. Because of the sensitivity of this research study, anonymity was guaranteed and the participants' identities were not revealed; hence, no one would, or will be in future, able to match their real names and identities. Anonymity was further guaranteed because no visual recording was done during an interview (Holloway & Wheeler 2010: 60, 61).

Confidentiality was also maintained by ensuring that the data collected were not made available to any outsider (those people that were not involved in data collection). Although assured of the confidentiality of the data collected, the participants were made aware that the research would "*contains some quotes from the interview data*" (Holloway & Wheeler 2010: 61). No participant objected to this aspect. The data was stored and locked away in a safe place "*for future academic reference*" where only the researcher can reach it; anonymity will remain during

presentation of the findings at conferences and when published in scientific journals (Holloway & Wheeler 2010: 61).

## **1.10 LAYOUT OF STUDY**

The layout of this study consists of chapters and annexures. The organisation of the chapters is indicated in Figure 1.1.

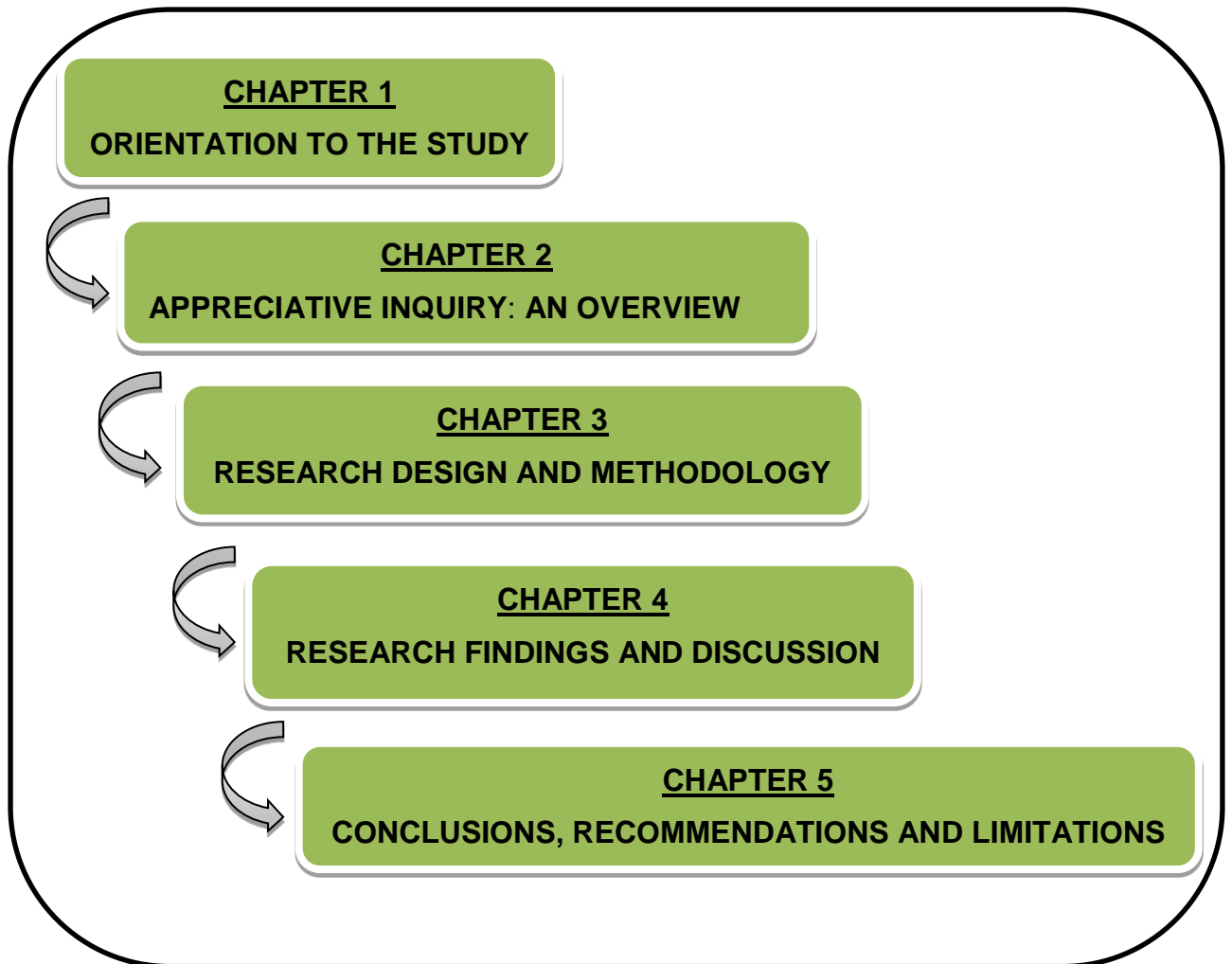


Figure 1.1: Schematic representation of the layout of the study

## 1.11 CONCLUSION

Chapter 1 introduced the study to the reader and focused on the background and problem statement, the research question, aim and objectives and the researcher's frame of reference. It also contained a short summary of the research methodology, design and methods that were used to address the aim and objectives of the study.

In Chapter 2 an in-depth literature review of AI, which was used as the research methodology for this study, is provided.

## 2 APPRECIATIVE INQUIRY: AN OVERVIEW

### 2.1 INTRODUCTION

Chapter 1 presented an orientation to the study. This chapter provides an overview of literature on Appreciative Inquiry (AI) that was used as the research methodology for this study. The rationale for providing an overview regarding AI was to convey to the reader what is known about the topic. Appreciative Inquiry laid the foundation for this study and prescribed how the data were generated and interpreted. The literature overview of AI is organised around the following areas: defining AI; providing a historical overview; principles of AI; traditional problem-solving versus the new process of AI; uses of AI; advantages of AI and limitations of the AI methodology.

### 2.2 DEFINITION

The practice of AI is a constructive approach to change as it brings people together to collaborate and discover, dream and design the organisation's optimum value and desire. It is an interactive process as it brings people from "*all levels and functions of an organisation to learn from one another*" in order to build a relationship for going forward and expanding their collective wisdom (Whitney & Trosten-Bloom 2010: 29).

Appreciative Inquiry focuses on "*what is working*", "*has gone well*" and "*does not need to be fixed*" (Knibbs et al. 2010: 486) thus emphasising what could be rather than "*what was*" (Steyn 2012: 320). In a study conducted by Steyn (2010: 320) the author observed that AI is "*applicable, provocative and collaborative*".

Appreciative Inquiry is the cooperative, co-evolutionary search for the best in people, their organisation, and the world around them. It involves the discovery of what gives life to the living system when it is most effective, alive, and capable in economic, ecological and human terms (Cooperrider et al. 2008: 3).

Appreciative Inquiry involves the art and practice of asking questions that strengthen the system's capacity to apprehend, anticipate, and heighten positive potential (Cooperrider et al. 2008: 3; Pretorius et al. 2013: 78).

Whitney and Trosten-Bloom (cited in Davis 2005: 2) and Steyn (2010: 320) emphasise that AI is based on questions and dialogues about strengths, successes, values, hopes and dreams. Indeed, AI focuses on the *“positive and not the negative, thus involving inquiry that begins with an appreciation of what is positive”* Cooperrider et al. (2008: 3) confirm.

Appreciative Inquiry is described by Knibbs et al. (2010: 486) as a search for knowledge and a theory of intentional collective action designed to help evolve a vision of a group, organisation, or society whereby issues are examined by discovering what is working particularly well in a domain. It involves imagining what it might be like if *“the best of what is”* occurred more often in the domain.

According to Stefaniak (2007: 43), Keefe and Pesut (2004: 103) and Bechtold (2010: 1), AI is regarded as a philosophy, a strategy where one can work from a positive stance to approach challenges and plan for sustainable change. Sandoval and Campos (2013: 1029) agree with Bechtold (2010: 1) that the interpretation of AI is that it is a philosophy that incorporates an approach to involve people to produce a positive and effective change. Cooperrider et al. (2008: 40) define Appreciate and Inquiry as follows:

- **Ap-pre'ci-ate**, v., 1. *Value; recognise the best in people or the world around us; affirm past and present strengths, successes, and potentials; to perceive those things that give life (health, vitality, excellence) to living systems. 2. To increase in value, e.g., the economy has appreciated in value. Synonyms: value, prize, esteem, regard, respect and honour.*
- **In-quire**, v., 1. *To explore and discover. 2. To ask questions; to be open to seeing new potentials and possibilities. Synonyms: discover, search, systematically explore, and study.*

## 2.3 HISTORICAL OVERVIEW

In the early 1980s Dr David Cooperrider was reading for his doctoral degree in organisational development at the Case Western Reserve University in Cleveland, Ohio, in the USA. When he was investigating the human aspects of the Cleveland Clinic, Cooperrider became aware of the positive way in which the clinic's employees worked together towards achieving success (Davis 2007:1).

Encouraged by his doctoral advisor, Suresh Srivastva, Cooperrider continued to focus his study on analysing the life-giving factors that formed the basis for the obvious success of new developments within the clinic (Davis 2007: 1; Harmon et al. 2012: 119; Stefaniak 2007: 43; Trajkovski et al. 2013: 1225; Whitney & Trosten-Bloom 2010: 78). The Cleveland Clinic was the first site where focusing on life-giving factors formed the basis for organisational analysis and Cooperrider's Appreciative Inquiry emerged as the new organisational change strategy in 1986 (Knell 2010: 2; Whitney & Trosten-Bloom 2010: 78).

Over the last three decades Appreciative Inquiry, Cooperrider's organisational development intervention, has been used throughout the world (Hall & Hammond 2004: 5) in community and organisational capacity building to ensure a sense of true involvement (Knibbs et al. 2010: 490). It was developed from a theory-building process used by academics as an organisational change process that enables organisations to generate their own theory (Cooperrider et al. 2003: 10). Appreciative Inquiry originates from psychology and organisational change movements, where it focuses on *distinctive ways of thinking, seeing and acting upon making proactive changes, oriented transformational changes and proactive-oriented transformational changes* (Davis 2007: 1; Sandoval & Campos 2013: 1029).

## 2.4 CORE PRINCIPLES

The practice of AI is informed by 8 principles (Whitney & Trosten-Bloom 2010: 51). Five principles were derived directly from the early writings of Cooperrider and Srivastva (Cooperrider et al. 2008: 8; Whitney & Trosten-Bloom 2003: 53) (view



Sections 2.4.1 to 2.4.5). Whitney and Trosten-Bloom (2003: 53) added 3 principles which evolved from the experience of applying AI to large-scale organisation and community change efforts (view Sections 2.4.6 to 2.4.8).

The 8 principles of AI are discussed from Section 2.4.1 to Section 2.4.8.

### **2.4.1 Constructionist principle**

The constructionist principle supports that human communication and language are at the centre of human organising and change (Whitney & Trosten-Bloom 2003: 53). This principle posits that meaning is made during conversation as it involves asking questions that strengthen the individual and organisation's capacity. Through conversation reality is created and knowledge generated (Whitney & Trosten-Bloom 2003: 54). Words, language and metaphors are suggested to be more than mere descriptions of reality; they create worlds (Brittain & Nisenbaum 2012: 8; Whitney & Trosten-Bloom 2003: 54). Meaning is made in conversation and reality *"is a social artefact resulting from communication among groups of people"* (Whitney & Trosten-Bloom 2010: 27).

The question asked becomes the material from which the *"when"* of the future is conceived and constructed; change therefore begins the moment the first question is asked (Calabrese & Cohen 2013: 4; Cooperrider et al. 2008: 9). According to Whitney and Trosten-Bloom (2003: 54) and Schooley (2012: 342), the power of language is a vehicle by which people create knowledge, share their vision and make meaning of their for the future in their collective setting. Whitney and Trosten-Bloom (2003: 54) state organisational change occurs *"through language, storytelling and human communication"*.

### **2.4.2 Simultaneity principle**

According to Whitney and Trosten-Bloom (2003: 54), the simultaneity principle holds that change occurs the moment we ask a question, in other words, *"inquiry creates change"*. This means that inquiry and change occur simultaneously, and that inquiry

is interventions where people think and talk about things they discover (Cooperrider et al. 2008: 9). This principle posits that questions posed to oneself or to another can create identities and give hope as the individual or system's is provided with an opportunity to give their own judgement (Brittain & Nisenbaum 2012: 8; Whitney & Trosten-Bloom 2003: 540).

Questions can stimulate ideas and innovations that lead to conversations. This frequently leads to the *“evolvment of new knowledge, theories and interventions”* which, in turn, can result in an organisation having a positive core where a new vision is generated (Calabrese & Cohen 2013: 4). The simultaneity principle states that inquiry is intervention: Systems, organisations and people tend to move in the direction which they study or ask questions about (Whitney & Trosten-Bloom 2003: 54). The questions asked set the stage for what is *“found”* or what is *“discovered”* (the data); the data become *“stories out of which the future is conceived, discussed and constructed”* (Whitney & Trosten-Bloom 2003: 57).

### 2.4.3 Poetic principle

The poetic principle states that organisations are endless sources of learning, inspiration and interpretation (Cooperrider et al. 2008: 9; Schooley 2012: 342;). It is almost similar to *“poetry or sacred texts, stories that can be told and retold, interpreted and reinterpreted”* (Whitney & Trosten-Bloom 2003: 54) through any frame of reference thus leading to a positive discourse approach to change. The choice of what to study are ours and ours alone. We can therefore choose to study any topic related to human organising, customer delight or dissatisfaction (Whitney & Trosten-Bloom 2003: 54). As Cooperrider et al. (2008: 9) confirm, virtually any topic related to human experience in any system or organisation can be studied.

Whitney and Trosten-Bloom (2003: 54) and Calabrese and Cohen (2013: 3) interpret organisational life as a story told by its various stakeholders and where the story is shared through interaction with one another, thus making sense of the context where they work. Each person in the organisation brings to the table a different story to describe and make meaning of collective strength in the organisation (Calabrese &

Cohen 2013: 4). The practice of AI starts with the selection of affirmative topics that place strategic significance on the choice of success-oriented and life-giving language and metaphors that create collective strengths for organisations (Calabrese & Cohen 2013: 4; Whitney & Trosten-Bloom 2003: 54).

#### **2.4.4 Anticipatory principle**

The anticipatory principle, as stated by Whitney and Trosten-Bloom (2003: 54), suggests that images of the future guide and inspire present day actions and achievements. According to this principle, organisations exist because they are made up of people who share images and projections of the future full of inevitable and unpredictable surprises. It is therefore possible that we can know that the future comes from what we hope, dream, and imagine; in fact, Whitney and Trosten-Bloom (2003: 54) and Stowell (2012: 18) concede that we embrace such a miracle when it comes.

Fiorentino (2012: 221) further agrees with Whitney and Trosten-Bloom (2003: 549) that the practice of AI ensures that an organisation's inner dialogue is full of rich accounts of past successes as well as vivid images of future potential (dreams for the future). Cooperrider (2008: 54) further states organisations exist because people who govern and maintain them share some sort of discourse of projection about what the organisation is, "*how it will function, what it will achieve, and what it will likely to become*". Thus, organisations need personal or human talent to create change in the organisation (Sandoval & Campos 2013: 1038).

#### **2.4.5 Positive principle**

Whitney and Trosten-Bloom (2003: 54) ascertain that the positive principle states that positive questions lead to a positive change. The posing of a positive question by members of the organisation thus creates their future and drives the development of theories about positive directions for the organisation's future (Fiorentino 2012: 221). Whitney and Trosten-Bloom (2003: 54) and Fiorentino (2012: 220) concur that

the momentum for change requires positive affect, hope, inspiration and joy when sharing ideas or stories with one another.

Positive questions bring out the best in people, inspire positive actions, and create possibilities for a positive future. Appreciative Inquiry requires that positive questions about those aspects of an organisation that rise up and sustain the life of the organisation should be posed (Fiorentino 2012: 220). According to Whitney and Trosten-Bloom (2003: 54), positive questions “*amplify the organisation’s positive core*”; they magnify the essence of the organisation at its best: “*the remembered past and its imagined future*”.

Cooperrider et al. (2008: 54) state people and organisations move in the direction of their inquiries. The positive core refers to the person or organisation’s *wisdom, knowledge, successful strategies, positive attitude, best practices, skills, resources and capabilities*. Furthermore, when opportunities are provided to study, learn, and dream about this positive core, people and organisations may feel hopeful and then get excited about ‘*what works*’ (Whitney & Trosten-Bloom 2003: 54). The more we inquire, the more we bring the positive core to life. The ultimate result is that people’s attention is drawn away from away from concentrating on the problems because inquiry becomes the motivation for change “*towards unfolding capabilities, potentials, dreams and visions*. (Calabrese & Cohen 2013: 4; Whitney & Trosten-Bloom 2003: 54) These principles provide clarity that positive imagining result in positive action.

#### **2.4.6 Wholeness principle**

The wholeness principle posits that the experience of wholeness brings out the best in people, relationships, and organisations. This experience emerges when people listen to each other and make sense of the different views during conversations, which then leads to successful change in organisations (Calabrese & Cohen 2013: 4). This principle leads participants to focus “on higher ground rather than common ground” (Whitney & Trosten-Bloom 2003: 54) and can create a context in which people can safely focus on issues of higher purpose and the greater good of the whole.

According to Whitney and Trosten-Bloom (2003: 54), wholeness means that everybody engages in the process of change by getting all the stakeholders in one room at the same time. When the whole system is in the room, trust ensues and a “*can do*” attitude prevails. Having the whole system involved also inspires uncommon action on behalf of the whole. Each person brings a new perspective and when all perspectives are combined it then creates the possibility for action through breaking the barriers down and creating a setting where respect and renewed relationships are regarded as important (Whitney & Trosten-Bloom 2003: 54).

### **2.4.7 Enactment principle**

The enactment principle suggests that transformation occurs by living in the present while dreaming about what we most desire in the future. Positive change comes about as images and visions of a more desired future are enacted in the present. We are advised to “*be here now*”, to be present and to live in the moment: “*act as if self-fulfilling*” (Whitney & Trosten-Bloom 2003: 72).

Whitney and Trosten-Bloom (2003: 54) reflect that the “*motion of enactment*” (meaning to live one’s dreams today) is a simple practice. These authors ascertain that effective organisational change requires that the process used for change be an enactment of a desired future. The practice of AI creates numerous opportunities for organisations to enact their more desired cultures and leadership styles. If the organisation wants the people to speak up and listen to one another it is important to acknowledge that all voices are equal and create forums for everyone to share their stories and insights (Whitney & Trosten-Bloom 2003: 54).

### **2.4.8 Free choice principle**

This principle suggests that people and organisations thrive when people are free to choose the nature and extent of their contribution. It posits that, by treating people as volunteers who have the freedom to choose to contribute as they desire, liberates both personal and organisational power (Whitney & Trosten-Bloom 2003: 54). To treat people as volunteers is to create a democratic work environment: people freely

choose how and when to participate based on their strengths, interests, values, hopes and dreams (Whitney & Trosten-Bloom 2003: 54).

According to Witney and Trosten-Bloom (2003: 54), when people have a free choice, organisations excel; free choice is an essential aspect of being a human, and being free to make one's own choices liberates power and results in high performance. In accordance with the principle of free choice, consistently creating opportunities for free choice thereby gives people options and encourages them to choose their work based on their intuitions, interests, strengths thus allowing them to strive towards their highest calling. The practice of AI is distinguished from other approaches to change by the number of choices it offers people. People are granted complete freedom to choose if, how, and when they will engage in the process. For example, they may choose to participate in the initial selection of affirmative topics and then drop out but, as confirmed by Whitney and Trosten-Bloom (2003: 54), people can, and do, choose to participate when they become curious, stimulated, or inspired by a task, activity, or dream for the future.

In conclusion, the eight principles are concerned with “*conversations that matter*” (Whitney & Trosten-Bloom 2003: 54). The phrase illustrates the power of AI to bring things to life, to literally make them matter. It further implies that AI conversations are about what matters the most to people. It involves two-way inquiry and dialogue among improbable pairs of people and focuses people's energies and efforts on what they value (Whitney & Trosten-Bloom 2003: 54).

## 2.5 APPLICATION IN PRACTICE

Cooperrider et al. (2008: 4) emphasise that AI is all about promoting appreciative conversations and relationships which can change attitudes and behavioural practices. These are interactions designed to bring about the best in people so that they can imagine a preferred future together. Davis (2005: 2), supporting Hall and Hammond (2004: 2), agrees that strengths can be the starting point for creating a positive change in an organisation or a person. Cooperrider et al. (2008: 3) concur, but also point out that AI offers a different way of solving problems that the traditional

method of solving it. In the latter an organisation is seen as a “*problem to be solved*” whilst in AI an organisation is a “*solution to be embraced*” (Cooperrider et al. 2008: 5).

Hall and Hammond (2004: 1), describe AI as a way to bring about change in organisations. According to these authors, AI works on the assumption that whatever one wants more of, already exists in all organisations. This means that in an organisation the researcher searches for solutions that already exist, amplify “*what is working*” and focuses on life-giving forces (Hall & Hammond 2004: 2). Appreciative Inquiry is more about learning and understanding something (that already exists) and thereby valuing it; in other words, AI is about expressions of appreciation (Cooperrider & Whitney 2008: 4).

Appreciative practitioners are discovering more effective ways to engage all stakeholders – thus placing the whole system at once in the centre of strategy formation, planning and implementation (Cooperrider & Whitney 2008: 4). Appreciative Inquiry is based on the fact that human systems are made and imagined by those who live and work within them. Appreciative Inquiry leads these systems more towards the “*creative images that reside in the positive core of an organisation*” (Cooperrider & Whitney 2008: 10). Myers and Bellini (2011: 271) confirm that organisations that use an AI approach in everyday practice start off by appreciating what is “*best about their system*” and use that as a starting point for improvement.

According to Cooperrider et al. (2008: 19), AI begins with an appreciative mind-set, eye, thoughts and vocabulary based on the “*Theory of Affirmative Organization*” whereby concepts such as organisations are made and imagined by the people who work there, Members in the organisation become excited when included in discussions and the desire to move towards a shared dream prevails.

The process of AI involves interviewing and storytelling to draw out the best from the past and then to visualise an effective future” (Stefaniak 2007: 43). Appreciative Inquiry uses a interview guide to elicit required responses in a positive story format

(Stefaniak 2007: 43). According to Manley and Shaw (2002: 163), AI offers an alternative approach to the SWOT analysis that is more positive and free of threats (view Section 2.5.2).

Appreciative Inquiry is used when an organisation and its stakeholders contemplate direction within a context of uncertainty. It is also used for securing an organisational change in a wide variety of settings. It has been successfully implemented in the public, private and non-profit sectors. Appreciative Inquiry is used for distilling and thereby uncovering deeply held organisational beliefs about shared values, practices, hopes and goals which can all be inputs into the design of future products, services or experience (Reed 2007: 3).

Havens et al. (2006: 3) state AI in nursing is used to create a positive future for nursing with the goal of improving the satisfaction of both employees and patients. Appreciative Inquiry is also used when evaluating the process of change, when describing “*what worked well*”, and in facilitating a positive culture change.

### **2.5.1 Organisational change**

Appreciative Inquiry is described as a way of thinking, specifically when focused on the task of achieving organisational change. The premise of AI is that “*whatever one desires to have more of, it already exists in the organisation*” (Reed 2007: 6). The power of Appreciative Inquiry is that it taps into the stories of what an organisation’s members believe is best (Reed 2007: 6).

Cooperrider and Srivastva (1987) (cited in Reed 2007: 23) depict that AI falls within the domain of action research (AR). Appreciative Inquiry emerged from the research conducted by Dr David Cooperrider with the support of his doctoral advisor, Suresh Srivastva, at the Case Western Reserve University in the USA when Cooperrider observed factors that contributed to the effective functioning of the Cleveland Clinic’s organisation. Cooperrider and Srivastva (1987) (cited in Bushe & Kassam 2008: 3) criticised traditional action research and problem-solving approaches to planned change. They argued that traditional action research does not lead to new



knowledge but that AI, which emerged out of their search for methods of inquiry, have the potential to create new images, models and theories of social organisation.

Bushe and Kassam (2008: 45) report indications are that AI is an increasingly popular organisational change method, but an almost complete lack of published research that examines it exists. Bushe and Kassam (2008: 49) state there are two specific outcome claims of AI that distinguishes it from other organisation development interventions. The first is that AI results in new knowledge, models, and theories, and secondly, AI can result in a metaphor that compels new action from the people involved (Bushe & Kassam 2008: 56). They argue that the most powerful force for change in social systems is a new idea and offer AI as a method of inquiry for generating new ideas.

Also, Bushe and Kassam (2008: 47) note there are two prescriptions for AI practice that distinguishes it from other organisational change and developmental methods. The first is that *“by creating a new ground”*, a much wider range of new possibilities emerge for the way system members think about things and do things. A *“new ground”* is about the substructure that influences what people think and do. Appreciative practitioners who work from this perspective focus more on uncovering and amplifying the *“positive core”* of the organisation (Bushe & Kassam 2008: 68).

The second prescription that distinguishes AI from traditional change management and organisational development practice is that it avoids creating plans and processes for *“implementing agreed-upon change”*; rather, it *“creates plans and processes that encourage and nurture improvised action by system members”* (Bushe & Kassam 2008: 68). By allowing this transformational process to operate from ground up to create systems for supporting local initiatives taken without consensual or hierarchical validation, more change takes place much faster than can occur from any attempt to control and implement something new (Bushe & Kassam 2008: 69).

## 2.5.2 Strategic planning

Strategic planning is done by organisations to plan the actions in order to achieve their goal and objectives (Sutherland & Stravos 2003: 8). Strategic planning is done by organisations on a yearly basis when they plan activities that should be followed by employees. According to Srdjevic, Bajcetic and Srdjevic (2012: 3380), a strategic plan assists in exploring the future direction of an organisation. The plan guides employees on how to achieve the goals and objectives of the organisation; therefore, the employees must perform their daily activities based on that plan. An example is the co-standards that must be exactly followed by all employees in any organisation to instil good practice standards competency.

Different categories of employees should be involved in the planning process of a strategic plan as stated by Harmon et al. (2012: 119). The strategic plan is a yearly plan where organisations plan ahead for the future. The top and middle management as well as lower categories are usually involved in the planning. The strategic planning is very important in organisations as the operational plans must be in line with it; that is, we have to operationalise it so that lower categories can better understand it. Its main objective is to meet the organisation's goals and objectives.

Two main AI approaches can be used when conducting a strategic planning sessions in organisations; it can be either the SWOT or the SOAR approach. Srdjevic, Bajcetic and Srdjevic (2012: 3380) mention that the acronym SWOT derives its name from the words **S**trength (**S**), **O**pportunities (**O**), **W**eaknesses (**W**) and **T**reats (**T**). The SOAR represents **S**trength (**S**), **O**pportunities (**O**), **A**spirations (**A**) and **R**esults approach (Havens, Woods & Leeman 2006: 2).

Table 2.1 illustrates the differences between the SWOT and the SOAR approaches to strategic planning.

**Table 2.1: Overview of the SWOT and SOAR approaches**

Model	Focus	Content
<b>SWOT</b>	Internal appraisal	<b>Strengths</b> <ul style="list-style-type: none"> <li>• Where can we outperform others?</li> </ul>
		<b>Weaknesses</b> <ul style="list-style-type: none"> <li>• Where others can outperform us</li> </ul>
	External appraisal	<b>Opportunities</b> <ul style="list-style-type: none"> <li>• How we might explore the market</li> </ul>
		<b>Threats</b> <ul style="list-style-type: none"> <li>• What/Who might take our market?</li> </ul>
<b>SOAR</b>	Strategic inquiry	<b>Strengths</b> <ul style="list-style-type: none"> <li>• What are our greatest assets?</li> </ul>
		<b>Opportunities</b> What are the best possible market opportunities?
	Appreciative intent	<b>Aspirations</b> <ul style="list-style-type: none"> <li>• What is our future preference?</li> </ul>
		<b>Results</b> What are the measurable results?

The SWOT and SOAR approaches are briefly discussed in Sections 2.5.2.1 and 2.5.2.2

### 2.5.2.1 SWOT approach

According to Cooperrider et al. (2008: 16), organisations have been using a deficit-based approach to problem solving since the 1930s. This approach begins by diagnosing the problem identified as “*the weakest link*”. It is a problem-solving approach to organisational change and the questions which are asked focus on the challenges, gaps and problems within the organisation (Hall & Hammond 2004: 1).

The **SWOT** (**S**trength, **O**pportunities, **W**eaknesses and **T**reats) approach is a tool that has been developed for strategic analysis and consists of the continuous evaluation of the confrontation between external development and internal capabilities. The external development is identified as the opportunities or threats for the organisation while the internal developments are identified as the strong or weak points of the organisation. In SWOT the negative aspects (weaknesses of and threats to the organisation) are mixed with the positive (strengths of and

opportunities for the organisation) from inside and outside (Kajanus et al. 2012: 2; Srdjevic et al. 2012: 3392; Uhrenfeldt et al. 2012: 7).

Srdjevic et al. (2012: 3392) posit that the identification of a relevant set of criteria for assessing alternatives and selecting the most desired one is an important issue in any criteria analysis. These authors indicate the SWOT analysis comprises a list of factors that can be used for assessing alternatives and selecting the decision criteria. Also, this analysis is used for identifying the key factors to assess the major aspects that impact on business performance (Uhrenfeldt et al. 2012: 7). In the opinion of de Bono and Heller (2006: 1), the SWOT analysis is one of the most trusted evaluation tools by management since it promotes the elimination of weaknesses by capitalising on the strengths and opportunities and thereby preventing the threats.

In this study the strengths were the positive factors that the healthcare professionals employed during their management of the adult female rape survivors in the emergency unit. The weaknesses referred to the negative factors involved in their management which needed some improvement. Optimising what was good and excellent about the management were the opportunities which included the fulfilment of the wishes of the female rape survivors with regard to female rape survivors' future management. The threats were the weaknesses, for example, long waiting times and a shortage of staff that the female rape survivors were exposed to during their management by healthcare professionals in the emergency.

### **2.5.2.2 SOAR approach**

Appreciative Inquiry follows a strength-based approach when undertaking strategic planning in an organisation by using the **SOAR (Strength, Opportunities, Aspirations and Results)** approach (Havens et al. 2006: 2). Unlike the traditional problem-solving approaches that separate and dissect pieces of a system, AI generates images that affirm the forces that give life and energy to the system (Hall & Hammond 2004: 1)

In the opinion of Havens et al. (2006: 2), SOAR offers a positive alternative to the well-known SWOT model because AI's primary strength focuses on the SOAR approach rather than on the traditional SWOT model (Havens et al. 2003: 6).

Whitney and Trosten-Bloom (2003:54) emphasise that AI is based on questions and dialogues about strengths, successes, values, hopes and dreams; it focuses on the positives and not the negatives. Appreciative Inquiry focuses on “*what is working*”, “*has gone well*” and “*does not need to be fixed*” (Stefaniak 2007: 43). In agreement with this statement, van Vuuren and Crous (2005: 25) add AI focuses on what “*can be*” and not on “*what was*”.

### 2.5.3 Appreciative Inquiry in nursing

A study done by Stefaniak (2007: 42) at the University of Kentucky Children’s Hospital in the USA indicated that the history of nursing shows there has always been a positive inclination towards formulating or appropriating new ideas, innovations and leadership practices to supplement professional nurse development and autonomous nursing practice. Stefaniak (2007: 43) used an AI approach in the study to provide nurses with an opportunity to reflect on their professional practice and identify what “*works well*” in their environment, and to explore what more they needed to perpetuate what was already working well.

According to Harmon et al. (2012: 119), nursing schools and institutions need an inclusive method to “*engage everyone, promote ownership and to jumpstart change*”. Appreciative Inquiry, although new to nursing, is frequently used to achieve change quickly. Spence, Garrick and McKay (2012: 409) found that the decision to “*use the AI approach for a bachelor’s degree in Health Science was initiated to evaluate possible changes that could be implemented in the mental health component of the nursing programme*”. Spence et al. (2012: 409) further assert that “*the changes were necessary because the nursing students were not getting enough exposure for this component*”. The decision to use an AI approach to evaluate these changes was congruent with the collaborative and generative way in which the curriculum changes had been developed, hence, a dialogue was encouraged among the stakeholders to affirm and generate ideas for further improvement in the preparation of undergraduate nursing students for practice in the mental health settings (Spencer et al. 2012: 410). According to Havens et al. (2006: 464), AI is used by nurses in

hospitals to conduct interviews regarding communication or collaboration so that staff nurses can be involved in decision-making about nursing practice and care.

In the United Kingdom (UK), the Department of Nursing used AI in four institutions in the country for different reasons (Havens et al. 2006: 465). One example is that in the Children's Hospital of Philadelphia (CHOP), AI was used to shape an initiative called "*Be part of our journey – There is no place like CHOP*". Nurses articulated a desired future for the Department of Nursing with their stories of excellence, co-operation and strengthened unity within the department which fuelled the initiative and subsequently it earned them recognition as an American Nurses Credential Centre Magnet Hospital (ANCCMH). In another initiative, the University of Kentucky Hospital (USA) initiated "*Nursing Excellence – The UK Way*" to produce a positive change in customer service where, according to Havens et al. (2006: 466), AI became part of the everyday life in that hospital. In a study conducted by Havens et al. (2006: 463), AI was used as a "*methodology for making a positive organisational change*" whereby six community hospitals were involved to improve communication and collaboration in nursing as nurses were involved in decisions making regarding patient care.

In this study, AI was used to discover positive themes regarding what the healthcare professionals in both Area 1 and Area 2 in the emergency unit were doing right to help female rape survivors. It was observed that if the "*what works well*" in the "*now*" were "*discovered*" through appreciative dialogue and the cooperation of all stakeholders, it could drive the "*what should be*" dream towards "*excellence*" in the future management of female rape survivors.

## 2.6 ADVANTAGES

According to Reed (2007: 3), the definition of a future state and how to achieve AI are rooted in organisational members' collective knowledge about what has worked in the past based on the organisation's strengths. Appreciative Inquiry works because it takes advantage of a well-known principle in psychology, namely that when individuals focus on past successes they experience an increased intrinsic

motivation to act (Reed 2007: 3). Appreciative Inquiry has the advantage that people are included in the research methodology, and people can learn from their past experiences and successes; AI is an interactive process and involves individuals, organisations and/or communities when transformation (a change) is envisioned and desired to be achieved (Roberts 2010: 14).

## 2.7 INTERVENTION MODELS

The main intervention model that is associated with AI is the 4-D cycle (Cooperrider et al. 2008: 55). The 4-D cycle is an elaboration of the principles for the practice of AI. The cycle begins with **Discover**, (“*appreciating what is*”) followed by **Dream** (“*imagining what could be*”) which leads to **Design** (“*determining what should be*”) and, finally, **Destiny** (“*creating what would be*”). The process of inquiry that defines AI practice is the collection of stories from system members and their stakeholders about their best experiences (Bushe & Kassam 2008: 49).

As mentioned before, Bushe and Kassam (2008: 47) note two prescriptions for AI practice that distinguishes AI from other organisational change and developmental methods. The first is that of creating a “*new ground*” wherein a much wider range of new possibilities emerge for the way system members think about things and do things; ground is about “*the substructure that influence what people think and do.*” Appreciative practitioners working from this perspective focus more on uncovering and amplifying the “*positive core*” of the organisation (Bushe & Kassam 2008: 68).

The second prescription distinguishing AI from traditional change management and organisational development practice pertains to the avoidance of creating plans and processes for implementing agreed-upon change. Rather, from the AI perspective, creating plans and processes that encourage and nurture improvised action by system members are the essence. Bushe and Kassam (2008: 69) observe that by allowing this transformational process following a bottom-up approach, systems are created where there is no hierarchical validation, leading to more and faster change.

## 2.8 LIMITATIONS

Reed (2007: 64) states that Ai is less effective in organisations where the people hold deeply seated and unexpressed resentments. This limits their ability to imagine a positive future, especially if the resentment is associated with an element of real or perceived unfairness that is not addressed. According to Bushe (2001) (cited in Reed 2007: 68), AI foregoes the value of negative images, which are eliminated from discussions. Appreciative Inquiry furthermore relies on a subset of all information as a basis for making choices (Reed 2007: 69).

## 2.9 CONCLUSION

Appreciative Inquiry was defined and a brief overview of its history was presented. The models of AI as well as the principles that guide this research methodology approach were described. Chapter 3 focuses on the research design and methods used in the study.



## 3 RESEARCH DESIGN METHODOLOGY

### 3.1 INTRODUCTION

In Chapter 2 an overview of Appreciative Inquiry was provided. Chapter 3 deals with the research methodology of the study. The research design and methods used to address the aim and objectives are discussed in depth. The research methods specifically focus on the setting, population, sampling, and the data collection technique and data analysis. The strategies implemented to enhance the rigor of the study are discussed. The ethical considerations that guided the study are summarised. Due to the sensitive nature of the study, strict adherence to these considerations was maintained throughout the research process.

### 3.2 RESEARCH METHODOLOGY

Research methodology is a way of systematically solving a research problem, that is, a science of studying how a research is done scientifically (Mbambo 2009: 36). In this study Appreciative Inquiry (AI) was used as the research method. The 5-D model of AI links the energy of the positive core to changes never thought possible in organisations (Cooperrider et al. 2008: 3; Trajkovski et al. 2013: 1226). The model involves 5 components, namely, **D**efine (affirmative topic of choice), **D**iscovery, **D**ream, **D**esign and **D**estiny (Cooperrider et al. 2008: 5) and is discussed in Sections 3.2.1 to 3.2.5. The 5-D cycle was used as the research methodology in this study. The application thereof is depicted in Figure 3.1.

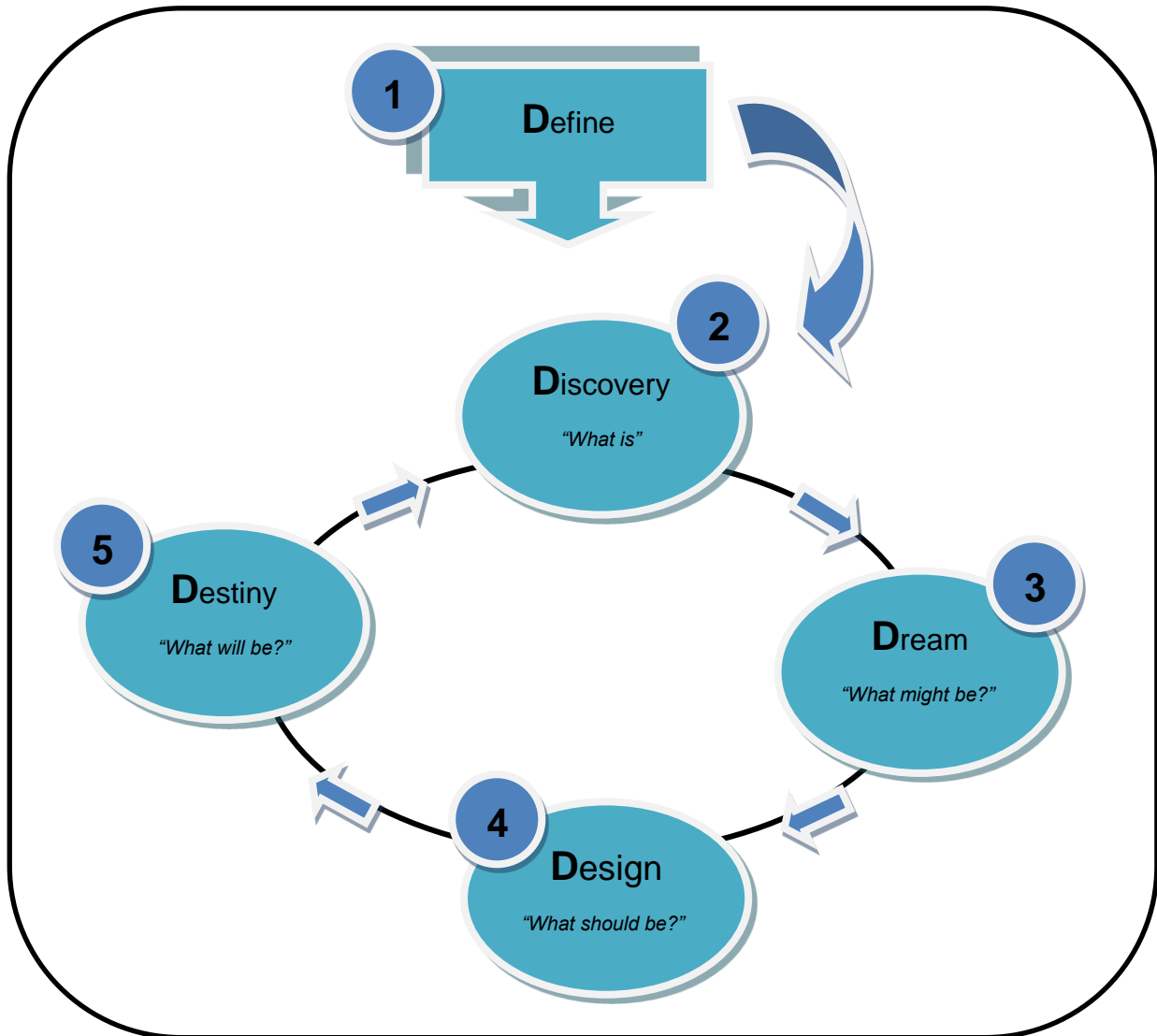


Figure 3.1: Appreciative Inquiry 5-D cycle (adopted from Cooperrider et al. 2003: 3)

Appreciative Inquiry is based on the assumption that every organisation has something that *works well*; things that we focus on become a reality where language and dialogue influences our reality and these strengths can be the starting point for creating positive change (Trajkovski et al. 2013: 1225). The AI model was introduced as a 4-D model consisting of four components, namely, **D**iscovery, **D**ream, **D**esign, and **D**estiny, and was founded by Cooperrider and his colleagues during their work at the Cleveland Clinic (Cooperrider et al. 2008: 3; Trajkovski et al. 2013: 1225). The 4-D cycle is used in various ways, for example, to guide conversations, and to serve as a framework for personal development and coaching (Whitney & Trosten-Bloom 2010: 6).

The 4-D cycle begins with the thoughtful identification of what is to be studied. The affirmative topic of choice is thus considered an important component of the process of AI and suggests that “*the seeds of change are implicit in the first question asked*” (Trajkovski et al. 2013: 1225; Whitney & Trosten-Bloom 2010: 7). But, because the topic of choice was defined, Cooperrider et al. (2008: 8) added a fifth ‘**D**’, namely ‘**Define**’ for the affirmative topic of choice. Hence, another ‘**D**’ was added to the 4-D cycle and the 5-D model of AI subsequently emerged.

The 5-D model of AI links the energy of the positive core to changes never thought possible in organisations (Cooperrider et al. 2008: 3: 103; Trajkovski et al. 2013: 1226). Appreciative Inquiry searches and finds out what an organisation is doing right, explores how it happened and how to do more of it, instead of focusing on the “*bad*” or the negative aspects of the organisation (Manley & Shaw 2002: 161). The model involves 5 components, namely, **Define** (affirmative topic of choice), **Discovery**, **Dream**, **Design** and **Destiny** (Cooperrider et al. 2008: 5). These five components of AI are discussed in Sections 3.2.1 to 3.2.5.

### 3.2.1 Define

Appreciative Inquiry is based on the premise that an organisation will grow in the direction of which present questions are asked. Defining the focus of inquiry, or the phenomenon (also referred to as the ‘affirmative topic of choice’), will begin with the constructive discovery and narration of the organisations’ life-giving stories that are stated in a positive, desirable way and identify with the objectives that people want (Cooperrider et al. 2008: 35; Trajkovski et al. 2013: 1226). This view is consistent with the view of van Vuuren and Crous (2005: 20) and Stowell (2012: 18).

Defining the focus of inquiry requires searching for the positive description of “*what is desired*” (Whitney & Trosten-Bloom 2010: 52). **Define** is considered as the first step in guiding the process; it leads to the 4Ds and is an additional “*definition phase*” in which the focus of inquiry, or the phenomenon, needs to be positively explored. If this first step of inquiry is not initiated in a positive manner, the problem may

escalate. Van Vuuren and Crous (2005: 20) and Trajkovski et al. (2013: 1226) also agree with this view.

In this study the healthcare professionals working in the emergency unit first discussed and then agreed that 'enhancing patient-centred approach for female rape survivors in the emergency unit' would be the focus of inquiry. The researcher defined the problem in the emergency unit and provided a background to support the problem statement (view Sections 1.2 and 1.3). In AI, once the focus of inquiry has been defined, questions guide the remaining four Ds, namely, **Discover** (appreciating "*what is*"), **Dream** ("*what might be*"), **Design** ("*what should be*") and **Destiny** ("*what will be*").

### 3.2.2 Discover

The primary task in the **Discover** component is to identify and appreciate the best of "*what is*". People seek to uncover and learn from time and situations when the organisation is at its best. This is done by sharing stories of exceptional accomplishments, discussing the core life-giving factors of their organisation, and deliberating on the aspects of their organisation's history that they most value and want to bring forward to their work in the future (Cooperrider 2008: 45). The focus of the discovery component is to provide insights and explore the phenomena through the generation of affirmative stories (Trajkovski et al. 2013: 1226).

The goal in the discovery component is to identify and appreciate the best of "*what is*" and "*what works*" in an organisation (Sandoval & Campos 2013: 1028). Once the appreciative elements have been uncovered, individuals and groups discern from memories, shared history, stories and data "*what values, beliefs and assumptions support a desired future*" (Keefe & Pesut 2007: 105). During the **Discover** component the goal is to become open to "*what is*", engage in dialogue and make meaning of the positive successes derived from "*what is*". Subsequently, consensus begins to emerge whereby an individual appreciation becomes a collective appreciation and an individual vision becomes the shared vision for the organisation (Keefe & Pesut 2007: 105; Pretorius et al. 2013: 79). The purpose of the **Discover**

component is to explicitly recognise what works and valuing those things that are worth valuing in an organisation (Cooperrider et al. 2008: 45; Cram 2010: 5).

In this study the female rape survivors were encouraged to indicate the healthcare professionals' management interventions in the emergency unit that were excellent. (View Annexure C). Based on their individual experiences when managed in the emergency unit, the participants (the female rape survivors) gave concrete examples such as "*they know how to treat people*" and "*I felt like I was the only person*".

### 3.2.3 Dream

The **Dream** component amplifies the positive core and challenges the status quo by envisioning more valued and vital futures than those that are currently envisioned by organisational members and stakeholders. The primary purpose of the **Dream** component is to expand or extend people's sense of what is possible. It is a practical component and is grounded in the organisation's history. It is also generative in that it seeks to expand the organisation's potential; thus, exploring "*what might be*" as it builds on the outcomes of the discovery phase but keeps the voices and hopes of its stakeholders in mind (Cooperrider 2008: 44; Trajkovski et al. 2013: 1226). Stefaniak (2007: 43) supports Keefe and Pesut's (2004: 106) view that in this component the participants will explore their hopes and dreams of "*what might be*".

The **Dream** component is a time for key stakeholders to collectively share their stories of the organisation's past and their historical relationship with the organisation. During this component the researcher engages with the participants on a one-to-one conversation about the organisation's position and her visualisation of new possibilities which relates to passionate thinking and a preferred future (Cooperrider 2008: 45; Pretorius et al. 2013: 81). The **Dream** component amplifies the positive core of AI, indicating the best of the past and envisioning a desired future (Cram 2010: 6).

In the present study the dream pertained to the current position of the healthcare professionals working in the emergency unit, how the female rape survivors

envisioned the future management of rape survivors. They envisioned a potential future with possibilities beyond the realm of present day thinking, which included patient-centred approach (Cooperrider et al. 2008: 84). (View Annexure C).

### 3.2.4 Design

The **Design** component is concerned with the collective construction of positive images of the organisation's future. It includes designing future plans based on the multiple positive dreams and possibilities emerging from the dream phase based on "*a chosen social architecture which helps to move the system to positive action on and intended results*" (Cooperrider et al. 2008: 46). Successful design involves identifying the needs that have to be designed and crafting the provocative propositions that integrate the **Discovery** and **Dream** ideals into the elements, and focusing on sustaining the desired envisioned future (Cooperrider et al. 2008: 46; Pretorius et al. 2013: 84; Trajkovski et al. 2012: 1226).

This component delivers an organisation to its destiny "*through innovation and action, discussing 'what should be' and what will innovate*" (Sandoval & Campos 2013: 1028). "*Appreciative Inquiry establishes a momentum of its own by seeking an imaginative and fresh perception of organisations (as if seen for the very first time), the appreciative eye takes nothing for granted but seeks to apprehend the basis of organisational life and works to articulate the possibilities for a better existence*" (Cooperrider et al. 2008: 46).

The **Design** component creates a context in which the group generates a plan to achieve the ideas that answers the question "*what should be*", hence directing their attention and action to becoming the designers of their future with the focus on the creation of "*mission*" – focus goals and plans that would define the future they most desire (Keefe & Pesut 2004: 107; Pretorius et al. 2013: 84).

As suggested by Havens et al. (2006: 465) and Reed (2007: 33), during the **Design** component, the female rape survivors in this study looked at the actions that needed to be in place for the dream (in this study it referred to a patient-centred approach) to

become a reality. These actions related to “*what should be*”. (View Annexure E). The female rape survivors were given an opportunity to indicate the actions that should be implemented in the emergency unit based on their experiences.

In this study strategies regarding the future management of female rape survivors were developed and put into a plan, for example, increasing human resources at the crisis centre so that Area 1 (emergency unit) can operate for 24hours without interruption and Area 2 (crisis centre). The information must be correct and consistently used! emergency unit) can only assist physically ill and injured patients.

### 3.2.5 Destiny/Delivery

The fifth “**D**” includes the creation of a vision; a set of tangible goals and outcomes or “*what will be enabling brilliance and the realization of dreams*” (Keefe & Pesut 2004: 108; Pretorius et al. 2013: 84). The key concept in this component is to sustain momentum and build an “*appreciative eye*” into the entire organisation’s system, procedures and ways of working. “*Provocative propositions may require an organisation to redesign its processes and systems in this component of inquiry. This component delivers on new images of the future and is sustained by nurturing a collective sense of purpose*” (Cooperrider et al 2008: 47).

Furthermore, there is a time for continuous learning, adjustment and improvisation. The momentum and potential for innovation and implementation are extremely high. Because of the positive image of the future, everyone is invited to align her or his interaction to co-create the future. During this component the stakeholders are typically invited into an open space planning and commitment session. The **Destiny** (or **Delivery**) phase is ongoing and will bring the organisation back to the full cycle of **discovery** (Cooperrider et al. 2008: 47).

The **Destiny** delivers new images of the future. Based on the findings obtained from the female rape survivors in this study, the researcher made recommendations (view Chapter 5) which healthcare professionals can utilise in future to manage female

rape survivors in the emergency unit; thus moving from a disease-centred towards a patient-centred approach (Preskill & Catsambas 2006: 20).

### 3.3 RESEARCH DESIGN

The research design refers to the overall plan for obtaining answers to the research question, including specifications for enhancing the study's integrity (Polit & Beck 2008: 765; Brink et al. 2010: 45). Mbambo (2009: 36) refers to the research design as the blueprint for conducting the study in a way that maximises control over the factors that could interfere with the validity of the research results. In this study the qualitative, explorative and descriptive design used is discussed in Sections 3.3.1 to 3.3.3.

#### 3.3.1 Qualitative design

Polit and Beck (2008: 763) describe a qualitative research design as the investigation of a phenomenon in an in-depth and holistic fashion. It is the collection of rich narrative materials using a flexible research design. According to LoBiondo-Wood and Haber (2010: 85), qualitative research is discovery-orientated, explanatory and descriptive in nature and makes the words of individuals visible to the rest of the world. Qualitative studies are grounded in the real-life experiences of people who have first-hand knowledge of a phenomenon.

Creswell (2009: 4) further defines a qualitative research design as "*a means for exploring and understanding the meaning of individuals or groups ascribe to a social or human problem*". In the opinion of Ospina (2004: 3) and Graebner, Martin and Roundy (2012: 278), a qualitative research design seeks to understand a given research problem from the local population's perspectives.

Qualitative research is a planned, ordered inquiry in which researchers follow rules to describe life experiences to acquire a better understanding of such experiences and give it meaning. Qualitative research focuses on the meaning and interpretation of the participants (Holloway & Wheeler 2010: 59). The AI refers to quality. In the



current study the adult female rape survivors (the individuals or population) who were managed in the emergency unit following the rape incident were interviewed to obtain their views regarding the management they had received in the emergency unit.

### 3.3.1.1 Characteristics

Merriam (2009: 14) notes the identified four main characteristics relating to qualitative research designs. In Table 3.1 these four characteristics are indicated. The table also indicates how the four characteristics of qualitative research were applied in the study.

**Table 3.1: Characteristics of qualitative research**

Characteristics	Explanation	Application
Focus on meaning and understanding	Qualitative researchers are interested in how people interpret their experiences. Their aim is to achieve an understanding of the phenomenon from the participant's perspective. (Merriam 2009: 14).	Using an AI interview guide, adult female rape survivors were interviewed on a one-to-one basis to obtain their views regarding the management received in the emergency unit. <b>(View Annexure C).</b>
Researcher as the primary instrument	The researcher can expand his or her understanding through verbal and non-verbal communication, can process information immediately, clarify and summarise material, and check with participants for accuracy. (Merriam 2009: 15).	The researcher collected the data, transcribed the data and re-listened to the interviews on the audio-recorder. The researcher then analysed the data with the assistance of the independent coder, derived themes, categories and sub-categories. The findings were discussed with the co-coder and verified by a literature control. <b>(View Sections 4.3; Table 4.2; Annexure D and F)</b>

Characteristics	Explanation	Application
An inductive process	The researcher works from the particular to the general. The findings that are inductively derived from data in a qualitative study are in the forms of themes and categories. (Merriam 2009: 16).	During data analysis, the researcher grouped similar themes into categories and sub-categories. Working according to the inductive process provided her an opportunity to obtain the data from the adult female rape survivor herself. ( <b>view Section 4.3 &amp; Table 4.2</b> ).
Rich description	Words and pictures rather than numbers are used to convey what the researcher has learned about the phenomenon. Data in the form of quotes from the participants' interviews are always included in support of the findings. (Merriam 2009: 16).	The verbatim quotations from the participants and a literature control were used to support and validate the adult female rape survivors' views. ( <b>View Section 4.3</b> ).

*Source: Merriam (2009: 16)*

### 3.3.1.2 Rationale

For the purpose of this study a qualitative research design was used as opposed to a quantitative research design. Qualitative researchers are concerned with the opinions, experiences and feelings of the individuals who produce the data (Hancock 2002: 3), and the meaning that people bring to them (Merriam 2009: 13). The researcher also opted to choose a research design which enabled her to communicate with the female rape survivors about their views relating to the management they received in the emergency unit. The qualitative research design is regarded as a flexible method which can be adapted at any time during data collection as it is an emergent design (Polit & Beck 2012: 739) which made the qualitative design attractive as it provided an opportunity for the researcher to adapt the strategies to collect data if it became problematic.

Henning (2004: 10) states the instrument of research in a qualitative research design is the human mind. In brief, this means researchers using a qualitative design become fully immersed in the data collection process since they are the instrument through which the data are collected. Burns and Grove (2005: 539) ascertain that the researcher as a whole person becomes involved by “*perceiving, reacting, interacting, reflecting, attaching meaning, and recording*”. As the researcher works from the particular to the general, he or she connects, combines and orders in his or her mind all the bits and pieces of information from the participants’ interviews and observations into larger themes (Merriam 2009: 15).

In this study the participants were adult female rape survivors. They were interviewed individually on a one-to-one basis to obtain different views (pieces of information) to advise how future services rendered to adult female rape survivors in the emergency unit could be improved. The analysis of the varied data resulted in the construction of coherent and understandable findings. The researcher envisioned that these findings would result in raising a possible awareness among the healthcare professionals what the views and needs of the female rape survivors are. The strategies were developed to guide practice and future management towards a more patient-centred approach. The healthcare professionals had the opportunity to implement the wishes suggested by the female rape survivors to move from a disease-centred to a patient-centred approach in the emergency unit (in both Area 1 and Area 2).

Qualitative research methods aim to study things in their natural setting, attempting to make sense of or interpret a phenomenon in terms of the meanings people bring to it (Boet et al. 2012: 165). In qualitative research the relationship between the researcher and the participants is less formal because the participants have an opportunity to respond more elaborately and in greater detail (Ospina 2004: 5). The participants in the current study were able to express themselves freely because of the type of questions that were asked. The AI guide had unstructured, open-ended questions and not closed-ended as the latter limits the participant to a “No” or “Yes” response. (View Annexure C).

Appreciative Inquiry dialogue made it possible for the researcher to listen to the female rape survivors and involve them in sharing their views on the management received. She could involve them in making suggestions to improve future management of female rape survivors and moving from a disease-centred to patient-centred approach. By asking questions and listening, the researcher was able to understand the realities of the participants. An interview guide was utilised to guide the dialogue between the researcher and the participants as suggested by Streubert Speziale and Carpenter (2007: 21) and Creswell (2007: 136).

Qualitative researchers are interested in understanding how people interpret their experiences, how they construct their words and what meaning they attribute to their experiences (Merriam 2009: 5). In this study the researcher wanted to find out from the female rape survivors how they valued the management they received at the emergency unit, and how they valued the healthcare professionals that assisted them after the rape incident. The researcher based her study on a positive stance to help her to move the management of female rape survivors from a disease-centred (or medical-centred) towards a patient-centred approach.

The following additional reasons based on the work of Ospina (2004: 10) guided the researcher to use a qualitative research design for the study:

- to enable the researcher to explore the views of female rape survivors regarding the management they received in the emergency unit as such a study had not been researched in the setting before
- to add rich detailed data on the views of female rape survivors regarding the management they received in the emergency unit
- to better understand the research topic
- to advance a novel perspective of the views of female rape survivors regarding the management they received in the emergency unit that was not based on research conducted previously
- to understand the complex phenomenon that is difficult or impossible to approach or capture quantitatively.

### 3.3.2 Descriptive design

According to Polit and Beck (2008: 752), the main objective of a descriptive research design is to accurately portray the characteristic of persons, situations, or groups and/or the frequency with which certain phenomena occur. Qualitative descriptive designs “*tend to be eclectic and are based on the general premise of naturalistic inquiry*” (Polit & Beck 2012: 226). Brink (2003: 11) asserts that the descriptive approach aims to “*obtain complete and accurate information about a phenomenon through observation, description and classification*”. This means the descriptive design allows for new information about the phenomenon to emerge and be recorded.

The researcher used the descriptive design to explore information about the participants’ perceptions so that these perceptions could be described in order to understand the view of the female rape survivors. The research findings were then utilised to make recommendations to move current practice towards excellence; thus, moving from a disease-centred or medical-centred approach to a patient-centred approach and answering the research question.

Descriptive designs are designed to gain information about characteristics within a particular field of study (Burns & Grove 2005: 232). These designs provide a picture of situations as they naturally occur. The female rape survivors were interviewed to find out or discover how the management of future rape survivors could be enhanced. Through AI dialogue, the female rape survivors were able to give their views regarding the management that they had received; they were afforded an opportunity to voice their wishes for the future management of female rape survivors in an emergency unit after the rape incident.

## 3.4 RESEARCH METHODS

The research methods refer to data gathering (Botma et al. 2010: 199). The research methods are discussed in terms of the population, sampling, sample, the research

setting, data collection, data analysis, relationships and rigour (trustworthiness). The research methods used in the study are discussed in Sections 3.4.1 to 3.4.8.

### 3.4.1 Population

Polit and Beck (2008: 761), Botma et al. (2010: 200) and Mbambo (2009: 36) describe population as the entire set of individuals conforming to specifications and which is of interest to the researcher and to whom the results can be generalised. This set of individuals possesses the characteristics as set by the inclusion criteria for participation in the study. The population comprised of female rape survivors who were assisted in the emergency unit (Area 1 and Area 2). The population in this study had to meet the inclusion criteria set out below.

#### 3.4.1.1 Inclusion criteria

The population in this study were selected according to the inclusion criteria stated hereunder.

- Females who had been admitted and managed in an emergency unit in a province, North West, following a rape incident.
- Females had to be older than 18.
- The rape incident and emergency treatment had to have occurred least three months before the interviews would take place, as suggested by the counsellor
- Rape incident must have taken place between 1 October 2010 and 31 May 2012
- Participants had to understand and speak English

### 3.4.2 Sampling

Sampling is the process of selecting a research sample from a given population to develop a rich understanding of the phenomenon (Polit & Beck 2008: 337). According to Burns and Grove (2005: 747), the “*conscious selection*” of participants

for research studies concentrates the attention of the researcher on the phenomenon that is being studied.

### 3.4.2.1 Purposive sampling

The purposive sample (also referred to as selective or judgemental sampling) is based on the judgement of the researcher to select those individuals that are knowledgeable about the phenomenon under study (LoBiondo-Wood & Haber 2010: 90). The participants that were selected were female rape survivors who were admitted and managed during the inclusive period of data collection (October 2010 to May 2012) at the emergency unit in the specific hospital in North West.

The researcher, in collaboration with the counsellor, was able to identify individuals who were mentally sound and stable at the time the study was conducted and who would therefore be suitable for interviews. The selected participants were able to provide narrative data that were relevant, rich in meaning and which could contribute to a better understanding of the views of adult female rape survivors on the management they had received in the hospital's emergency unit as suggested by Burns & Grove (2005: 342).

### 3.4.3 Sample

A sample refers to a *“subset of a population selected to participate in a study”* (Polit & Beck 2010: 567). Although qualitative studies use small samples because of the sheer quantity of data that can be collected from in-depth interviews, a rich amount of data can be yielded even if the sample is small (Green & Thorogood 2004: 80). *“A qualitative research study's theoretical richness is not dependent on the number of participants included in a study, but rather on the quality and depth of the descriptions of the experiences that the participants describe. It is the density and relevance of these experiences that will enable the researcher to distil richness, texture and coherence from the data”* (Holloway 2005: 74).

When this study was undertaken, the researcher worked (and still works) at the emergency unit in the particular hospital in North West. The researcher decided to choose a purposive sample of the female rape survivors who had visited Areas 1 and 2 in the emergency unit. Not all female rape survivors had a chance to be included in the study; only female rape survivors who were 18 years and older were allowed to participate in the study (view Section 3.4.1.1).

#### **3.4.4 Selection process**

Acknowledging the intimate and distressing event the female rape survivor had been exposed to, the researcher aimed to pursue a rigorous process to gain access to the participants. The process is therefore discussed in-depth and reflected in Figure 3.1. Firstly, the researcher obtained approval from (1) the Research Ethics Committee of the Faculty of Health Science at the University of Pretoria and (2) from the public hospital management where this study was conducted.

Secondly, the participants were selected by the counsellors before they were referred to the researcher. Every patient who was managed after a rape incident in the emergency unit was referred to a counsellor prior to discharge. In order to select the best possible sample for this study, the researcher collaborated with the counsellors to assist with recruitment and enrolment of the most suitable participants. The counsellors were briefed about the study, the aim and the value thereof was emphasised. The counsellors identified and contacted individuals who met the inclusion criteria.

Once identified as a potential participant, the counsellor contacted the individual within approximately three months after the incident and told her about the proposed study. The counsellor asked permission of the participants that were willing to participate in the study to reveal their names and contact details to the researcher. However, those participants that wished to remain anonymous agreed upon a pseudonym with the counsellor that was used during contact with the researcher. The counsellor then negotiated a time and date during which the researcher could contact the participant. Rape survivors who indicated that they did not wish to



participate, was thanked for considering the option and their details were not conveyed to the researcher. Only at this stage was the researcher allowed to have access to the participants, and the interview was arranged at a date and time that suited both parties. Written informed consent was obtained from the participants before initiating the interview.

The following figure, Figure 3.1, indicates how the researcher gained entry into the setting.

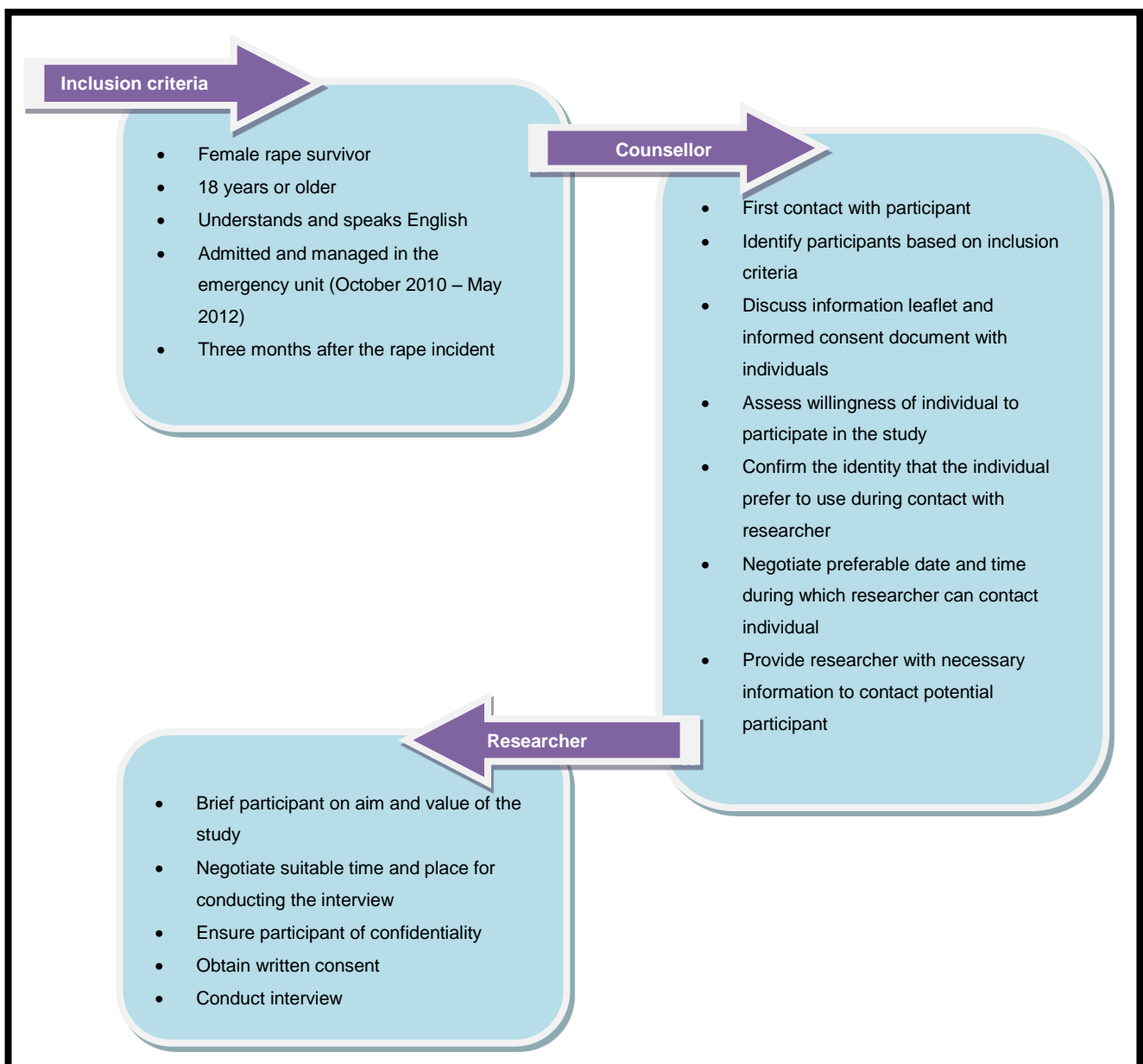


Figure 3.1: Schematic representation of gaining access to conduct the interview

### 3.4.5 Data collection

Polit and Beck (2008: 751) describe data as pieces of information obtained in a study. Data collection was done by means of unstructured interviews as the researcher wished to obtain the participants' views of the management they received in the emergency unit.

The reason for using unstructured interviews and not structured ones was because an interview guide is used with the focus on the topic areas to be covered by the researcher. The sequencing of questions depends on the process of interview and the responses of each individual; therefore, the sequencing is not the same for each individual participant. In the case of this study a structured interview would not have been appropriate as it directs informants' responses (Holloway & Wheeler 2010: 90). The unstructured interviews conducted were audio-recorded. A referral system was available for counselling and/or debriefing of participants if required during or following every interview.

Brink et al. (2010: 141) describe the interview as a method of data collection in which the interviewer obtain responses during one-on-one encounters. The interview guide was used during one-on-one interviews with the female rape survivors (view Annexure C) because unlike questionnaires which use structured questions, the questions that were asked were not the same for each individual interviewee. The questions depended on the answers that the individual interviewee gave.

During the introductory phase the researcher explained the aim and value of the study, the role that the interview would play in the study and the approximate time required. The rationale for using an audio recorder was explained and the researcher indicated that she would make notes during the interview. The participants were reminded that they could withdraw at any time if they wished and that there would be no negative consequences if they decided not to continue (Botma et al. 2010: 207).

The following criteria as suggested by Botma et al. (2010: 200) and Morse (2000: 4) were taken into consideration by the researcher:

- the quality of data generated; it included paying attention to legible transcripts and clear audiotapes
- she paid close attention to the amount of useful information provided
- she continued with the interviews until data saturation was reached
- she confirmed with the co-coder and supervisors that data saturation had indeed occurred.

#### **3.4.5.1 Data collection instrument**

As indicated by Brink et al (2010:41) a data collection instrument is a device used to collect data. In this study an interview guide was the data collection instrument that the researcher used to collect data (view Annexure C). Using AI as a research methodology the discover, dream and design components guided the questions in the interview guide.

- “Think about the management you received in the emergency unit. Please share with me your most satisfying experience.”
- “What did you value about the management you received?” (Discover).
- “What did you value about the healthcare professionals (nurses and medical doctors) that assisted you?” (Discover).
- “What do you want for future female rape survivors managed in the emergency unit?” (Dream).
- “Share your wishes for the management of female rape survivors in the emergency unit in the future. What suggestions do you have for us as nurses and doctors working in the emergency unit to do in future?” (Design).

#### **3.4.5.2 Probing**

Probing is the technique used to obtain more information in a specific area of the interview (Burns & Grove 2009: 716). As indicated by Mariampolski (2001: 1), the

researcher followed the participant's answer or comment in order to find out more about it, for example, "tell me more" or "why was that?" Questions used to probe in order for the participants to elaborate on specific information included:

- "can you tell me more?"
- "why was that important to you?"
- "how did that affect you?"
- "how did the healthcare practitioners (nurse or medical doctor) support you?"

#### **3.4.5.3 Saturation of data**

Data saturation is described by LoBiondo-Wood and Haber (2010: 576) as "*a point when data collection can stop*". Data saturation was reached after 5 (five) interviews when no new data or information of importance to the study emerged and the various elements of all the themes and categories had been accounted for (Holloway & Wheeler 2002: 288; Polit & Beck 2010: 321). The 5 (five) interviews were sent to the independent co-coder for analysis. The researcher continued with interviews until she had interviewed 10 participants.

#### **3.4.5.4 Field notes**

Field notes are a short summary of observations made during data collection (LoBiondo-Wood 2010: 272). The field notes, as stated by LoBiondo-Wood and Haber 2010: 272), are usually taken to "*represent a narrative set of narrative notes intended to paint a picture of a social situation in a more general sense*". The researcher made field notes of what the participants said and noted emotions and gestures they made, such as frowning or nodding the head.

#### **3.4.5.5 Process leading to the interview**

The researcher recruited female rape survivors who were raped and managed at the emergency unit and came for a three monthly review through the counsellor's assistance. The counsellor identified the participants according to the inclusion criteria and contacted them, discussed the information leaflet with each individual

and assessed the willingness of the individual to participate in the study. The identity that the individual preferred to use during the interview was confirmed by the counsellor before the counsellor forwarded the contact information of each potential participant to the researcher.

The researcher then briefed the potential participant on the aims and value of the study telephonically. A suitable time and venue were negotiated with the participant for an interview. During the interview the researcher welcomed the participant and briefed her again about the objectives and the value of the study. The researcher explained the information leaflet and consent form (view Annexure B). The researcher then obtained a written informed consent from the participant and conducted the interview. Ten interviews were conducted and they took approximately 20 to 45 minutes each

### **3.4.6 Data analysis**

According to Polit and Beck (2008: 751), data analysis is the “*systematic organisation and synthesis of research data*”. Streubert Speziale (Streubert-Speziale??) and Carpenter (2007: 96) state data analysis requires researchers to “*dwell with or become immersed in the data*”. The interviews were transcribed verbatim, ensuring that the data transcribed were correct and reflected a full account of every interview (Botma et al. 2010: 2014). Qualitative analysis, as described by Polit and Beck (2010: 464), is a process of “*fitting together, making the invisible obvious and of linking and attributing consequences to antecedents*”.

Content analysis was used to analyse the data. Data analysis began when the researcher listened to the participants’ verbal descriptions, followed by her reading and re-reading the verbatim transcriptions. The researcher identified and extracted significant statements which were transcribed onto index cards. Content analysis is a procedure for the categorisation of verbal data in order to classify and summarise the information in a systematic manner (Elo & Kyngas 2007: 108).

The contents can be analysed on two levels (Elo & Kyngas 2007: 108). The basic level is a descriptive account of the data, that is, what was actually *said* by the participant. The higher level is interpretive and is concerned with what was *meant*, *inferred* or *implied* by the participant's response. In this study the researcher as well as the co-coder used the following eight steps of Tesch (cited in Creswell 2009: 293) for the data analysis:

- **Step 1:** The researcher made sense of the whole by reading the transcripts carefully and noting things (ideas, thoughts) that came to mind whilst reading and writing it down.
- **Step 2:** The researcher selected a random transcript and asked the question: "What is this about?" Notes were made in the margin if any thoughts came to her mind.
- **Step 3:** When she had completed this process with several transcripts, the researcher made a list of the topics that could be categorised as 'major topics', 'unique topics' and 'left-overs'.
- **Step 4:** Taking the categorised list of topics, the researcher returned to the data. The topics were abbreviated as codes and the codes were written next to the appropriate text. The researcher tried the preliminary organising scheme to see whether new categories and codes emerged.
- **Step 5:** The researcher reduced the topics to categories. Next, she decided on the most descriptive wording for these categories and then grouped similar topics (not categories/) together.
- **Step 6:** The researcher made a final decision about the topics, codes and categories.
- **Step 7:** Using the cut and paste method, the researcher put together all the information belonging to the same category.
- **Step 8:** The researcher began writing the report.

After the co-coder had verified the themes and categories, the researcher started to interpret the analysed text. She compiled a written account of the interpretations and used literature to support the research findings as suggested by Botma et al. (2010: 227).

### 3.4.7 Trustworthiness

In qualitative research trustworthiness refers to “*the methodological soundness and adequacy of a study*” (Holloway & Wheeler 2002: 54; Polit & Beck 2008: 39). Polit and Beck (2008: 768) define trustworthiness “*as the degree of confidence qualitative researchers has in their data*”. Validity and reliability in quantitative research is replaced by trustworthiness in qualitative research.

By thoroughly describing the background, problem statement, research question, aim and objectives and the study method the methodological soundness and adequacy of this study promoted its trustworthiness (Holloway & Wheeler 2002: 254; Polit & Beck 2008: 39). Trustworthiness which, according to Polit and Beck (2008: 768), pertains to the degree of confidence qualitative researchers has in their data, was ensured by using the strategies identified by Lincoln and Guba (Polit & Beck 2008: 539).

Trustworthiness is summarised in Table 3.1. The strategies to ensure trustworthiness are: (i) credibility (truth value), (ii) dependability, (iii) confirmability, and (iv) transferability and are described hereunder.

**Table 3.2 Summary of strategies to enhance trustworthiness**

Strategies	Explanation	Application
Credibility	<ul style="list-style-type: none"> <li>• Refers to the true reflection of the phenomenon (Polit &amp; Beck 2008:196)</li> <li>• Believability of the external readers (Koch 2006: 92)</li> </ul>	<ul style="list-style-type: none"> <li>• Prolonged engagement with the participants</li> <li>• Researcher is a trauma and emergency specialist nurse</li> <li>• Auditing and transcripts of data</li> <li>• Comprehensive field notes were taken</li> <li>• Data saturation was reached following 5 participants, where no new data emerged</li> </ul>

Strategies	Explanation	Application
Dependability	<ul style="list-style-type: none"> <li>Audited and stable process</li> </ul>	<ul style="list-style-type: none"> <li>An expert co-coder audited interpretations, themes, categories and sub-categories that emerged from the data and study findings</li> <li>Field notes contained rich descriptions of what transpired during the interviews</li> <li>All information was carefully recorded during field notes</li> </ul>
Confirmability	<ul style="list-style-type: none"> <li>Potential for congruency between two or more independent people</li> <li>Representation of participants' information are provided</li> <li>Findings not from the researcher's imagination</li> </ul>	<ul style="list-style-type: none"> <li>Independent coder involved</li> <li>Themes, categories, and sub-categories supported by direct quotations of the participants</li> <li>Findings kept for future academic reference</li> </ul>
Transferability	<ul style="list-style-type: none"> <li>Transferring data to other settings (Polit &amp; Beck 2008: 539)</li> </ul>	<ul style="list-style-type: none"> <li>Provision of thick description of study setting and findings</li> <li>Comprehensive field notes were taken</li> </ul>
Authenticity	<ul style="list-style-type: none"> <li>Faithfulness and fairness of the research (Botma et al. 2010:234)</li> </ul>	<ul style="list-style-type: none"> <li>Views of female rape survivors indicated</li> <li>Independent co-coder involved</li> <li>Prolonged engagement was ensured by taking 20 to 30 minutes before commencing the unstructured interview</li> </ul>

Each of the trustworthiness strategies are discussed in Sections 3.4.7.1 to 3.4.7.5.

### 3.4.7.1 Credibility (truth value)

Credibility refers to confidence in the truth of the data and its interpretation; credibility is about making sure that the study results are a true reflection of the phenomenon under study (Polit & Beck 2008: 539, 196). Credibility involves believability and taking steps to demonstrate credibility to the external readers. It is the opinion of Koch (2006: 92) that researchers should describe and interpret their experience to enhance the credibility of a research study.



In this study, credibility was ensured by the researcher's prolonged engagement in Area 1 and Area 2 of the trauma and emergency unit in the specific hospital. She has worked in this unit as a trauma and emergency specialist nurse for 10 years, holds a Bachelor of Nursing degree and a diploma in Trauma and Emergency Nursing, and is registered as a professional nurse. She was supervised at Pretoria University by the research expert who is also trained as a trauma and emergency specialist nurse at the Faculty of Health Science with extensive experience in trauma nursing care. Prolonged engagement also promoted data saturation (Polit & Beck 2010: 495)

Using multiple data sources further enhanced the credibility of this study. The researcher interviewed multiple key participants (10 adult female rape survivors) about the same topic. An audit trail and the interview technique (using multiple data collection methods such as semi-structured interviews and taking field notes) ensured credibility in this study (Tobin & Begley 2004: 392). Credibility of the data was also established by allowing the participants to revise their interviews as a check (member checks) as indicated by Memarian, Ahmadi and Vaismoradi (2008: 48).

#### **3.4.7.2 Dependability**

According to Koch (2006: 92), the research study is dependable when its process has been audited. Polit and Beck (2008: 539) refer to dependability as the stability or reliability of the data. These authors further assert that credibility cannot be attained without dependability just like validity and reliability in quantitative research.

The purpose of the study was clearly communicated before obtaining consent in order to gain the participants' cooperation. In this study dependability was established by repeatedly listening to the participants' audio recordings, transcribing exactly what the participants had said, and the repeated reading of the raw data during the content analysis. By doing this, the researcher made certain that there was consistency in the emerging themes, categories and sub-categories as advised by Elo and Kyngas (2007: 113) and thus further ensuring that consistent, accurate and reliable findings were obtained (Polit & Beck 2008: 539).

A co-coder who is an expert in qualitative data analysis was requested to audit the interpretations of the data, the themes, categories and sub-categories that emerged, and the study findings. Dependability in this study was related to consistency of the findings which relied on the literature control (Hsieh, Feng & Shu 2009: 154)

### **3.4.7.3 Confirmability**

Polit and Beck (2008: 539) state confirmability is being objective about the data's accuracy, relevance or meaning. These authors define confirmability as the *"potential for congruence between two or more independent people about the data's accuracy, relevance and meaning"* (Polit & Beck 2008: 539). This criterion is thus concerned with establishing that the data represent the information participants provided, and that the interpretations thereof are not from the researcher's imagination. The findings must therefore reflect the participants' own experiences and not the perspectives of the researcher.

In this study the researcher involved an independent coder to assist with the data analysis and to ensure the accuracy of the interpretation of the transcribed information. The themes, categories and sub-categories that emerged during the data analysis process were supported by direct quotations from the verbatim transcribed interviews. (Polit & Beck 2010: 492). The original data and the recordings of the interviews and the analysis procedures were kept safe for future academic review (Hsieh et al. 2009: 154).

### **3.4.7.4 Transferability**

Koch (2006: 92) points out that transferability is dependent upon the degree of similarity between two contexts. Transferability refers to the *"generalizability of the data, that is, the extent to which findings from data can be transferred to or have applicability in other settings or groups"* (Polit & Beck 2008: 539). The researcher provided a complete and thick description of the study setting and findings so that the applicability of the data to other contexts can be evaluated and considered.

### 3.4.7.5 Authenticity

Authenticity as stated by Botma et al. (2010: 234), is the faithfulness and the fairness of the research. Polit and Beck (2008: 748) describe authenticity as the extent to which qualitative researchers fairly and faithfully show a range of different realities in the analysis and interpretation of the data. In this study, authenticity was ensured by prolonged engagement of the researcher with the participants while building a trusting relationship with them during an unstructured interview for 20 to 30 minutes with each participant. The independent co-coder was also involved in analysing the data.

## 3.5 ETHICAL CONSIDERATIONS

Maintaining honesty and integrity contributed to the high ethical standard of the current study. Based on the ethical principles as presented in Table 3.1, the study participants were protected from harm, remained anonymous and confidentiality was guaranteed throughout the study process (Polit & Beck 2008: 170-174; Botma et al. 2010: 284).

As the ethical principles considered in the study have been discussed in depth in Chapter 1 (view Section 1.9), the specific ethical considerations adhered to in the current study are only summarised in Table 3.3.

**Table 3.3: Specific ethical considerations adhered to**

Ethical considerations	Explanation	Application
Informed consent and voluntary participation	Verbal and/or written agreement by a person to participate in a research study (Burns & Grove 2009: 157)	Participants each gave verbal and written informed consent (view Annexure B) Participation was voluntary, meaning that the adult female rape survivors could choose whether they wanted to participate in the study or decline participation

Ethical considerations	Explanation	Application
Maintaining anonymity, confidentiality and privacy	Participants' identity and any information that could identify them were kept secret. The participants' information was not divulged to anyone outside the research study (Burns & Grove 2009: 162)	Participants were allowed to use pseudonyms to enhance anonymity (view Table 4.1)
		No video recorder was used and interviews were audio-taped with the participants' consent
		Pseudonyms rather than real names were used
Protection of human rights	Being free from harm and discomfort (be it physical, mental or emotional) was ensured. Participants were hence not subjected to stress. The research should only be undertaken by a qualified people especially in a sensitive case as was in this study (Burns & Grove 2009: 153)	Ethical approval obtained (view Annexures A)
Protection of human rights		Every participant was informed and assured that she could withdraw from the study at any time or stage if she felt she did not want to continue without giving a reason and without prejudice
		A pre-arranged counsellor was on standby during every interview in case a participant should request or needed counselling

### 3.6 CONCLUSION

Chapter 3 provided an in-depth discussion on the research methodology used in the study as well as the research design and methods. In Chapter 4 the research findings and a discussion on the related literature are portrayed.

## 4 RESEARCH FINDINGS AND DISCUSSION

### 4.1 INTRODUCTION

Chapter 3 focused on the research design and methods used to answer the research question. Chapter 4 provides an overview of the study findings. The data comprising of the 10 female rape survivors' responses were collected during one-to-one unstructured interviews and analysed using the eight steps identified by Tesch. The findings of this study are presented as themes, categories and sub-categories and are discussed relating to current literature available on the topic.

### 4.2 DEMOGRAPHIC DESCRIPTION

The participants were identified by the counsellor and once they had given permission the researcher contacted them and consensus was reached on a suitable place, date and time to schedule the interview. Ten female rape survivors were interviewed and their demographic information are summarised in Table 4.1. Data saturation was obtained after five interviews but a further five interviews were conducted to ensure that no additional themes emerged. No new themes emerged.

The participants' occupations did not have any significant impact on them being the victims of rape. However, as shown in Table 4.1, four of the females were students (school and university) and four were unemployed.

**Table 4.1: Description of demographic data of the participants**

Participants	Age	Gender	Occupation	Remarks
P1	34 years	Female	Unemployed	Passed Grade 10
P2	20 years	Female	Unemployed	Passed Grade 7
P3	18 years	Female	Grade 10 learner	Lived with parents
P4	28 years	Female	Unemployed	Passed Grade 12 and lived with parents
P5	18 years	Female	University student	Lived with mother; father deceased
P6	18 years	Female	Grade 12 learner	Lived with parents
P7	20 years	Female	Grade 11 learner	Lived with parents
P8	22 years	Female	Nursing student	Passed Grade 12; had one child
P9	31 years	Female	Receptionist	Passed Grade 7
P10	19 years	Female	Unemployed	Passed Grade 12 in 2009; was waiting for admission to university in 2013

### 4.3 OVERVIEW OF THE RESEARCH FINDINGS

The research findings were based on the AI interviews conducted with ten (10) female rape survivors to address the objectives of the study. These objectives were to explore and describe their views regarding the management received at the emergency unit and to make recommendations to healthcare professionals responsible for managing the female rape survivors in a specific emergency unit in North West to promote a patient-centred approach during the management of these patients.

An overview of the themes and related categories and sub-categories is reflected in Table 4.2. The findings are presented based on the first two objectives of the study.

The first two questions were asked during the unstructured interviews to address the first objective (view Annexure C). The findings are presented in Table 4.2 as Theme 1: Therapeutic environment and Theme 2: Optimal healthcare received.

The first objective was to:

- explore and describe the views of female rape survivors regarding the management received at the emergency unit.

**Table 4.2: Objective 1 – Summary of themes, categories and sub-categories**

Themes	Categories	Sub-categories
<b>Theme1</b> Therapeutic environment <i>Section 4.3.1</i>	Caring/Nurturing approach <i>Section 4.3.1.1</i>	
	Person-centred approach <i>Section 4.3.1.2</i>	
	Empathic approach <i>Section 4.3.1.3</i>	
	Respectful attitude <i>Section 4.3.1.4</i>	
	Open and trusting relationship <i>Section 4.3.1.5</i>	
	Non-judgemental attitude <i>Section 4.3.1.6</i>	
	Hopeful and motivating <i>Section 4.3.1.7</i>	
<b>Theme 2</b> Optimal healthcare received <i>Section 4.3.2</i>	Effective management received <i>Section 4.3.2.1</i>	Healthcare education

The third question was asked during the interview to address the second objective (view Annexure C). The findings are presented in Table 4.3 as Theme 3: Excellence in service delivery.

The second objective was to:

- make recommendations to healthcare professionals responsible for managing the rape survivors in the emergency unit to promote patient-centred management.

**Table 4.3: Objective 2 – Summary of themes, categories and sub-categories**

Themes	Categories	Sub-categories
<b>Theme 3</b> Excellence in service delivery  <i>Section 4.3.3</i>	Dedicated available centre staff  <i>Section 4.2.3.1</i>	
	On-going therapeutic interventions  <i>Section 4.3.3.2</i>	Peer support  Spiritual support
	Confidentiality  <i>Section 4.3.3.3</i>	
	Medication  <i>Section 4.3.3.4</i>	

Each of the three themes is discussed in depth in Sections 4.3.1 to 4.3.3. Data collected from the participants are included as quotes to support the study findings. A discussion then follows to compare and contrast the findings with existing theories and previous research.

### 4.3.1 Theme 1: Therapeutic environment

The main theme that emerged from the interviews with the female rape survivors was building a therapeutic relationship in a therapeutic environment with the healthcare professionals. The participants indicated that the healthcare professionals (nurses and medical doctors) who worked in the emergency unit “*listened*” and “*empathised*” with them when they presented at the emergency unit for assistance following the rape incident.

According to the participants, the environment (Area 1 as well as Area 2 in the emergency unit) where they were assisted by the healthcare professionals when admitted was a “*therapeutic environment*”. The following verbatim quotations from four of the participants support this finding:

- “... *what I [female rape survivor] valued most was their [healthcare professionals] kindness ...*”
- “... *they [healthcare professionals] are very supportive ...*”



- “... *they* [healthcare professionals] *took extra caution when caring for me...*”
- “... *I* [female rape survivor] *could feel that we* [female rape survivor and the nurse] *are in the same room...*”

**Discussion:** Webb (2011: 1) and Roche (2011: 24) confirm that a therapeutic environment refers to a relationship in which the healthcare professional has the ability to listen to clients with a trained listening ear which brings a new perspective into the relationship. According to Bergh and Theron (2009: 456), in a therapeutic relationship the healthcare professionals initiate management to address the emotional and/or psychological problems that may occur following a crisis. In other words, the care that the participants received from the healthcare professionals allowed them to initiate the healing process immediately following the incident, a view supported by Miller (2012: 1).

The participants indicated that there was good communication and understanding between the female rape survivors and the healthcare professionals. In a study conducted by Campbell et al. (2010: 70) in which female rape survivors were asked to explain how they experienced being interviewed by the researcher, the participants confirmed that in order to become a survivor one's main initial need was to be enfolded in a therapeutic environment when admitted for the first time.

Wright (2010: 155) and Keefe and Hage (2009: 5) agree that a therapeutic environment is the creation of a strong relationship between the healthcare professional and the client; it is an environment where a trusting relationship exists between these two individuals to the extent that the client (the female rape survivors in the current study) feels safe and comfortable. In essence, the environment that was created for the female rape survivors encouraged them to express their feelings openly so that the healthcare professionals could assist them to come to terms with what had happened. Wright (2010: 154) states the creation of a therapeutic environment is an integral part of the nursing

profession. In this study the environment was valued by the participants following the crisis they had endured.

The following seven (7) categories emerged from Theme 1:

- Category 1: Caring/Nurturing approach
- Category 2: Person-centred approach
- Category 3: Empathic approach
- Category 4: Respectful approach
- Category 5: Open and trusting relationship
- Category 6: Non-judgemental attitude
- Category 7: Hopeful and motivating

Each of these categories is discussed in Sections 4.3.1.1 to 4.3.1.7.

#### **4.3.1.1 Caring/Nurturing approach**

The participants voiced that the approach of the healthcare professionals when they were admitted to the emergency unit was “*caring*” and “*nurturing*”. The following quotations support the views of the participants relating to the “*caring*” and “*nurturing*” approach with which they were managed within the emergency unit:

- “... *and I [female rape survivor] value it [the management] ...*”
- “... *they [counsellors] took extra caution ...*”
- “... *what I value about her [counsellor] is that she did not advise me like a counsellor ... she advised me like a parent ...*”
- “... *they [healthcare professionals] are very supportive ... they listen to your [female rape survivor] story and reassure us that we are not alone in this [rape incident] ...*”
- “... *they [healthcare professionals] know how to treat people... [female rape survivors] in trouble ...*”

- “... what I like about them [nurses and counsellors] is that they made me think of things I [female rape survivor] couldn't think of at that time ...”

**Discussion:** The participants valued the positive approach that was followed by the healthcare professionals (nurses, counsellors and medical doctors) during the management they received in the emergency unit. The healthcare professionals were “supportive” and took “extra caution”. They were sensitive to the female rape survivors as indicated by comments such as “reassure[d] us that we are not alone in this” and “she did not advise me like a counsellor ... she advised me like a parent”. This caring approach is emphasised by Martsolf et al. (2010: 492) who state healthcare providers should be “available”, “sensitive” and “take extra time” when assisting and managing persons in a crisis. In a study conducted by Roche (2011: 24) it was found that the female rape survivors felt very relieved because the counsellor was empathic, gave them time to tell their stories, and listened to them.

According to Campbell et al. (2010: 21), part of patient care is for nurses to provide rape survivors with relevant and important information. In this study the healthcare professionals did give the female rape survivors information they needed. One participant reflected that the nurses and counsellors made her “think about things” she was not able to consider or think about at the time. By providing her with the necessary information, the healthcare professionals enabled this participant to think for herself and make her own choices.

Arend et al. (2012: 7) emphasise the importance of one-on-one care to a female who has survived a rape incident. Campbell et al. (2010: 21) concur, stating one of the main goals of patient care to female rape survivors is to help restore the survivor’s dignity by offering individual support. The participants in this study indicated that due to the caring and nurturing approach they received, they felt “free” to phone the nurses and counsellors to ask for advice even after they had been discharged. Campbell, Greeson and Patterson (2011a: 21) emphasise that one of the main aspects of patient care is to provide the patient with information. The participants in this study were happy with the information that

was given to them as indicated by their quotes such as “*she advised me like a parent*”.

The participants said that the healthcare professionals’ welcoming (“*warm*”) attitude made them feel “*free to talk*” about what had happened to them. In a study conducted by Fehler-Cabral, Campbell and Patterson (2011: 3621) in Canada, it was reported that female rape survivors felt safe and in control if the sexual assault nurse examiners (SANEs) demonstrated a caring attitude towards them during their admission and management following sexual assault. One should also acknowledge that sexual assault survivors may feel traumatised by the management they receive in the emergency unit if there is no caring from the nurses (Fehler-Cabral et al. 2011: 3618).

#### 4.3.1.2 Person-centred approach

The participants communicated that they experienced healthcare received from the healthcare professionals when admitted to the emergency unit as a “*client/person centred*” approach. This is supported by the following quotes from the female rape survivors:

- “... *I felt like I was the only patient... they [nurses, counsellors and medical doctors] treated me like I am the only one...*”
- “*I had the opportunity to tell my story the way I could... the way I wanted to and... if ever [when??? even??? Whenever???) I wanted to take a break I was allowed to take a break... no one [nurses, counsellors or medical doctors] said I must stop [taking the break]...*”
- “... they [nurses, counsellors and medical doctors] *don’t push you [female rape survivor] around, they treat you well and they don’t make you do something you don’t want to do...*”
- “... *what I like about them [nurses, counsellors and medical doctors] is that they made me think of things I [female rape survivor] couldn’t think of at that time ...*”

**Discussion:** Patient-centeredness is a concept embraced in the current healthcare systems as a means of improving quality of care for patients and to ensure positive outcomes (Ferguson et al. 2013: 286). The participants indicated that the healthcare professionals (nurses, counsellors and medical doctors) treated them well and with respect (“*they treat you well and they don’t make you do something you don’t want to do*”). They were not forced to share what had happened or managed in a domineering way. The rape survivors were allowed to tell their “*own story*” in their own way; they were allowed to take their time and could stop at any time (“*if ever I wanted to take a break I was allowed to take a break*”). Ekman et al. (2011: 3) agree with Hudson et al. (2011: 158) that a person-centred approach to care promotes a person’s view about any life situation and condition thus enhancing patient satisfaction.

Allowing the female rape survivors to tell their story at their own pace was positive because, as mentioned by Keefe and Hage (2009: 5), such stories can bring painful memories and emotions. It is important to acknowledge that the female rape survivors may present with feelings of intense loss of power and control; therefore, empowering them with the right to choose what is to happen to them enable them to regain their personal control (McGregor et al. 2009: 26). For this reason the female rape survivor should choose whom she would have present during the examination (McGregor et al. 2009: 26). McCormack et al (2010a or b?: 96) assert that a person-centred approach is characterised by qualities enabling human thriving and flourishing as they change the way they engage and relate to others at individual or group level. A study conducted by Sammer et al. (2010: 157) emphasise that person-centred care has to be centred on the patient.

The person-centred care process should focus on the delivery of care through engaging clients, having sympathy and sharing decision making to provide a holistic care (McCormack et al. 2010a or b?: 106). A female rape survivor said she valued being treated as though she was the “*only patient*”. In other statements female rape survivors said they were afforded the opportunity to be “*free*” and were able to talk about “*things*” that they would not think they would

talk about; thus patient-centred care was enhanced. Nolan et al. (2004: 46) hold that person-centred care is centred on the individual's needs and mandates that practitioners need to have knowledge of people as individuals and respect them as individuals. This is consistent with the views of Sammer et al. (2010: 157) and Ekman et al. (2011: 2) that the patient is an active participant in his or her own care; embedded in the bigger picture is that by recognising the individuality and right of the client in decision making positive liaison between the hospital and the community is promoted.

In a study conducted by Schreiber (2010: 22) the SANE who was interviewed concerning the rape survivor's needs said that, because she always has the survivor's interest at heart, she allowed the rape survivor to be in charge of the whole examination. The SANE let the rape survivor choose what she wanted in order for her to regain the power that was taken from her by the perpetrator. Nolan et al. (2004: 46) conclude that treating people as consumers of health and promoting a philosophy that treats people as individuals, results in the emergence of person-centred care.

#### **4.3.1.3 Empathic approach**

The participants described the healthcare received from the healthcare professionals when they were admitted to the emergency unit as an "*emphatic approach*". The following quotations support the views of the participants relating to the empathic approach with which they were managed:

- "... *and I could feel that we [counsellor and the female rape survivors] are in the same room and we... the feeling... is mutual...*"
- "... *hence like I said they [nurses, counsellors and medical doctors] know how to treat people and they are supportive...*"
- "... *I would like that they [nurses and counsellors] not only do it [empathy] for me [female rape survivor] but that they also do it [empathy] to other people...*"

- “... *she [counsellor] advised me like a parent and whatever I felt she [counsellor] felt emotionally...*”

**Discussion:** The participants revealed that the healthcare professionals who assisted them in the emergency unit when they needed help were able to empathise with them. Empathy, as explained by Schapiro (2011: 93), is the morality of cooperation where we put ourselves in others’ shoes and the cognitive awareness of another person’s feelings and perceptions. Campbell and Adams (2009: 397) share that it is psychologically beneficial for the rape victims to share their stories with empathic listeners; one female rape survivor who was interviewed in the current study said “*whatever she felt*” the counsellor “*felt it emotionally*”.

The healthcare professionals adopted an empathic attitude towards the female rape survivors which enabled the latter to feel safe (Keefe & Hage 2009: 5); therefore the female rape survivors were able to disclose what had happened without fear of being judged. The empathic and supportive attitude towards the female rape survivors facilitated recovery as stated by Wadsworth and van Order (2012: 434). The words of the female rape survivor who said she “*could feel that the feeling is mutual*” echoed the feelings of the female rape survivors that they felt safe, they felt they were understood and that they were not only physically but also emotionally taken gentle care of.

#### 4.3.1.4 Respectful attitude

The healthcare that the participating female rape survivors received from the healthcare professionals was given with a “*respectful attitude*” as evidenced by the following verbatim quotes.

- “... *and they [nurses, counsellors and medical doctors] respect you [female rape survivor]... they make you feel like a person...*”
- “... *they [nurses, counsellors and medical doctors] know how to treat people with respect... they respect your decision...*”

- “I [rape survivor] was treated with respect ... as I was taken to a private room by them [nurses, counsellors and medical doctors] so that I can talk freely ... not in front of everybody [other patients and staff]...”
- “... they [health care professionals] were not inhuman when they attended to me ... and that meant a lot to me... ‘

**Discussion:** The female rape survivors reported being treated with respect by the healthcare professionals. Of the 10 participants seven (7) reported they experienced respectful treatment by the healthcare professionals. Being treated with respect enabled them to ventilate and tell their stories as it had happened. Patterson and Campbell (2010: 200) are of the opinion that sexual assault survivors will feel more at ease during their management if they are treated with respect. The healthcare professionals communicated with the female rape survivors in a non-judgemental way that made the survivors feel respected as human beings; they “*make you feel like a person*” by really listening and respecting the decisions the participants chose to make (Campbell et al. 2010: 70). The female rape survivors felt respected, believed, supported, informed and felt that they were given emotional support after living through their ordeal (Fehler-Cabral et al. 2011: 3620). McGregor et al. (2009: 36) emphasise that rape survivors who are treated as worthy human beings replaces unfounded feelings of guilt within themselves with a sense of self-worth and dignity

#### 4.3.1.5 Open and trusting relationship

The participants indicated that the healthcare professionals in the emergency unit provided healthcare within an “*open and trusting relationship*”. The verbatim transcribed words of the participants support their view that the healthcare providers afforded them the opportunity to form an “*open and trusting relationship*” with them.

- “... they [nurses, counsellors and medical doctors] made me feel free ... I felt comfortable ... to say anything ... to talk openly...”



- “... I feel free to an extent that now I [female rape survivor] have one of the members who helped me... I have her telephone numbers I can even talk about my private things ... such as my studies and so forth...”
- “... we [female rape survivors] talk about things that we can’t talk with our parents...”
- “... the social worker told me [female rape survivor] her story ... I felt free and I started talking about everything...”

**Discussion:** Creating a safe environment and a trusting relationship is very important for the female rape survivors (Keefe & Hage 2009: 5) to enable them to “*feel free*” and tell their stories openly and honestly. Allowing them to decide when to start and when to take a break contributed to their feeling of being “*comfortable*” and at ease to speak openly and take their own time.

A very important aspect that needs to be noted is that one participant shared that the negative experience resulted in her and the healthcare professional sharing a bond to the extent that she could contact the healthcare provider and talk to her about her life (“*I can even talk about my private things ... such as my studies and so forth..*”). This is proof that a supportive, compassionate and understanding professional can initiate positivity where there was negativity. Similarly, by sharing her own story with a female rape survivor, the social worker created a trusting atmosphere which encouraged the survivor to share her own story.

Although the female rape survivors were treated with respect and dignity, the fact that there are still critical issues in emergency units such as long waiting periods, limited staff numbers, staff who are not trained in forensics and also the fact that healthcare professionals in emergency units often triage female rape survivors as healthy and not urgent (Zerr 2012: 7). During triage in an emergency unit healthcare professionals (nurses and medical doctors) focus on the severity of physical injuries, thus often overlooking the emotional trauma endured by the female rape survivor and acknowledging the seriousness of the event. Unfortunately, one of the participants in this study shared that she was

given two pills and told to come “*back on Monday for treatment and counselling*”. This experience of one participant verifies that her emotional trauma was not considered as critical and was thus not attended to forthwith.

#### 4.3.1.6 Non-judgemental attitude

The participants shared that they experienced a “*non-judgemental attitude*” from the healthcare providers in the emergency unit.

- “... *they [counsellors] don't judge, that is one thing that I like about them...*”
- “... *and by the look of things I [female rape survivor] was not judged ... she [counsellor] didn't judge me...*”
- ... *she [nurse] told me that this [rape incident] was not my fault ... when I walk into the room ... she [nurse] told me that ... that [what she told me] really assured me...*”
- “... *they [healthcare professionals] were not inhuman ... when they attended to me ... and that meant a lot to me...*”

**Discussion:** An exploration of how sexual assault survivors were treated by healthcare workers indicated that healthcare workers in South Africa “*were often extremely judgmental and rude*”, and that patients rated the sympathy of healthcare workers “*alongside competence as one of the factors that mattered most to them*” (Christofides et al. (2006) cited in Govender & Penn-Kekana 2007: 15).

One participant mentioned that the counsellor did not judge her but supported and believed her. According to Luce, Schragger and Gilchrist (2010: 491), healthcare professionals should use a gentle, non-judgemental approach when taking history from the rape survivor and document it in the rape survivor’s own words. It is stressed in the Irish National Rape Crisis Statistics (2011: 41) that a rape survivor must be supported by compassionate, competent and sensitised professionals who do not demonstrate judgemental attitudes or behaviours. In a

study conducted by McGregor et al. (2009: 33) it was emphasised that the SANE must be non-judgemental, assuring the female rape survivor that she did nothing wrong. One participant in this study voiced that the fact that the healthcare professional treated her in a human way “*meant a lot*” to her.

In Ireland the Forensic Clinical Examination Guidelines requires that healthcare professionals should have “*a caring, non-judgemental approach when providing services to victims of sexual assault*” (National Guidelines on Referral and Forensic Clinical Examination 2010: 41). Also, Thompson’s (2010: 341) advice that it has to be explained to a female rape survivor that she must not hold herself responsible for what has happened (rape trauma), was evident in the words of a survivor who said when she walked into the room the nurse told her the rape incident “*was not my fault ... when I walk into the room ... she told me that*”. The healthcare professional clearly treated the participants in a non-judgemental and unbiased manner.

#### 4.3.1.7 Hopeful and motivating

The healthcare professionals managed the participants in a way that made the latter “*hopeful*” and “*motivated*” them. The rape survivors mentioned that they were filled with hope and motivation because they were told that there is still “*life*” after rape even if the possibility of having contracted HIV because of the rape incident was a reality to be faced.

- “... *they [nurses and counsellors] make you [female rape survivor] feel that you know what ... there is still life after this [rape] ... there is still life after rape ... and HIV ... you must still go back to school ... go on with life...*”
- “... *the thing is they [nurses, counsellors and medical doctors] motivate you to an extent that you raise your head up and you hold it high...*”
- “... *and then I realised that what happened ... has happened and that I [female rape survivor] have to go on with my life...*”
- “... *as I was able to build myself with the help of nurses, social workers and doctors ... I was able ... like let it go...*”

**Discussion:** In a study conducted in Rwanda by Mukamana and Bysiewicz (2008: 382), the rape survivors had lost hope for the future after having contracted HIV as a result of rape. The female rape survivors interviewed in this study had hope for the future as they were told by the counsellor that there is still life after “*rape and HIV*”. In a study conducted (also in Rwanda) by Yohani and Hagen (2010: 208) among refugee women, the rape survivors had similarly lost hope for their future because they were no longer regarded as virgins and were therefore rendered as unsuitable for marriage. In this study female rape survivors were supported and motivated by the healthcare providers to realise they still had a future; they were empowered to believe in themselves and their future: “*I was able to build myself*”; “*... you must still go back to school ... go on with life*”; “*motivate you to an extent that you raise your head up and you hold it high*”. Moreover, the healthcare professionals informed them that although they might have been infected with HIV, it should not discourage them or let them lose hope. If infected, they could be helped through treatment to prevent pregnancy as well to live a full life with HIV treatment and management.

#### 4.3.2 Theme 2: Optimal healthcare received

Optimal healthcare received was the second theme that emerged from the data. The participants appreciated the positive management they received from the healthcare professionals at the emergency unit. The following quotations support the views of the participants relating to the healthcare received when they were managed within the emergency unit:

- “... *they* [health care professionals] *help me ... the doctor help me ...*”
- “... *I* [female rape survivor] *thought that whenever I would take them* [medication] *I would vomit ... but they* [medication] *worked just fine...*”
- “... *when they* [healthcare professionals] *need to give me* [female rape survivor] *the treatment that I need* at that point in time they give it [treatment] *without any explanation ...*”
- “... *no allergies, they* [treatment] *were working just fine...*”

**Discussion:** Collecting evidence may be “a *challenging task*” for nurses (Maier 2012: 1317) since a physical examination of a rape victim includes the latter having to expose their bodies; it can be uncomfortable and traumatic for the rape survivor, especially during the vaginal examination. In this study it was found that the healthcare providers provided compassionate care before, during and after the physical examination. Wadsworth and Records (2012: 263) state participants in their study voiced that the care the healthcare professionals provided was optimal. It included a sensitive, caring approach during the physical examination as well as emotional support throughout the ordeal of having to tell, thereby re-living their trauma of having been raped. Although Campbell et al. (2012: 180) found in a study that the emergency-based approval to post-assault healthcare and forensic is not optimal, the participants in this study agreed that the healthcare provided was optimal. One out of 10 participants indicated that the treatment that was given to her by healthcare professionals was not explained to her, as she clearly said “*when they needed to give me treatment, they gave it without any explanation*”.

Very important though, is that the female rape victim be protected against HIV infection. In this discussion the optimal care which included advice, information and instructions on treatment for preventing HIV and other STIs are focused on.

The following category and sub-category was derived from Theme 2: Optimal healthcare received:

- Category 1: Effective management received
  - *Sub-category: Health education*

The category and sub-category are discussed Section 4.3.2.1.

#### **4.3.2.1 Effective treatment received**

The participants indicated that the drugs for Post Exposure Treatment (PEP) provided as treatment that they received from the healthcare professionals was effective. Although experiencing side effects, the participants agreed that the

PEP and treatment for sexually transmitted infections (STIs) they received from the healthcare professionals were explained thoroughly to them beforehand.

They were told about the side effects of the various drugs and how to minimise or prevent the side effects as evidenced in the next quotes:

- “... *the treatment was fine ... the only thing they [treatment] had side effects...*”
- “... *the treatment that they [healthcare professionals] gave me ... they checked those [treatment] several times to ensure that the medication was proper...*”
- “... *the medication works more especially when you [rape survivor] can't eat ... medication that made me [rape survivor] strong...*”
- “... *when they need to give me [rape survivor] treatment that I need at that point ... they [healthcare professionals] give it to me without any explanation.*”

**Discussion:** In a study conducted by Campbell et al. (2012: 381) the nurses emphasised the importance of health education being given to the rape survivor pertaining to care and treatment; but as far as whether to continue with legal processes or not the female rape survivor has to make her own choice. In this study one out of 10 participants stated that the side effects were not explained thoroughly by the healthcare professionals. Arend et al. (2012: 154) also found that despite experiencing physical side effects, eight out of 10 participants explained that taking PEP did not elicit in any emotional reaction because of the health education they received from the healthcare professionals.

⇒ **Health education**

In the current study the participants indicated the health education they received from the healthcare professionals was effective despite the side effects they endured. The participants indicated that the healthcare professionals gave them health education on how and when to take treatment as well as the side effects

to watch out for. The following quotations support the views of the participants relating to the effective treatment they received from the healthcare professionals within the emergency unit:

- “... *they* [nurses and medical doctors] *told me* [female rape survivor] *that it’s* [treatment] *going to cause diarrhoea or vomiting...*”
- “... *they* [nurses and medical doctors] *advise me accordingly ... they told me the conditions ... and that I am going to feel nauseous...*”
- “... *the treatment had side effects ... but they* [nurses and medical doctors] *warned me about it...*”
- “... *they* [nurses and medical doctors] *told us the condition and the repercussions of taking medication [PEP]...*”
- “...*then they* [nurses and counsellors] *counselled me for blood test ... tested me for HIV/AIDS and for eh ... pregnancy ... so the counselling was good...*”

**Discussion:** The participants in this study were satisfied that they received the best possible care. Healthcare professionals did the necessary tests (for HIV and STIs), gave them sufficient, relevant information and advised them on the side effects they may expect from PEP. The healthcare professional, who attends to a female rape survivor, has to thoroughly educate a female rape survivor on her options for treatment and forensic examination. The patient must understand that she is the one with the right to give consent for the physical examination but that she can also ask for the examination to be stopped at any time (Zerr 2012: 32). As stated in Wadsworth and van Order (2012: 435), it is important to empower women through education to have control over their healthcare needs and to reassure them that they are the only ones who can make the decision regarding the examination and treatment that must be given.

In a study conducted by Dawson, Hubbert and Poon (2010: 14) participants mentioned that rape survivors need formal support in the form of public education and awareness. The health system is often the first point of contact

for women who survive rape. There is a perception that for a woman to come forward and speak out about her rape ordeal, public or personal stigmatisation and even victimisation can follow. But rape is a violation of her basic human rights that she must be made aware about not only by healthcare providers who help her, but also by all sectors of society (Garcia-Moreno et al. 2005: viii)..

### 4.3.3 THEME 3: EXCELLENCE IN SERVICE DELIVERY

The third theme which emerged from the data pertained to excellence in service delivery. The participants were satisfied with the service they received from the healthcare professionals. As indicated in the following quotes they used words such as “good”, “undivided attention” and “well” to describe the services received.

- “... well ... the hospitality was good ... I [female rape survivor] felt like I was the only patient...”
- “... they [healthcare professionals] give you [female rape survivor] eh ... undivided attention...”
- “... and they [healthcare professionals] don’t push you [rape survivor] around ... they treat you well...”
- “... they [healthcare professionals] were patient ... mmm ... it was like I was talking to someone my [female rape survivor’s] age ... I felt comfortable...”
- “... I haven’t encountered a problem with them [healthcare professionals] ... and I met different people [healthcare professionals] that treated the same...”

**Discussion:** The female rape survivors interviewed in this study were provided with holistic care (Eogan, McHugh & Holohan 2012: 48), meaning that despite having been attended to by different healthcare professionals in the emergency unit, the participants were provided with the best practice service (medical attention and emotional support) by all professionals in the emergency unit.



The participants in this study really appreciated the freedom that they were given to talk about their experience and the anonymity associated with the meeting they had with the healthcare professionals (Arend et al. 2012: 159). As promoted by Arend et al. (2012: 160), the adult female rape survivors were given consistent psychological support (“*undivided attention*”) by the healthcare professionals; even during their follow-up post-rape incident they communicated the healthcare professionals did not “*push you [them]*” but treated them “*well*”.

The following four categories emerged from Theme 3: Excellence in service delivery

- Category 1: Dedicated available centre staff
- Category 2: Ongoing therapeutic interventions
- Category 3: Confidentiality
- Category 4: Medication

Each category is individually discussed in Sections 4.3.3.1 to 4.3.3.5.

#### **4.3.3.1 Dedicated available centre staff**

In spite of the positive experiences shared by the participants (non-judgemental attitude of the personnel; compassionate care; holistic approach; receiving relevant information; being educated on their rights and so forth), the participants did voice some concerns about their experiences in the emergency unit at the specific hospital.

They wished for a dedicated centre staff to be available 24 hours a day to assist them without any delays. They wished for nurses, medical doctors, counsellors and police officers to be situated at the centre to provide female rape survivors with relevant management following the rape incident. The following quotations express the views of the participants relating to the availability of a dedicated centre staff and access to them at all hours.

- “... if it can be included that ... we [female rape survivors] *must not stay for a long time without seeing anybody* [nurses, counsellors, medical doctors] ... *when you [female rape survivor] come, I don't sit first ... there is somebody [nurse, counsellor or medical doctor] staying here waiting to help me ... I wish it could be like that...*”
- “... here are many counsellors ... but nurses ... the ones who have to a finger prick and all ... most of them [nurses] work at casualty...”
- “... she [the nurse] could not come immediately when she was called because she was busy...’
- “... I [female rape survivor] only went twice and I had to go four times because she [social worker] was unavailable to help me...”

**Discussion:** The participants communicated that dedicated centre staff is important so that they should not wait for a long period before being attended to. It was the wish of the participants that the centre should provide an uninterrupted 24-hour service to rape survivors. Campbell, Patterson and Bybee (2011b: 379) support the participants' wish by stating that a 24-hour service either in a hospital or a non-hospital clinic setting should be provided for rape survivors. According to Eogan et al. (2012: 47), appropriate staff should be available 24-hours a day and seven days a week to provide medical and supportive care and for the collection of forensic evidence.

Some female rape survivors' comments included references to nurses not being available immediately as they were working in casualties or that “*she [nurse] could not come immediately when she was called because she was busy*” or that “*the social worker was not always available*”. It is, however, crucial that health services and adequate follow-up is provided to female rape survivors as indicated by literature.

#### 4.3.3.2 Ongoing therapeutic interventions

The participants indicated that the healthcare they received from the healthcare professionals when admitted to the emergency unit was “*therapeutic*” in nature as confirmed by the following quotes:

- “... *they [healthcare professionals] make you [female rape survivor] feel like a person...*”
- “... *they referred me to a counsellor ... the counselling was good...*”
- “... *they [healthcare professionals] give you undivided attention...*”
- “... *they [healthcare professionals] are very supportive and whatever that they give you ... they make sure that it is something that you [female rape survivor] need...*”
- “... *I now have one of the members’ [healthcare professionals’] numbers who helped me ... I can even talk my private things with her...*”

**Discussion:** According to Wright (2010: 156), a therapeutic relationship is of greater value than specific counselling. Female rape survivors should be provided with emotional support, peer support as well as spiritual activities (Tabor 2011: 206) as indicated by the participants during their one-on-one interviews. Knapik, Martolf and Draucker (2008: 346) depict that spirituality is an integral aspect of the healing process for many sexual survivors. It was the adult female rape survivors’ wish that they should be provided with spiritual activities in order to assist the process of healing. Knapik et al. (2010: 645) also agree that the use of spirituality may be one way the survivors can cope with the experience of sexual assault.

The female rape survivors expressed a need to have peer and spiritual support from other survivors, relatives and pastors or church leaders in order for them to heal physically, emotionally and psychologically. To accomplish this healing, peer and spiritual support should be included in the future management of the female rape survivors as recommended by the participants. It is clear that female rape survivors want to be supported in order to cope with what has happened to them, as they felt this would contribute towards their healing from

the inside. Two sub-categories emerged from the data relating to ongoing therapeutic interventions, namely *peer support* and *spiritual support* which are discussed below.

⇒ **Peer support**

Although the participants were positive about the support received from the healthcare professionals in the emergency unit, a general wish was expressed to form a support group for female rape survivors to support one another during the rape trauma experience. The following quotations support the views of the participants relating to the “*peer support*” sessions that they intended to form:

- “... I [female rape survivor] wish rape survivors ... we can council other rape survivors...”
- “Counsellor told me [female rape survivor] her story ... I felt free and I started talking out everything ... that’s when I realised that even ... anyone can be raped...”
- “... I feel that some of the people who counsel us could be someone like us [female rape survivors] ... who [had] undergone same trauma [rape incident]...”
- “... we [female rape survivors] people that have been raped ... they [centre] can open a session for us ... like maybe meeting twice or thrice a week so that we are able to help each other to come to terms with what has happened to us...”
- “I [female rape survivor] have seen many people [female rape survivors] whom I have tried to talk to them ... I have tried to help two or three people [female rape survivors] ... even now they still phone and ask whether I am all right ... these things [support groups] can build us [female rape survivors] ...”

**Discussion:** Yohani and Hagen (2010: 216) state it is very important to reach out to women through other women. They view it as vital for physically violated women to integrate with support groups. The participants stated their intent of

forming a support group with sessions that could be attended by rape survivors as stated by Yohani and Hagen (2010: 214). According to McGregor et al. (2009: 27), community-based groups have the capacity to counsel women for ongoing psychological symptoms related to trauma as in the case, for example, of female rape survivors. The participants in this study confirmed the latter as one said that she tried to help other female rape survivors by contacting them telephonically to find out how they were coping and feeling.

It is important to refer female rape survivors to counselling (Wadsworth & van Order 2012: 437) where they can receive support for healthcare consequences in a post-rape crisis. Female rape survivors need to be supported by other rape survivors as well as the healthcare professionals. Patterson and Campbell (2010: 193), who conducted a study in the USA, found that the SANE provided the rape survivors with emotional support and crisis intervention as well as compassionate caring. It is quite clear that the female rape survivors in this study needed the support of a SANE.

Tabor (2011: 206) contends that positive coping strategies for rape survivors includes emotional support and seeking peer support as indicated by the female rape survivors during the one-on-one interviews. The female rape survivors wanted to let other survivors know that they were not alone but that other women also survived rape trauma (Campbell & Adams 2009: 76). One participant, for example, said: “*I wish we could help other rape survivors ... people like us*”. Counselling and other forms of emotional and psychological support (Arend et al. 2012: 9) should be a care aspect for post-sexual assault intervention.

⇒ ***Spiritual support***

The participants indicated that they would like to be provided with spiritual support as a means to help them to come to terms with rape trauma. The following quotations support the views of the participants relating to the “*spiritual support*” to help them overcome the trauma they experienced.

- “... she [counsellor] motivated me ... she even gave me a paper with a prayer in it ... when I woke up ... I looked at that prayer ... and every day when I ... woke up I looked at it [the prayer]...”
- “... I [female rape survivor] believe in God ... I wish there will be somebody spiritually that can counsel us [female rape survivors] ... that can teach us about forgiveness ... it is easier when you forgive but ... you [female rape survivor] can move on with your life ... you cannot forget...”
- “.. I got help from my mama and pastor ... they have been leading and guiding me with the Bible ... the words I received were encouraging ... I managed to get out of the bubble I was in...”

**Discussion:** The participants experienced that spiritual support enabled female rape survivors to come to terms with sexual violence. According to Knapik et al. (2010: 2), the use of spirituality “*may be one way rape survivors can cope with the experience of sexual violence*”. Knapik et al. (2010: 3) believe that finding spiritual meaning can aid in recovery for sexual trauma. In this study the participants also believed that spiritual support was essential to emotionally survive the rape incident. Some believed that spiritual guidance would help them to forgive perpetrators; and although they would not forget, it was possible that by forgiving the perpetrators the female rape survivors would be able to go on with life.

For these rape survivors to have some “*connection*” with God (Crisp 2004: 7) could lead to greater religious involvement. Spirituality in rape survivors has benefits since being in contact with the “*Higher Being*” would bring emotional comfort and enhance their self-acceptance; therefore, it is very important to support rape survivors spiritually by involving religious leaders (Bryant-Davis et al. 2011: 1603; Crisp 2004: 7; Knapik et al. 2010: 7; Yohani & Hagen, 2010: 214). It is the opinion of Knapik et al. (2008: 346) that support in the form of a strong spiritual connection creates the possibility for sexual survivors to overcome the trauma and live with hope for the future.

The participants indicated that they needed spiritual activities (Tabor 2011: 206) to empower them to cope with the rape trauma. Major health crises (Maree 2012: 298) such as rape trauma often result in clients turning to spirituality to find meaning in their illness (in this case, sexual assault). Therefore, the spiritual dimension should form part of holistic management of the female rape survivors as wished for by the participants in this study. Thompson (2010: 331) concludes that, in order to become a survivor, women have to work through the rape trauma. The author found in a study that for most women the process facilitated emotional and spiritual changes. Subsequently, they described themselves as survivors because they talked about the incident while other victims have not spoken about it which may have hindered their emotional healing. As indicated by Tillman et al. (2010: 60), it is very important to avail support systems for female rape survivors.

#### 4.3.3.3 Confidentiality

When they were admitted to the emergency unit, the participants indicated that confidentiality was maintained during their health management. Confidentiality is the most important factor when dealing with clients that have been sexually assaulted. Fearing disclosure is one of the main reasons why female rape survivors do not to seek medical assistance on time. Of the 10 participants that were interviewed, only one participant was worried about confidentiality. This particular participant felt that she wanted to keep the incident to herself and did not consider sharing it with anybody, not even her friends:

- “... I used to tell them [counsellors] that a lot of people [friends and family] don't know what happened ... even the people [friends] that I go with ... it [being raped] is very serious and should be treated like that [confidential] ... I know it's something that ... I want to live with [want to keep it to myself] ...”

**Discussion:** Cole (2011: 367) explains confidentiality as the key element of caring for rape survivors and a matter of life and death in some cases. Discussing clients without giving information that could lead to identifying the

victim (Cole 2011: 367), as was the case in this study when the researcher interviewed the rape survivors, is called confidentiality. The healthcare professionals should enter into a confidentiality agreement (Cole 2011: 369) with the clients before taking any history or information from the client to alleviate any doubt in the latter's mind regarding confidentiality.

The Human Rights Commission (2007: 9) asserts that “*privacy can be violated in other ways during rape examination*” of female rape survivors. An example would be to allow the police officer, even if being female, into the examination room as it can threaten the rape survivor's confidentiality. Rape survivors are usually very concerned about the fact that if they seek assistance after the rape incident, their reputation will be ruined because healthcare professionals do not respect confidentiality (Vetten & Jacobs 2008: 4). However, it is on the other hand essential that both the medical doctor and the female rape survivor should understand that there is no absolute guarantee of confidentiality as the doctor may be ordered by the courts to disclose anything during cross examination (McGregor et al. 2009: 32).

#### **4.3.3.4 Medication**

The participants indicated that the medication they received from the healthcare professionals was effective despite the fact that it had some side effects. The participants anticipated the side effects of the medication because they were already informed as to what side effects to expect when on PEP. The following quotations support the views of the participants relating to the medication received from the healthcare professionals:

- “... *the medication that they [nurses and medical doctors] give me ... and they overlook [checked] them [medication treatment] several times to ensure that the medication was proper...*”
- “... *the treatment was fine ... the only thing was ... I had side effects ... I had swollen legs...*”



- “... when they [nurses and medical doctors] need to give me the treatment that I need at that point in time ... they give it [treatment] to me without any ... conversation ... so I like it...”
- “... the treatment side effects was ... it made me [female rape survivor] vomit ... but for 3 to 4 days and thereafter I was well...”
- “ ... you don't feel alright...you feel dizzy...in between that cycle of me [female rape survivor] taking that medication and afterwards ...”

**Discussion:** The participants agreed that the medication that was given to them was good and effective except for some side effects. The mutual agreement indicates that the participants valued the treatment that they were given by the healthcare professionals. In a study conducted by Vetten and Jacobs (2008: 5) rape survivors valued the availability of PEP and the courtesy they received from the healthcare professionals when administering the treatment. Arend et al. (2012: 6) reiterate that rape survivors would want to finish the treatment course despite side effects experienced. In this study one participant indicated that PEP was “*bad*” and thought that if possible “*medication should be reduced*” because of its “*horrible side effects*”. In spite of the side effects she experienced, this participant did finish the course.

The study conducted by Arend et al. (2012: 154) showed that sexual survivors are “*often traumatized when they seek medical attention*” and as such are unable to understand the importance of taking PEP as a prophylaxis to minimise the risk of contracting HIV. Therefore it is important for the healthcare professionals to explain the importance at every contact. In contrast to the study conducted by Wadsworth and van Order (2012: 437) in which it was found that adherence by sexual assault survivors to the full course of PEP was poor, the female rape survivors in this study completed PEP because of the support and health education given by the healthcare professionals. Greeson and Campbell (2011: 991) agree adherence to PREP is sometimes poor, but as found in the current study the female rape survivors most likely completed their 28-day course of treatment since they communicated that the management that they received during treatment was good. The further stated they were treated with

respect and courtesy by the healthcare professionals. One said she appreciated the fact that the healthcare professional administered PEP “*without conversation*”, in other words without referring to the rape incident or making small talk.

Although PEP has side effects, the participants did not default on the treatment. In a study conducted by Chacko et al. (2012: 339) it was also found vomiting as a side effect resulted in women not completing the course. In this study the female rape survivors were given starter packs for 2 to 5 days as shared by one participant who said she was given treatment for “*two days*” and was to return on the Monday for more. Chacko et al. (2012: 337) state in some institutions rape survivors were provided with starter packs ranging from 2 to 7 days. Abrahams et al. (2010: 1175) state follow-up is arranged for collection of further PEP medication.

#### **4.4 CONCLUSION**

The study findings corroborated by a literature control were discussed in Chapter 4. The participants experienced the support and help received when admitted to the centre as positive: they were treated with respect and this allowed them the freedom to openly and honestly share their traumatic experience. They were not judged by the healthcare professionals; not being judged allowed the participants to keep their self-worth and dignity. Also, the professional healthcare team strengthened their belief in their future, made them aware that they could still live a full life even if they had been infected with HIV or STIs since it was both treatable. The participants expressed they were attended to holistically – attention was paid not only to their physical injuries, but also to their emotional needs and fears. Yet, one (1) survivor indicated that the interaction with healthcare professionals was negative because of staff shortages. She stated: “*I went several times to the social worker but I did not find her*”.

On the other hand it was found that the participants wished for the crisis centre attached to the emergency unit to provide a 24-hour service so that female rape survivors who arrive at the centre could be attended to immediately. This centre should also be facilitated by a multidisciplinary team, that is, it must have its own doctors, trained SANEs (forensic nurses), psychologists, a female police officer and counsellors under one roof to achieve a higher standard of optimal care for female rape survivors.

Literature studies indicate that PEP adherence was often poor; but in this study female rape survivors were more likely to complete the entire 28 day course because of the support they received from the healthcare professionals and their families. Of the 10 participants interviewed, one spoke specifically about healthcare professional as her role models. She noted that the counsellors “*came to her level,*” they talked to her “*like parents*” and as such they became her role models.

In Chapter 5 the conclusions of the findings, recommendations and limitations are presented.

## 5 CONCLUSIONS, RECOMMENDATIONS AND LIMITATIONS

### 5.1 INTRODUCTION

Chapter 4 was dedicated to the discussion of the research findings and related literature. Chapter 5 concludes the study of exploring the views of female rape survivors regarding their management in an emergency. In addition suggestions for future research are made.

### 5.2 AIM

The overall aim of this study was to explore the views of female rape survivors regarding the management received at an emergency unit in North West, a province in South Africa.

The conclusions and recommendations are discussed in terms of the objectives identified for the study in Sections 5.3 and 5.4.

### 5.3 OBJECTIVE 1

The first objective was:

To explore and describe the views of female rape survivors regarding the management received at the emergency unit.

The female rape survivors responded positively to the first objective that related to the views of female rape survivors regarding the best aspects of management received in the emergency unit. Their positive stories shared during the one-to-one in-depth interviews indicated that there were a number of excellences with regard to what was “*working well*” about the management that they received in the emergency

unit at the hospital. If these excellences could be maximised, it could lead to an outstanding performance by the healthcare professionals and significant positive changes in the management of the female rape survivors in the emergency unit at the hospital. The findings regarding the strengths and passions of the female rape survivors related to the management they received are summarised in Section 5.3.1.

### **5.3.1 Theme 1: Therapeutic environment**

The female rape survivors found that the healthcare professionals that assisted them in their time of need created a therapeutic environment in the emergency unit. This therapeutic environment was enhanced by the therapeutic relationship between the healthcare professionals and the female rape survivors. The fact that they were in therapeutic relationship with the healthcare professionals in the emergency unit encouraged the female rape survivors to tell their stories without the fear of being judged. They experienced the management that they received as person-centred because of the trusting relationship and respectful attitude the healthcare professionals demonstrated towards them. Literature confirmed that if a therapeutic environment is created for the female rape survivors during their time of need, it enables them to tell their stories without fear of being judged as verified by the statements of the participants.

The female rape survivors signified that they were treated as if they were the only people around in the emergency unit because the healthcare professionals respected whatever decisions they made during their management; in other words, the female rape survivors were allowed to make their own choices. Because the healthcare professionals created a therapeutic environment for the female rape survivors during their crisis in the emergency unit at the hospital, the female rape survivors became motivated not only for their own future but also for the future management of other female rape survivors.

As indicated, the healthcare professionals that assisted the female rape survivors during their time of need provided them with support in a caring and nurturing manner which enabled them to freely tell their stories. The healthcare professionals

made themselves available when they were needed by the female rape survivors. As indicated by the female rape survivors, the healthcare professionals were very “welcoming”; they showed the female rape survivors respect and empathy which encouraged them “to feel free to talk” and share their distress.

The female rape survivors admitted that the healthcare they received from the healthcare professionals encouraged and motivated them to ventilate their problems without fear of criticism or being judged. During the one-to-one interviews the female rape survivors indicated being hopeful because during counselling session it was explained to them that there is still “life after rape” because they were going to be given post exposure prophylaxis (PEP).

### 5.3.1.1 Recommendations

As identified by the female rape survivors, the most satisfying aspect of the management that was received should be carried forward to influence a positive change in the management of future adult female rape survivors in the emergency unit of the hospital. The recommendations made regarding the therapeutic environment are presented below.

- The healthcare professionals should continue with the current caring and nurturing approach used during the management of female rape survivors since it is highly valued by these patients when finding themselves in such a personal and harrowing crisis.
- Nurses working in the emergency unit should be sent for training with regard to identification, assessment and treatment of female rape survivors.
- The person-centred approach management style demonstrated by the healthcare professionals should be continued. By listening attentively and with empathy to the female rape survivors when “telling their stories” enhances the person-centred approach in the management of female rape survivors.
- The healthcare professionals should continue with the current management principles of being empathetic and portraying a respectful attitude towards the

female rape survivors as it will allow the latter to feel safe, secure and without feeling that they are being judged.

- The healthcare professionals should continue to treat female rape survivors with respect and dignity as this will enhance the possibility that they will return for support after leaving the emergency unit of the hospital.
- Female rape survivors should be recognised as a priority, starting from triage, because of their emotional and psychological trauma.
- A unique colour coded system (triage sticker) designed specifically to identify the patient as a female rape survivor should be implemented. This will promote awareness among the healthcare professionals to manage these patients as a priority in the emergency unit.
- Healthcare professionals should adopt a non-judgmental attitude in caring for the female rape survivors during their management
- Healthcare professionals should spend ample time with the female rape survivor to provide her with an opportunity to “*tell her story*”. This will assist the female rape survivor to open up and ventilate to the healthcare professionals. For a female to find herself in this kind of crisis undoubtedly requires time and patience from the healthcare professionals’ side. Spending time with the female rape survivor will also help the healthcare professional to document her history in the rape survivor’s own words.
- Female rape survivors should be managed in a dedicated area which is available and accessible 24 hours on daily basis to promote continuous care by healthcare professionals trained to manage rape survivors.

### 5.3.2 Theme 2: Optimal healthcare received

The healthcare received from the healthcare professionals as communicated by the female rape survivors during their management at the emergency unit was “*good*”. Nurses and counsellors were able to give them the psychological support they needed so that they were able to make their own decisions and choices. The healthcare received encouraged the female rape survivors to feel free to telephone nurses and counsellors once they were discharged in order to ask for advice. Although one out of the 10 participants indicated that the treatment that was given to

her were not thoroughly explained, most of the female rape survivors indicated that the treatment (drugs) that was provided as a prophylaxis was thoroughly explained to them through health education by the healthcare professionals.

Because of the caring attitude that the healthcare professionals had, the female rape survivors were able to observe the treatment side effects as they were told and reported them to the healthcare professionals. As a primary responsibility for the healthcare professionals, nurses and medical doctors were able to help restore the female rape survivors' dignity by offering them undivided attention and support during their crisis management at the emergency unit in the hospital. It is stated in the literature that, if healthcare professionals offer support and undivided attention to the female rape survivors during the crisis, they will earn the faith and respect of the female rape survivors which will lead them to return for follow-up visits and thus support at the emergency unit of the hospital.

### **5.3.2.1 Recommendations**

The most gratifying aspects of the healthcare received as identified by the female rape survivors should be carried forward to influence a positive change in the management of female rape survivors during their visit to the emergency unit. The recommendations made regarding optimal healthcare received are listed next.

- Female rape survivors should be referred to wellness clinics for further management, support and follow-up treatment should they be found to be HIV positive so that their CD 4 counts could be checked directly following the rape incident.
- Female rape survivors found negative directly following the incident should receive PEP to prevent HIV and STIs as well as to prevent a pregnancy.
- Health education with regard to PEP side effects should be emphasised with each follow-up contact session to enhance the compliance of the female rape survivors to complete the treatment and decrease their risks for contracting HIV, STIs and a possible pregnancy.



- It is important to emphasise health education with regard to PEP side effects with each follow-up session to enhance compliance with the treatment protocol.

## 5.4 OBJECTIVE 2

The second objective was:

To make recommendations to healthcare professionals responsible for managing the rape survivors in the emergency unit to promote patient-centred management.

The female rape survivors' responses to the second objective revealed a number of wishes for the future management of female rape survivors.

### 5.4.1 Theme 3: Excellence in service delivery

The realisation of the wishes voiced by the female rape survivors focused on the importance of providing excellent service delivery when managing the female rape survivors in the emergency unit.

To improve the management of the female rape survivor, an increase in the healthcare professionals dedicated to the management of female rape survivors was suggested. The female rape survivors explained that, for example, from 19h00 no counsellors and social workers were available for counselling of female rape survivors. If the female rape survivors are seen after 19h00 or during the night, they can only be seen for counselling the next day for further management – this is problematic because it can lead to re-victimisation of female rape survivors as they are required to re-tell their story over and over again. As verified in the literature, the female rape survivors should be seen by different professionals (nurses, counsellors) on the same day that they present at the emergency unit to prevent re-victimisation.

The other aspect the female rape survivors wanted to be included in the management was spiritual support. They felt strongly that pastors should be included for the management of the inner person. If spiritual counselling and accompaniment are provided as part of the management of a female rape survivor in the emergency unit, it can strengthen her inner self and boost her feeling of self-worth thus preventing that she feels also spiritually violated and broken by the actions of the perpetrator. The female rape survivors indicated that having a spiritual leader, for example, the pastor or the deacons included in their management could spiritually help them to come to terms with what has happened. They felt the provision of spiritual support can lead to the realisation of the dream to move on with their lives as it can lead them to forgive their perpetrators. Literature confirmed that spirituality can help the female rape survivors to come to terms with what has happened to them and to continue with their lives

The female rape survivors envisioned that the management of female rape survivors should include health education, medication and confidentiality which would enhance optimal service delivery (view Sections 5.4.1.1 to 5.4.1.3).

#### **5.4.1.1 Health education**

The female rape survivors felt that the health education they received from the health care professionals during their time of need when they were in crisis was “good”. They agreed that they were given information with regard to medication (PEP) as to how much to take, the importance of taking medication as well as which side effects to anticipate. This information enabled them to take their treatment and finish the course as directed because they knew the importance thereof. The female rape survivors were able to complete the required dose of PEP medication as directed by the healthcare professionals during information giving despite the side effects endured. It was recommended that this health education be reinforced during follow-up visits of these women to stress the importance of completing PEP medication.

#### 5.4.1.2 Medication

The medication that was given to the female rape survivors during the management that they received included PEP medication, antibiotics to prevent STIs and pregnancy prevention.

#### 5.4.1.3 Confidentiality

The other component that one of the female rape survivors stressed was confidentiality. Although confidentiality was maintained during the management of female rape survivors at the emergency unit, the participants felt that it was very important to maintain privacy because they would not want to hear what was said between the female rape survivor and the healthcare professionals outside those premises. The female rape survivors stressed that they did not want anybody to hear or to know what had happened to them. One participant mentioned that “*it is premafacia* [prima facie]”. The healthcare professionals suggested that it was of paramount importance that all healthcare professionals who work in an emergency unit sign confidentiality forms before examining the female rape survivor just to make sure that they (healthcare professionals) stick to the confidentiality clause.

#### ⇒ Recommendations

The following recommendations were made for continued excellence in service delivery.

- Dedicated healthcare professionals and support staff, including the counsellor, social worker and the police officer should all be available 24 hours at the emergency unit to obtain the relevant information and history to prevent re-victimisation if the female rape survivor is taken to the police station.
- A patient-centred approach should be encouraged through implementing the following suggested supportive interventions:
  - organising a peer support group for the female rape survivors

- introducing relaxation exercises during follow-up treatments
- involving church leaders, pastors and ministers for spiritual support following the rape incident
- strictly maintain the confidentiality of female rape survivors throughout the management process.
- confidentiality form to be signed by emergency unit staff members.
- provide additional anti-emetic drugs to prevent or reduce nausea and vomiting which are adverse effects of the PEP drugs.

## 5.5 LIMITATIONS OF THE STUDY

Despite the positive results obtained from this study, the methodological limitations needs to be mentioned. There were a few of these methodological limitations regarding the sample and data analysis, but had no adverse effect on the study results.

The purposeful sample in this study was limited to one provincial government funded hospital in North West, one of the nine provinces in South Africa. The data were collected from only ten participants. The findings were only applicable to the representative sample. Only adult female rape survivors were included as participants. The purposeful sample of the adult female rape survivors was relatively small which makes generalisation to other settings difficult. Replication with a larger sample sizes and wider settings were noted. The female rape survivors in this study might not have been representative of all female rape survivors who were managed in the emergency unit of the hospital.

The views of the participants may be different from the general population's view. It is quite possible that the views and wishes for the future female rape survivors stated in this study may be different from those of their male counterparts.

## 5.6 FUTURE RESEARCH

Based on the research findings future studies should be conducted around the views of female rape survivors in the emergency unit. Specific topics identified for future research are mentioned below.

- The views of rape survivors regarding the management they receive at emergency units/Thuthuzela centres.
- Implementation of recommendations and re-evaluation of whether the strategies have enhanced a patient-centred management approach for female rape survivors in the emergency unit.
- The impact of peer and spiritual support on the management of female rape survivors.
- The views of Sexual Assault Nurse Examiners (SANE) with regard to the management of rape survivors.
- Providing a comprehensive management strategy for survivors of rape/intimate partner violence.

## 5.7 PERSONAL REFLECTION

When I started my dream to enrol for my master's degree, I thought the journey would be smooth and without any significant problems or difficulties. However, I soon discovered it was not easy to walk this path to realise my dream.

The first obstacle I encountered was that I was not computer literate. As master's students we were required to attend a one-week computer literacy course at the University of Pretoria to improve our computer skills. I had to travel 300 km from where I stay and where my place of work is in North West to attend classes as well as contact sessions with my supervisors. I found it tiring and challenging to travel 600 km to and fro on a regular basis. The fortunate part was that I was not travelling alone; I was travelling with my colleague who encouraged me a lot during these journeys when we set off in the early hours of the morning.

At first it was extremely difficult to even develop the proposal but I was overjoyed when I finally managed to complete it. It made me realise I simply had to rise above any challenges that came my way. I started enjoying my monthly travels to the UP for classes and contact sessions with my supervisors. I will never forget the day that my supervisor informed me that my proposal had been approved by the Faculty of Health Sciences Research Ethics Committee. I then faced the task of presenting my proposal to the Ethics Committee of the Department of Health for approval. Although nervous, I faced the panel of eight members which included the Deputy Director General (the Chairperson of the Committee) and the Assistant Director in Equity and People with Disability Department. The presentation took approximately 45 minutes. The Chairperson congratulated me on the proposal and even commented that he might copy some of the lines that he found very interesting for his study. All the members mentioned that it was the very first time they had heard about Appreciative Inquiry where the researcher was taking a positive stance.

The first three interviews were a disaster. It was supposed to be pilot interviews but I lost all the information and had to start all over again. My recorder was not working properly so I had to return it to the supplier and that is when I lost my data. At that stage I felt very demoralised because by then I had realised how difficult it was to get even one participant to agree to an interview because of the sensitivity of the topic.

I am very humbled by the knowledge that I have acquired from conducting this study. Conducting a research study can be a frightening experience. It needs a person to be fully committed to work. I have learnt that through hard work, perseverance and sacrificing one's personal life for the sake of the study is the only way one can ever achieve success. To me success did not only mean completing the project, it also meant that I had fulfilled my dream and had hopefully made a positive and real contribution to give female rape survivors, who so often suffer in silence, a voice and a dream of their own.

## 5.8 CONCLUSION

In Chapter 1 of the study the introduction, background and rationale for the topic of the study were presented. The problem statement, research question, aims and objectives of the study were outlined. The context of the study was described to the reader to enlighten them about the setting. Also in Chapter 1 the paradigm and the theoretical framework were discussed. The assumptions were discussed and the readers were introduced to the key concept of the study, the research method, trustworthiness and the ethical considerations that were adhered to as well as the limitations of the study.

In Chapter 2 an overview of Appreciative Inquiry as the theoretical framework for the study was discussed in detail. The research designs and methods used to conduct the study and rationale for using these designs and methods were outlined in Chapter 3.

Chapter 4 presented the rich narrative data gathered by conducting a qualitative, explorative and descriptive study. The findings were aligned to Appreciative Inquiry as the framework for the study. Direct quotations from the research participants were included and referred to in the discussions. The literature control indicated that the findings in this study significantly related to the findings in other research studies.

Finally, in Chapter 5 a summary of the findings was done by identifying and describing the factors that influence the management of the female rape survivors in the emergency unit of the hospital in North West. Recommendations for the management of female rape survivors in the emergency unit of the hospital and the North West Province regarding the implementation of the findings were presented as they could lead to excellence in the future management of these patients. Furthermore, it was indicated that these findings could also be applied with positive results in the emergency unit. Future research recommendations were also made.

The research methodology and the design selected for this study has proved to be an effective means of gaining insight into the lived experiences of adult female rape

survivors regarding the management received in the emergency unit during their crisis. Using a qualitative research approach by means of one-to-one semi-structured interviews as a method of data collection, the researcher was able to study the female rape survivors in their context and to explore their stories and their wishes regarding the future management of female rape survivors.

The experiences of the adult female rape survivors as regards the management they received in the emergency unit at the hospital were explored and described in detail. The female rape survivors told their lived experiences of the management received in the emergency unit. It was also found that their experiences were confirmed by literature. The information derived from this study is important for the future management of female rape survivors.



## REFERENCE LIST

Abrahams, N, Jewkes, R, Lombard, C, Matthews, S, Campbell, J & Meel, B 2010, Impact of telephonic psycho-social support on adherence to Post Exposure Prophylaxis (PEP), *Aids Care*, Routledge, 22(10), 1173-1181.

Anguita, LA 2012, Tackling corrective rape in South Africa: the engagement between the LGBT CSOs and the NHRIs (CGE and SAHRC) and its role, *The International Journal of Human Rights*, Routledge, 16(3), 489-516.

Arend, E, Maw, A, de Swardt, C, Denny, LA & Roland, M 2012, South African sexual survivors' experience of post-exposure prophylaxis and individualized nursing care: a qualitative study, *Journal of Association of Nurses in AIDS Care*, Elsevier, 24(2), 154-165.

Barry, MJ & Edgman-Levitan, S 2012, Shared decision making – the pinnacle of patient centred care, *The New England Journal of Medicine*, Perspective, 780-781.

Bechtold, M 2010, Improving worker morale through the use of appreciative inquiry, Arab cultural factors and AI, Research paper, 1-6.

Bergh, ZC & Theron, AL 2009, *Psychology in the work context field of study and practice areas in industrial and organizational psychology*, Oxford University Press, Cape Town.

Boet, S, Sharma, S, Goldman, J & Reeves, S 2012, Medical education research: an overview of methods, *Canadian Anesthesiologists' Society*, Review article, Springer, 59, 159-170.

Botma, Y, Greeff, M, Mulaudzi, FM & Wright, SCD 2010, *Research in health sciences*, Heinemann, Cape Town.

Brink, HI 2003, *Fundamentals of nursing research methodology for health care professionals*, Juta, Pretoria.

Brink, H, van der Walt, C & van Rensburg, G 2010, *Fundamentals of research methodology for health care professionals*, 2nd edition, Juta, Cape Town.

Brittain, C & Nisenbaum, J 2012, Facilitative supervision and management: a model for improved performance, *National Child Abuse & Neglect Conference*, 1-16.

Bryant-Davis, T, Ullman, SE, Tsong, Y & Gobin, R 2011, Surviving the storm: the role of the social support and religious coping in sexual assault recovery of African American women, *Violence Against Women*, Sage, 17(12), 1601-1618.

Burns, N & Grove, SK 2005, *The practice of nursing research, conduct, critique and utilization*, 4th edition, Elsevier, Missouri.

Burns, N & Grove, SK 2009, *The practice of nursing research appraisal, synthesis, and generation of evidence research*, 6th edition, Saunders Elsevier, Missouri.

Bushe GR & Kassam AF 2008, When is Appreciative Inquiry transformational? A meta-case analysis, *The Journal of Applied Behavioural Science*, 41(2), 161-181.

Calabrese, R & Cohen, E 2013, An Appreciative Inquiry into an urban drug court: cultural transformation, *The Qualitative Report*, 18(2), 1-14.

Campbell, R & Adams, AE 2009, Why do rape survivors volunteer for face-to-face interviews? A meta-study of victims' reasons for and concerns about research participation, *Journal of Interpersonal Violence*, Sage, 24(3), 395-405.

Campbell, R, Adams, AE, Wasco, SM, Ahrens, CE & Sefl, T 2010, What has it been like for you to talk with me today: the impact of participating in interview research on rape survivors, *Violence against Women*, Sage, 16(1), 60-83.

Campbell, R, Patterson, D & Bybee, D 2011b, Using mixed methods to evaluate a community intervention for sexual survivors: a methodological tale, *Violence against Women*, Sage, 39(3), 376-388.

Campbell, R, Greeson, M & Patterson, D 2011a, Defining the boundaries: how sexual assault nurse examiners (SANE's) balance patient care and law enforcement collaboration, *International Journal of Forensic Nursing*, 17-26.

Campbell, R, Bybee, D, Kelly, KD, Dworkin ER & Patterson, E 2012, The impact of sexual nurse examiner (SANE) program services on law enforcement investigational practices – a mediational analysis, *International Association for Correctional and Forensic Psychology, Criminal Justice and Behaviour*, 39(2), 169-184.

Chacko, L, Ford, N, Sbati, M & Siddiqui, R 2012, Adherence to HIV post-exposure prophylaxis in victims of sexual assault: a systemic review and meta-analysis, *Sex Transm. Infect*, 88, 335-341.

Cole, J 2011, Victim confidentiality on sexual assault response teams (SART), *Journal of Interpersonal Violence*, Sage, 26(2), 360-376.

Cooperider, DL, Whitney, D & Stavros, JM 2003, *Appreciative Inquiry handbook*, Bedford Heights, Lakeshore.

Cooperrider, DL, Whitney, D & Stavros, JM 2008, *Appreciative Inquiry handbook for leaders of change*, 2nd edition, Crown Custom, USA.

Cram, F 2010, Appreciative Inquiry. MAI Review, 3. Available from: <http://review.mai.ac.nz> [Accessed 7 May 2011].

Creswell, JW 2003, *Research design: qualitative, quantitative and mixed methods approaches*, 2nd edition, Sage Publication, California.

Creswell, JW 2007, *Qualitative inquiry and research design: choosing among five approaches*, 2nd edition, Sage Publications, Thousand Oaks.

Creswell, JW 2009, *Qualitative, quantitative and mixed method approaches*, 3rd edition, Sage, Thousand Oaks, USA.

Crisp, BR 2004, Spiritual direction and survivors of sexual abuse, *Journal of Interpersonal Violence*, 43(2), 7-17.

Davis, CM, 2005, A tool for transformational learning, *Appreciative Inquiry*, Selected Work, Conference Paper, Michigan State University, 1-7, available from: [http://works.bepress.com/christopher\\_davis/2](http://works.bepress.com/christopher_davis/2) [Accessed give day month year].

Davis, LB 2007, The power of educational technology: demonstrating the power of technology to transform learning, energize communities and inspire innovative thinking: assumptions of Appreciative Inquiry, available from: <http://edtechpower.blogspot.com/> [Accessed 16 April 2011].

Dawson, M, Hubbert, MJ & Poon, J 2010, Documenting resources for victims and survivors of violence in Canada. A workshop discussion paper, *Social and Legal Response to violence in Canada Research Unit*, 1-75.

De Bono, E & Heller, R 2006, Thinking managers. SWOT: assess the strengths, weaknesses, opportunities and threats of your business with SWOT analysis, available from: <http://www.thinkingmanagers.com/management/strengths-weaknesses> [Accessed 5 April 2011].

---

De Vos, AS, Strydom H, Fouché CB & Delport, CSL 2011, *Research at grass roots for the social sciences and human service profession*, 4th edition, Van Schaik, Pretoria.

Ekman, I, Swedberg, K, Taft, C, Lindseth, A, Norberg, A, Brink, E, Carlsson, J, Dahlin-Ivanoff, S, Johansson, IL, Kjellgren, K, Lindén, E, Ohlen, J, Olsson, LE, Rosén, H, Rydmark, M & Sannerhagen, KS 2011, Person-centred care. Ready for prime time, *European Journal of Cardiovascular Nursing*, 10(4):248-251.

Elo, S & Kyngas, H 2007, 'Jan research methodology: the qualitative content analysis process', *Journal of Advanced Nursing*, 62(1), 107-115, available from: <http://academic.csuohio.edu/kneuedorf/c63309/articlesFromClassMembers/Army.pdf> [Accessed 9 August 2011].

Eogan, M, McHugh, A & Holohan, M 2012, The role of sexual assault centre, *Best Practice & Research Clinical Obstetrics and Gynaecology*, Elsevier, 27, 47-58.

Fehler-Cabral, G, Campbell, R & Patterson, D 2011, Adult sexual survivors' experiences with sexual assault nurse examiners (SANEs), *Journal of Interpersonal Violence*, 26(18), 3618-3639.

Ferguson, LM, Ward, H, Gard, S, Sheppard, S & McMurtry, J 2013, Putting the patient back into patient-centred care: an education perspective, *Nurse Education in Practice*, Elsevier, 13, 283-287.

Fiorentino, LH 2012, Positive perspectives on the profession: refraining through Appreciative Inquiry, *Quest*, 64(4), 209-228.

Frampton, S, Guastello, S, Brady, C, Hale, M, Horowitz, S, Smith, SB & Stone, S 2008, *Patient-centred care improvement guide*, Planetree, Picker Institute, Derby, 1-247.

---

Garbett, R & McCormack, B 2004, A concept analysis of practice development. In: B. McCormack, K. Manley & R. Garbett (Eds.), *Practice development in nursing*, Blackwell Publishing, Oxford.

Garcia-Moreno, C, Jansen, HAFM, Ellsberg, M, Helse L, & Watts, C 2005, WHO multi-country study on women's health and domestic violence against women: initial results on prevalence, health outcomes and women's responses, World Health Organization, Avenue Appia, 1211 Geneva 27, Switzerland.

Gokdogan, MR & Bafra, J 2009, Development of a sexual assault evidence collection kit: the need for standardization in Turkey, *Nurse Education Today*, 30(4), 285-290.

Govender, V & Penn-Kekana, L 2007, *Gender biases and discrimination: a review of health care interpersonal interactions*, Background paper prepared for the Women and Gender Equity Knowledge Network of the WHO Commission on Social Determinants of Health, June 2007, 15.

Graebner, ME, Martin, JA & Roundy, PT 2012, Qualitative data: cooking without recipe, *Strategic Organisation*, Sage, 10(3), 276-284.

Green, J & Thorogood, N 2004, *Qualitative methods for health research*, Sage, London.

Greeson, MR & Campbell, R 2011, Rape survivors' agency within the legal and medical systems, *Psychology of Women Quarterly*, Sage, 35(4), 582-595.

Greeson, MR & Campbell, R 2012, Sexual assault response teams (SARTs): an empirical review of their effectiveness and challenges to successful implementation, *Trauma, Violence & Abuse*, Sage, 14(2), 83-95.

Hammond, SA 1998, *The thin book of Appreciative Inquiry*, Thin Book Publishing, Plano.

Hall, J & Hammond, SA 2004, *What is Appreciative Inquiry?*, available from: [http://1.61.store.up.scs.yahoo.com/lib/thin book](http://1.61.store.up.scs.yahoo.com/lib/thin%20book) [Accessed 10 November 2010].

Hancock, B 2002, Trend focus for research and development in primary health care, *Methods of collecting qualitative data*, Trend Focus Group, 9-20.

Harmon, RB, Fontaine, D, Plews-Ogan, M & Williams, A 2012, Achieving transformational change: using Appreciative Inquiry for strategic planning in a school of nursing, *Journal of Professional Nursing*, Elsevier, 28(2), 119-124.

Havens, DS, Woods, SO & Leeman, J 2006, Improving nursing practice and patient care, *The Journal of Nursing Administration*, 36(10), 463-470.

Henning, E 2004, *Finding your way in qualitative research*, Van Schaik, Pretoria.

Hofstee, E 2009, *Constructing a good dissertation*, EPE, Sandton.

Holloway, I & Wheeler, S 2002, *Qualitative research in nursing*, 2nd edition, Blackwell Science, Oxford.

Holloway, I & Wheeler, S 2010, *Qualitative research in nursing and healthcare*, 3rd edition, Blackwell Science, United Kingdom.

Hudson, C, Fortin, M, Haggerty, JL, Lambert, M & Eve-Poitras, ME 2011, Measuring patients' perceptions of patient-centred care: a systematic review of tools, *Annals of Family Medicine*, 9(2), 155-164.

Hsieh, HF, Feng, JY & Shu, BC 2009, The experiences of Taiwanese women who have experienced domestic violence, *Journal of Nursing Research*, 17(3), 153-160.

Human Rights Commission, 2007, Submission to the South African Human Rights Commission: *Public Inquiry into the right to have access to health care services*, National Working Group, South Africa, 1-17.

Husain, R & Khan, A 2008, Women's perception and experiences of sexual violence in marital relationships and its effect on reproductive health, *Health Care for Women International*, Taylor & Francis, 29, 468-483.

Jina, R, Jewkes, R, Munjanja, SP, Mariscal, JDO, Dartnall, E & Gebrehiwot, Y 2010, Report of the FIGO working group on sexual violence/HIV: guidelines for the management of female rape survivors of sexual assault, *International Journal of Gynaecology and Obstetrics*, 109, 85-92.

Jina, R, Jewkes, R, Christofides, N & Loots, L 2013, Knowledge and confidence of South African health care providers regarding post-rape care: a cross-sectional study, *BMC Health Services Research*, Open Access, 13, 1-13.

Kajanus, M, Lekinen, P, Kurttila, M & Kangas, J 2012, making use of MCDS methods in SWOT analysis – lesson learnt in strategic natural resources management, *Forest Policy and Economics*, Elsevier, 20, 1-9.

Keefe, MR & Pesut, D, 2004, Appreciative Inquiry and leadership transitions, *Journal of Professional Nursing*, 20(2), 103-109.

Keefe, MR & Pesut, D 2007, Appreciative Inquiry and leadership transitions. *Journal of Professional Nursing*, 20(2), 103-109.



Keefe, A & Hage, E 2009, Assisting refugee and asylum seeking women affected by rape or sexual violence, *Vulnerable Women's Project Good Practice Guide*, 1-16.

Kelly-Heidenthal, P 2003, *Nursing leadership and management*, Thompson Delmar Learning, New York.

Kim, J, Mokwena, L, Ntlemo, E, Dwane, N, Noholoza, A, Abramsky, T & Marinda, E 2007, Developing an integrated model for post-rape care and HIV post-exposure to prophylaxis in rural South Africa, available from: [http://pdf.usaid.gov/pdf\\_docs/PNADK615.pdf](http://pdf.usaid.gov/pdf_docs/PNADK615.pdf) [Accessed 19 August 2011].

Knell, K 2010, *Appreciative Inquiry*, Blue Summit Strategy, California, available from: <http://bluesummutstrategy.com/collaboration/appreciativeinquiry/2010>, [Accessed 26 June 2011].

Knibbs, K, Underwood, J, MacDonald, M, Schoenfeld, B, Lavoie-Tremblay, M, Crea-Arsenio, M, Meagher-Steward, D, Stamler, LL, Blythe, J & Ehrlich A 2010, Appreciative Inquiry: a strength-based research approach to building Canadian public health nursing capacity, *Journal of Research in Nursing*, Sage, 17(5), 484-494.

Knapik, GP, Martsolf, DS & Draucker, CB 2008, Being delivered: spirituality in survivors of sexual violence issues in mental health nursing, *Informa Healthcare*, 29, 335-350.

Knapik, GP, Matsolf, DS, Draucker, CB & Strickland, KD 2010, Attributes of spirituality described survivors of sexual violence, *National Institute of Health*, 15(3), 644-657.

Koch, T 2006, Establishing rigour in qualitative research: the decision trial, *Journal of Advanced Nursing*, 53(1), 91-103.

LoBiondo-Wood, G & Haber, J 2010, *Nursing Research: Methods and critical appraisal for evidence-based practice*, 7th edition, Elsevier, China.

*Longman dictionary of contemporary English*, 2009, 5th edition, Pearson & Longman, Milano.

Luce, H, Schrager, S & Gilchrist, V 2010, Sexual assault of women, *American Family Physician*, 81(4), 489-495.

Lutwak, N 2012, The rape and oppression of women remains a worldwide problem, *Feminist Theology*, 21(2), 209-210.

Luxford, K, Piper, O, Dunbar, N, & Poole, N 2010, *Patient-centred care: improving quality and safety by focussing care on patients and consumers*, Discussion paper draft for public consultation, Australian Commission on Safety and Quality in Health Care, Sydney, 1-86.

Maier, S 2012, Sexual nurse examiner's perception of the re-victimization of rape victims, *Journal of Interpersonal Violence*, Sage, 27(2), 287-315.

Manley, TR & Shaw, WH 2002, Action research, Appreciative Inquiry and organizational learning, available from: <http://ieeexplore.ieee.org/stamp/stamp.jsp?tp=&arnumber=1038394> [Accessed 19 July 2013].

Maree, JG 2012, Promoting children's rights: rekindling receptivity, *South African Journal of Psychology*, 42(3), 95-300.

Mariampolski, H 2001, *Qualitative market*, available from: [Doi:http://dxdoi.org/10.4135/9781412985529](http://dxdoi.org/10.4135/9781412985529) [Accessed 15 June 2012].

Martin, TL & Calabrese, RL 2011, Empowering at-risk students through Appreciative Inquiry, *International Journal of Educational Management*, 25(2), 110-123.

Martsof, DS, Drauker, CB, Cook, CB, Ross, R & Stidham, AW 2010, A meta-summary of qualitative findings about professional services for survivors of sexual violence, *National Institute of Health*, 15(3), 439-406.

Mbambo, DE 2009, Factors contributing to adolescent mothers' non-utilization of contraceptives in Piet Retief area, *Research Methodology*, UNISA, South Africa, 1-70.

McCormack, B, Dewing, J, Breslin, L, Coyne-Nevin, A, Kennedy, K, Manning, M, Peelo-Kilroe, L, Tobin, C & Slater, P 2010a, Developing person-centred practice: nursing outcomes arising from changes to the environment in residential settings for older people, *International Journal of Older People Nursing*, Blackwell, 5, 93-107.

McCormack, B, Manley, K & Garbett, R 2010b, *Practice development in nursing*, Blackwell Publishing, Oxford.

McGregor, M, Du Mont, J, White, D & Coombes, ME 2009, Examination for sexual assault: evaluating the literature for indicators of women-centered care, *Health Care for Women International*, Routledge, 30, 22-40.

McKenzy, AS 2003, Change from within, *American School Board Journal*, July, 37-38.

Merriam, SB 2009, *A guide to design and implementation, Qualitative research, higher and adult education series*, Jossey-Bass, San Francisco.

Memarian, R Ahmadi, F & Vaismoradi, M 2008, The leadership concept in Iranian nursing, *Journal Companion: International Council of Nurses*, 48-54.

Miller, AK 2012, Expressed sexual assault legal context and victim culpability attributions, *Journal of Interpersonal Violence*, Sage, 20(6), 1023-1039.

Mukamana, D & Bysiewicz, P 2008, The lived experience of genocide rape survivors in Rwanda, *Journal of Nursing Scholarship*, Sigma Theta Tau, 40(4), 379-384.

Myers, JS & Bellini, LM 2011, Resident handoffs: appreciating them as a critical competency, *J Gen Intern Med*, 27(3), 270-272.

Naidoo, K 2013, Rape in South Africa: a call to action, *South African Medical Journal*, SAMJ, 103(4), 210-211.

National Rape Crisis Statistics and Annual Report 2011, Rape Crisis Network Ireland, 1-84.

National Guidelines on Referral and Forensic Clinical Examination in Ireland, 2010, Sexual Assault, 2nd edition, Health Service Executive, 1-70.

Nolan, MR, Davies, S, Brown, J, Keady, J & Nolan, J 2004, Beyond "person-centred care": a new vision for gerontological nursing, *International Journal of Older People Nursing* in association with *Journal of Clinical Nursing*, Blackwell, 13(3a), 45-53.

Oliver, P 2010, *The student guide to research ethics, ethics and research process*, 2nd edition, McGraw-Hill, England.

Ospina, S, 2004 'Qualitative research methods overview: a data collector's field guide', in *Encyclopedia of Leadership*, *Family Health International*, Sage, 1-12.

Patterson, D & Campbell, R 2010, Why rape survivors participate in the criminal justice system, *Journal of Community Psychology*, Wiley, 38(2), 191-205.

Polit, DE & Beck, CT 2008, *Nursing research: generating and assessing evidence for nursing practice*, 8th edition, Sage, RSA.

Polit, DF & Beck, CT 2010, *Essentials of nursing research appraising evidence of nursing practice*, 7th edition, Lippincott Williams & Wilken, Philadelphia.

Polit, DF. & Beck, CT 2012, *Generating and assessing evidence for nursing practice, nursing research*, 9th edition, Lippincott, Place: Philadelphia.

POWA Report, 2010, Shadow Report on Beijing + 15, Solidarity with women who speak out, AIDS Legal Network, 1-26.

Preskill, H & Catsambas, TT, 2006, *Reframing evaluation through Appreciative Inquiry*, Sage, London.

Pretorius, JPH, du Toit, S, Martin, C & Daries, G 2013, ABBA: an educational appreciation, *Journal of Aesthetic Education*, 47(1), 73-103.

Rape statistics, 2010, Rape statistics – South Africa & worldwide, available from:

[http://www.rape.co.za/index2.php?option=com\\_content&do\\_pdf=1&id=875](http://www.rape.co.za/index2.php?option=com_content&do_pdf=1&id=875),

[Accessed 10 November 2010].

Reed, J 2007, *Appreciative Inquiry research for change*, Thousand Oaks, Sage, London.

Reuben, DB & Tinetti, ME 2012, Goal-oriented patient care – an alternative health outcome paradigm, *The England Journal of Medicine, Perspective*, 777-779.

Republic of South Africa, Department of Health, 2005, Sexual Offences Act, (Act no. 23 of 1957), Government Printer, Pretoria.

Republic of South Africa, 2007, Criminal Law (Sexual Offences and Related Matters) Amendment Act (Act 32 of 2007), Government Printer, Pretoria.

Republic of South Africa, 2007, Human Rights Commission: Public Inquiry into the right to have access to Health Care Services, National Working Group on Sexual Offences, 1-17.

Republic of South Africa, National Department of Health 2011, *National Core Standards for Health Establishments in South Africa, Towards Quality Care for Patients*, Tshwane, South Africa, 1-52.

Reyes, HLM, Billings, DL, Paredes-Guitan, Y & Zuniga, KP 2012, An assessment of health sector guidelines and services for treatment of sexual violence in El Salvador, Guatemala, Honduras and Nicaragua, *Reproductive Health Matters*, Elsevier, 20(40), 83-93.

Roberts GW 2010, *Appreciative Inquiry - a new approach to problem based learning. A new model of inquiry for students and practitioners*, Cardiff University, Caerdyd.

Roche, M 2011, How can I help you? An exploration of the experience of telephonic helpline, *Workers in a Crisis Intervention Centre*, 1-49.

Roland, ME, Myer, L, Martin, LJ, Maw, A, Batra, P, Arend, E, Coates, TJ & Denny, LA 2011, Preventing human immunodeficiency virus infection among sexual assault survivors in Cape Town, South Africa: an observational study, *AIDS Behaviour*, Open Access, 16, 990-998.

Sandoval, M & Campos, R 2013, Appreciative Inquiry: new form to generate change in education organizations, *ECORFAN Journal*, Case: Polytechnic University of Zacatecas-UPZ, 4(9), 1027-1038.

Sammer, CE, Lykens, K, Singh, KP, Mains, DA & Lackan, NA 2010, What is patient safety culture? A review of literature, *Journal of Nursing Scholarship*, Sigma Theta Tau International, 42(2), 156-165.

Schapiro, T 2011, Empathy as a moral concept: comments on John Deigh's "Empathy, Justice, and Jurisprudence", *The South African Journal of Philosophy*, Spindel Supplement, 49, 91-98.

Schooley, S, E, 2012, Using Appreciative Inquiry to engage the citizenry: four potential challenges for public administrators, *International Journal of Public Administration*, 35(5), 340-351

Skhosana, RM & Peu, DM, 2009, Experiences of health care providers managing sexual assault victims in an emergency unit. Part 1: Background and methodology, *Health SA Gesondheid*, 14(1), 110-116.

Schreiber, S 2010, Sexual assault nurse examiners train in forensics, but specialize in patient care, *Beyond Nursing*, Law Enforcement Technology, 18-23.

Srdjevic, Z, Bajcetic R, & Srdjevic, B 2012, Identifying the criteria set for multicriteria decision making based on SWOT/PESTLE analysis: a case study reconstructing a water intake structure, *Water Resource Manage*, Springer Science+Media, 26, 3379-3393.

Smith, JR, Ho, LS, Langston, A, Mankani, N, Shivashanker, A & Perera, D 2013, Clinical care for sexual assault survivors multimedia training: a mixed

methods study of effect on healthcare providers' attitudes, knowledge, and practice in humanitarian settings, *Conflict and Health*, Open Access, 7(14), 1-10.

Stefaniak, K 2007, Discovering nursing excellence through Appreciative Inquiry, *Nurse Leader*, 42-46.

Stowell, F 2012, The Appreciative Inquiry method – a suitable candidate for action research?, *Systems Research and Behavioural Science*, Wiley & Sons, 30, 15-30.

Spence, D, Garrick, H & Mckay, M 2012, Rebuilding the foundations: major renovations to the mental health component of an undergraduate nursing curriculum, *International Journal of Mental Health Nursing*, 27, 409-418.

Streubert Speziale, HJ & Carpenter, DR 2007, *Qualitative research in nursing, advancing the humanistic imperative*, 4th edition, Lippincott Williams & Wilkins, Philadelphia.

Steyn, GM 2010, Reframing professional development for South African schools: an Appreciative Inquiry approach, *Education and Urban Society*, Sage, 44(3), 318-341.

Suffla, S 2004, Intimate partner and sexual violence: implications for the prevention of violence against women in South Africa, *Journal of Injury and Violence Prevention*, 2(1), 41-47.

Suffla, S, Seedat, M & Nascimento, A 2002, A qualitative evaluation of medico-legal services in Gauteng, South Africa, available from: [http://search.sabinet.co.za/WebZ/Authorize?sessionid=0&bad=ejour/ejour\\_bads\\_earch.html&portal=ejournal&next=images/ejour/safety/safety\\_v1\\_n1\\_a4.pdf](http://search.sabinet.co.za/WebZ/Authorize?sessionid=0&bad=ejour/ejour_bads_earch.html&portal=ejournal&next=images/ejour/safety/safety_v1_n1_a4.pdf) [Accessed 19 August 2011].

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Sutherland, J & Stravos, J 2003, The heart of appreciative strategy, AI Practitioner, available from:

<http://appreciativeinquiry.case.edu/practice/executiveDetail.cfm?coid=5265>.

[Accessed 15 December 2013].

Tabor, PD 2011, Vicarious traumatising: concept analysis, *Journal of Forensic Nursing*, Review Article, 7, 203-208.

Teerapong, S, Lumbiganon, P, Limpongsanurak, S & Udomprasertgul, V 2009, Physical health consequences of sexual assault victims, *J Med Assoc Thai*, 92(7), 885-890.

The Hospital 2011, Emergency unit statistics, Unpublished, The Hospital.

Thompson, M 2010, Life after rape. A chance to speak, *Sexual and Relationship Therapy*, 15(4), 325-343.

Tobin, GA & Begley, CM 2004, Methodological rigour within a qualitative framework, *Journal of Advanced Nursing*, 48(4), 388-396.

Tillman, S, Bryant-Davis, T, Smith, K & Marks, A 2010, Shattering silence: exploring barriers to disclosure for African American sexual assault survivors, *Trauma, Violence & Abuse*, Sage, 1(2), 59-70.

Tonnessen, L 2012, From impunity to prosecution? Sexual violence in Sudan beyond Darfur, *NOREF Report*, 1-10.

Trajkovski, S, Schmied, V, Vickers, M & Jackson, D 2013, Implementing the 4D cycle of Appreciative Inquiry in health care: a methodological review, *Journal of Advanced Nursing*, Blackwell, 69(6), 1224-1234.

Uhrenfeldt, L, Lakanmaa, RL, Flinkman, M, Basto, ML & Attree, M 2012, Collaboration: a SWOT analysis of the process of conducting a review of

nursing workforce policies in five European countries, *Journal of Nursing Management*, Blackwell, 1-14.

Urden, LD, Stacy, KM & Lough, ME 2006, *Thelan's critical care nursing: diagnosis and management*, 5th edition, Mosby Elsevier, Philadelphia.

Van Vuuren, LJ & Crous, F **2005**, Utilizing Appreciative Inquiry (AI) in creating a shared meaning of ethics in organisations, *Journal of Business Ethics*, 37, 399-412.

Vetten, L & Jacobs, T 2008, Towards developing and strengthening a comprehensive response to the health care needs of rape survivors, Policy Brief, 1-6.

Wadsworth, P & van Order, P 2012, Care of the sexually assaulted woman, *The Journal for Nurse Practitioners (JPN)*, American College of Nurse Practitioners, 8(6), 433-440.

Wadsworth, P & Records K 2012, A review of health effects of sexual assault on African American women and adolescents, *Journal of Obstetric, Gynecologic & Neonatal Nursing (JOGNN)*, 42(3), 249-273.

Watkins, JM, Mohr, BJ & Kelly, R 2011 *Appreciative Inquiry: change at the speed of imagination*, 2nd edition, John Willey & Sons, USA, available from: <http://appreciativeinquiry.case.edu/intro/definition.cfm> [Accessed 18 Augustus 2012].

Webb, L 2011, *Nursing: communication skills for practice; prepare for practice*, Oxford University Press, New York.

Whitney, D & Trosten-Bloom, A 2003, *The power of Appreciative Inquiry: a practical guide to positive change*, Berrett-Koehler, San Francisco.

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Whitney, D & Trosten-Bloom, A 2010, *The power of Appreciative Inquiry: a practical guide to positive change, putting today's most popular approach to change in practice*, 2nd edition, Berrett-Koehler, San Francisco.

World Health Organization 2001, Declaration of Helsinki, *Bulletin of the World Health Organization*, 79(4), 373-374.

World Health Organization 2003, Guidelines for medico-legal care for victims of sexual violence, available from: <http://whqlibdoc.who.int/publications/2004/924154628X.pdf> [Accessed 10 November 2010].

World Health Organization 2010, Preventing intimate partner violence against women: taking action and generating evidence, available from: [http://www.who.int/violence\\_injury\\_prevention/publications/violence/9789241564007\\_eng.pdf](http://www.who.int/violence_injury_prevention/publications/violence/9789241564007_eng.pdf) [Accessed 10 November 2010].

World Health Organization 2012, *Violence against women – intimate partner and sexual violence against women*, Fact Sheet no 239, November 2012, Media Centre, Geneva.

Wright, KM 2010, Therapeutic relationship: developing a new understanding for nurses and care workers within an eating disorder unit, *International Journal of Mental Health Nursing*, 19, 154-161.

Yohani, SC & Hagen, KT 2010, Refugee women survivors of war related to sexualised violence: a multicultural framework for service provision in resettlement countries, *Trauma Foundation*, 8(3), 207-221.

Zerr, L 2012, Exploring the sexual assault nurse examiner role within the nurse-patient interaction: making connections to advanced practice nursing competencies, available from <http://hdl.handle.net/1828/4007> [Accessed on 14 August 2013].

# *Annexure A*

## **Ethical approval to conduct the research**

- A.1 University of Pretoria, Faculty of Health Science: Ethics Committee
- A.2 Department of Health: North West Province
- A.3 The Hospital

A.1

University of Pretoria, Faculty of Health Science: Ethics  
Committee

A.2

Department of Health: North West Province

A.3

The Hospital

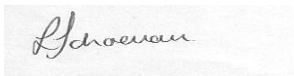
<b>Number</b>	:	<b>S165/2011</b>
<b>Title</b>	:	The views of female rape survivors regarding the management received at an emergency unit in the North West Province
<b>Investigator</b>	:	Koonyatse Maureen Mosang, Department of Nursing Science, University of Pretoria (SUPERVISOR: Dr T Heyns / Dr IM Coetzee)
<b>Sponsor</b>	:	<b>None</b>
<b>Study Degree:</b>		<b>M. Cur (Clinical)</b>

**This Student Protocol was reviewed by the Faculty of Health Sciences, Student Research Ethics Committee, University of Pretoria on 14/11/2011 and found to be acceptable. The approval is valid for a period of 3 years.**

Prof M J Bester	BSc (Chemistry and Biochemistry); BSc (Hons)(Biochemistry); MSc (Biochemistry); PhD (Medical Biochemistry)
Prof R Delport	(female)BA et Scien, B Curationis (Hons) (Intensive care Nursing), M Sc (Physiology), PhD (Medicine), M Ed Computer Assisted Education
Prof J A Ker	MBChB; MMed(Int); MD – Vice-Dean (ex officio)
Dr NK Likibi	MBB HM – (Representing Gauteng Department of Health) MPH
Dr MP Mathebula	Deputy CEO: Steve Biko Academic Hospital
Prof A Nienaber	(Female) BA (Hons) (Wits); LLB (Pretoria); LLM (Pretoria); LLD (Pretoria); PhD; Diploma in Datometrics (UNISA)
Prof L M Ntlhe	MBChB(Natal); FCS(SA)
Mrs M C Nzeku	(Female) BSc(NUL); MSc Biochem(UCL,UK)
Snr Sr J. Phatoli	(Female) BCur (Et.Al); BTech Oncology
Dr R Reynders	MBChB (Pret), FCPaed (CMSA) MRCPCH (Lon) Cert Med. Onc (CMSA)
Dr T Rossouw	(Female) MBChB.(cum laude); M.Phil (Applied Ethics) (cum laude), MPH (Biostatistics and Epidemiology (cum laude), D.Phil
Mr Y Sikweyiya	MPH (Umea University Umea, Sweden); Master Level Fellowship (Research Ethics) (Pretoria and UKZN); Post Grad. Diploma in Health Promotion (Unitra); BSc in Health Promotion (Unitra)
Dr L Schoeman	(Female) BPharm (NWU); BAHons (Psychology)(UP); PhD (UKZN); International Diploma in Research Ethics (UCT)
Dr R Sommers	<b>Vice-Chair</b> (Female) - MBChB; MMed (Int); MPharMed.
Prof T J P Swart	BChD, MSc (Odont), MChD (Oral Path), PGCHE
Prof C W van Staden	<b>Chairperson</b> - MBChB; MMed (Psych); MD; FCPsych; FTCL; UPLM; Dept of Psychiatry

#### **Student Ethics Sub-Committee**

Prof R S K Apatu	MBChB (Legon,UG); PhD (Cantab); PGDip International Research Ethics (UCT)
Mrs N Briers	(female) BSc (Stell); BSc Hons (Pretoria); MSc (Pretoria); DHETP (Pretoria)
Prof M M Ehlers	(female) BSc (Agric) Microbiology (Pret); BSc (Agric) Hons Microbiology (Pret); MSc (Agric) Microbiology (Pret); PhD Microbiology (Pret); Post Doctoral Fellow (Pret)
Dr R Leech	(female) B.Art et Scien; BA Cur; BA (Hons); M (ECI); PhD Nursing Science
Dr S A S Olorunju	BSc (Hons). Stats ( Ahmadu Bello University –Nigeria); MSc (Applied Statistics (UKC United Kingdom); PhD (Ahmadu Bello University – Nigeria)
Dr L Schoeman	CHAIRPERSON: (female) BPharm (North West); BAHons (Psychology)(Pretoria); PhD (KwaZulu-Natal); International Diploma in Research Ethics (UCT)
Dr R Sommers	<b>Vice-Chair</b> (Female) MBChB; M.Med (Int); MPhar.Med
Prof L Sykes	(female) BSc, BDS, MDent (Pros)



.....  
**DR L SCHOEMAN**; BPharm, BA Hons (Psy), PhD;  
Dip. International Research Ethics  
**CHAIRPERSON** of the Faculty of Health Sciences  
Student Research Ethics Committee, University of Pretoria



.....  
**DR R SOMMERS**; MBChB; M.Med (Int); MPhar.Med.  
**VICE-CHAIR** of the Faculty of Health Sciences Research  
Ethics Committee, University of Pretoria





**health**

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REPUBLIC OF SOUTH AFRICA

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Tel: (018) 367 57 57  
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www.nwhealth.gov.za

**POLICY, PLANNING, RESEARCH, MONITORING AND EVALUATION**

To : Ms K.M Mosang

From : Policy, Planning, Research, Monitoring & Evaluation

Subject: Research Approval – Views of Female Rape Survivors Regarding the Management Received at an Emergency Unit in the North West Province.

**Purpose**

To inform your good selves that permission to undertake the above mentioned study has been granted by the North West Department of Health. The researcher is expected to issue this letter as prove that the Department has granted approval to the districts or health facilities that form part of the study.

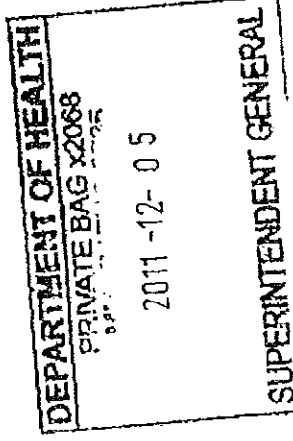
Arrangements in advance with managers at district level or facilities shall be facilitated by the researcher and the department expects to receive the final research report upon completion.

Kindest regards

*[Signature]*  
Director Policy, Planning, Research, Monitoring & Evaluation  
Mr B Redlinghys

*[Signature]*

Date



Healthy Living for All



# health

Department of  
Health  
North West Province  
REPUBLIC OF SOUTH AFRICA

Tel: (018) 383 2005 x 1014  
Fax: (018) 383 2376/3643  
mmoromane@nwpg.gov.za

## HOSPITAL

To : Ms Mosang KM  
From : CEO  
Date : 09 January 2012  
Subject: Approval to conduct Research

This communiqué serves to inform you that your request to conduct research in our institution has been granted.

Kind regards

Lebotse RL  
Acting CEO

*Request: Approved*  
*[Signature]*  
*Acting CEO*  
*10/01/2012*

CHIEF EXECUTIVE OFFICER

PRIVATE



Healthy Living for All



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**POLICY, PLANNING, RESEARCH, MONITORING AND EVALUATION**

To : Ms K.M Mosang

From : Policy, Planning, Research, Monitoring & Evaluation

Subject: Research Approval – Views of Female Rape Survivors Regarding the Management Received at an Emergency Unit in the North West Province.

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Arrangements in advance with managers at district level or facilities shall be facilitated by the researcher and the department expects to receive the final research report upon completion.

Kindest regards

Director, Policy, Planning, Research, Monitoring & Evaluation  
Mr B Redlinghys

5/12/11  
Date

**DEPARTMENT OF HEALTH**  
PRIVATE BAG x2068  
2011-12-05  
**SUPERINTENDENT GENERAL**



Healthy Living for All

# *Annexure B*

## **Participant information leaflet and informed consent**

---

## Participation leaflet and informed consent

Dear Participant,

### TITLE OF STUDY

### THE VIEWS OF FEMALE RAPE SURVIVORS REGARDING THE MANAGEMENT RECEIVED AT AN EMERGENCY UNIT IN THE NORTH WEST PROVINCE

#### 1. Introduction

You are invited to participate in a research study. This information leaflet will help you to decide if you want to participate. Before you agree to take part you should fully understand what is involved. If you have any questions that this leaflet does not fully explain, please do not hesitate to ask the interviewer, Maureen Mosang.

#### 2. The nature and purpose of this study

As nurses and doctors working in the emergency unit we tend to focus on medical management and not always on what the patient we attend to perceive as important. In order for us to improve our practice, we need to understand how you view of the management you received in the emergency unit.

The overall aim of this research is to explore the views of female rape survivors regarding the management received at an emergency unit in the North West Province.

From the abovementioned research aim, the objectives for the study follow:

- To discover "**what is**" the views of rape survivors regarding the best aspects of management received in the emergency unit
- To dream "**what could be**" the ideal management of rape survivors in the emergency unit

- 
- To design "**what should be**" the strategies to enhance the management of rape survivors in the emergency unit
  - To deliver "**what will be**" the strategies that can be implemented by the multi-disciplinary team members to move towards a patient-centred approach

### **3. Explanation of procedures to be followed**

Once you have given consent to participate in the study I (Maureen Mosang) will contact you and we will meet at a specific date time and place that is convenient for you. I will then ask you some questions on how you viewed the management you received at the emergency unit following the rape incident.

### **4. Risk and discomfort involved**

There are no risks involved in the study. The interview **will not** focus on the rape incident, but **only focus** on the management you received at the emergency unit. If the interview reminds you of the rape incident and you feel that you require counselling, the researcher will assist you to do so. Counselling following the interview will not be compulsory.

### **5. Benefits of the study**

Although you will not benefit directly from the study, the results of the study will enable us to address the suggestions you have made in future when managing female rape survivors in the emergency unit. Based on your feedback during the interview, nurses and doctors working in the emergency unit will understand your view of the management, which will enable us to enhance our current practice.

### **6. What are your rights as a participant?**

Your participation in this study is entirely voluntary. You can refuse to participate or stop at any time during the interview without giving a reason. Your withdrawal will not affect your access to the emergency unit or hospital in any way.

### **7. Has the study received ethical approval?**

---

The study has received written approval from the Research Ethics Committee of the Faculty of Health Sciences at the University of Pretoria and the Hospital. A copy of the approval letters is available if you wish to have one.

## **8. Information and contact person**

The contact person for this study is Maureen Mosang. If you have any questions about the study please contact her at 082 947 8421. Alternatively you can contact Dr Tanya Heyns, my supervisor at 083 287 3929.

## **9. Compensation**

Your participation is voluntary. No compensation towards your transport expenses will be given for your participation.

## **10. Confidentiality**

All information that you give will be kept strictly confidential. Once we have analysed the information no one will be able to identify you. Research reports and articles in scientific journals will not include any information that may identify you.

## **CONSENT TO PARTICIPATE IN THIS STUDY**

I confirm that the person asking my consent to take part in this study has told me about the nature, process, risks, discomforts and benefits of the study. I have also received, read and understood the above written information (Information Leaflet and Informed Consent) regarding the study. I am aware that the results of the study, including personal details, will be anonymously processed into research reports. I am participating willingly. I have had time to ask questions and have no objection to participate in the study. I understand that there is no penalty should I wish to discontinue with the study and my withdrawal will not affect my access to the emergency unit or hospital in any way.

---

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

Participant's name .....(Please print)

Participant's signature: ..... Date.....

Investigator's name .....(Please print)

Investigator's signature ..... Date.....

Witness's Name .....(Please print)

Witness's signature ..... Date.....



*Thank you for your participation.  
Your inputs are valued and appreciated.*





# *Annexure C*

## **Interview guide**

## **THE INTERVIEW GUIDE**

- Think about the Management that you received in the Emergency Unit. Please share with me the following:
- What did you value most about the management that you received?
- What did you value most about the Healthcare Professionals (nurses and doctors) that assisted you?
- What are your wishes for the future management of female rape survivors in the Emergency Unit?

## **QUESTIONS USED FOR PROBING PARTICIPANTS**

- Can you tell me more?
- How did that affect you?
- Why was that important to you?
- How did the Healthcare Professionals (nurses and doctors) support you?

# *Annexure D*

## **Example of transcribed interviews**

Interview 001

R: Morning madam

P: Morning ma'am

R: How are you

P: I am good and you

R: fine

P: My name is sister Busang neh

P: okay

R: and what is yours

P: My name is

P: Kelerato Zondo\*

R: Okay my dear we are going to talk about what you have valued in this institution regarding the management that you received

P: okay

R: in this unit neh

P: Okay

R: Can you tell me how did they receive you in this unit

P: Well the hospitality was great everything was just good, I felt like I was the only patient, they treated me like I was the only one

*Client centered approach*

R: Mm... Huh, tell me more, what do you mean, they treated you just like you were the only one

*Unconditional attention*

P: They give... they give you eh... undivided attention, if they are working they are working

R: Okay, alright, now tell me how did you find our treatment here? The treatment that they give you

*S/E*

P: he treatment was fine the only thing, they had side effects, I had swollen legs, but they warned me about it

*Provided information.*

*Information about S/E*

*Health education.*

# *Annexure E*

## **Example of data coded**

Table:

Themes	Categories	Sub-categories
Theme 1: Therapeutic approach 4/5 articles lead by example →	1.1 Caring/ Nurturing approach 1.2 Client centred approach 1.3 Empathetic approach 1.4 Respectful attitude 1.5 Open and trusting → 1.6 Non-judgemental → 1.7 Hopeful and motivating 1.8 Role model → Prove by behaviour	? strategies Personal traits Empathetic aspect, self care 4 years → Emotionally humble → Emotionally Control
Theme 2: Treatment/ healthcare received	2.1 Effective treatment received 2.2 Health education 2.3 Medication (PEP)	Treatment → HIV
Theme 3: Wishes for the service	3.1 Dedicated available centre staff 3.2 Confidentiality 3.2 Therapeutic interventions – ongoing peer and spiritual support →	

Enhance  
Pract

What did you experience --  
 I wonder about --  
 (4-6 quotes to substantiate.)  
 Tell me more --  
 What do you mean by --  
 In other words / Am I right --  
 (Summary of what the po said)  
 Can you explain more --

RESEARCH DATA ANALYSIS REPORT

FOR:  
 DATE:  
 STUDY:

I need more information --  
 I want to come back --  
 name that will --

# *Annexure F*

## **Letter from independent coder**

## RESEARCH DATA ANALYSIS REPORT

**FOR:** M MOSANG

**STUDY:**

**INDEPENDENT CODER:** Annatjie van der Wath

**Method:** Data analysis was done following the steps described by Tesch (1990: 142-145) in Creswell (2009: 125):

Step 1. The coder read through the data to obtain a general sense of the information and to reflect on its overall meaning, checking for general ideas, tone of the ideas, and impression of the overall depth and credibility of information as verbalized by the participants.

Step 2. The coder identified categories as it emerged from the data in order to answer the research question as the lens for analysis. The coder read each transcribed interview and highlighted sentences or paragraphs and coded those according to the meaning displayed in the highlighted narrative.

Step 3. The categories were clustered together according to the theme represented by the clustered categories.

Step 4. A coding scheme was created utilising the themes and categories that have been identified. The coder used qualitative data analysis to identify the different themes and sub/categories represented in the data. The specific sections of all the interview data that represented the themes and/ or sub/ categories were highlighted in colour and coded.

Step 5. Quotes were selected that best illustrate the meaning of each category.

**Saturation of data** was achieved related to the major themes – The researcher conducted 10 interviews. The researcher was advised to conduct member checking for certain categories that lacked data saturation (in cases where four to six verbatim quotes are not available to substantiate themes).



Annatjie van der Wath (M Cur Psychiatric Nursing) (PhD) [annavdw@mweb.co.za](mailto:annavdw@mweb.co.za)

## **Qualitative Data Analysis**

**M MOSANG**

**M Cur Nursing Science**

This serves to confirm that Annatjie van der Wath has co-coded the following qualitative data: Ten interviews for the study:

I declare that the candidate and I have reached consensus on the major themes and sub/ categories as reflected in the findings during a consensus discussion.

Annatjie van der Wath  
[annavdw@mweb.co.za](mailto:annavdw@mweb.co.za)

# *Annexure G*

## **Letter from editor**

*Suzette M. Swart*

***FULL MEMBER: Professional Editors' Group***

---

**1 February 2014**

**TO WHOM IT MAY CONCERN**

**I, Suzette Marié Swart (ID 5211190101087), confirm that I have edited the noted thesis. The accuracy of the final work is still the student's own responsibility.**

**Student:**

***Ms KM Mosang***

**Title:**

***The views of female rape survivors regarding the management received at an emergency unit in the North West province***

**The edit included the following:**

- Spelling
- UK vs USA English
- Vocabulary
- Punctuation
- Grammar (tenses; pronoun matches; word choice etc.)
- Language tips
- Correct acronyms (please supply list)
- Consistency in terminology, italisation etc.
- Sentence construction
- Suggestions for text with unclear meaning
- Basic layout, font, numbering etc.
- Logic, relevance, clarity, consistency
- Checking reference list (reference guide to be supplied by student) against in-text sources

**The edit excluded:**

- Correctness of crediting another's work – PLAGIARISM.
- Content
- Correctness or truth of information (unless obvious)

- Correctness/spelling of specific technical terms and words (unless obvious)
- Correctness/spelling of unfamiliar names and proper nouns (unless obvious)
- Correctness of specific formulae or symbols, or illustrations
- Style
- Accuracy of reference list
- Professional formatting

Thank you

Suzette M Swart (not signed – sent electronically)  
0825533302  
smswart@vodamail.co.za

**LANGUAGE PRACTITIONER/EDITOR/FACILITATOR:**

The Consortium for Language and Dimensional Dynamics (CLDD)  
University of Pretoria (UP)  
Tshwane University of Technology (TUT)  
University of Johannesburg (UJ)  
Stellenbosch University (US)  
University of South Africa (UNISA)  
Milpark Business School  
Aston University (UK)  
South African National Defense Force (SANDF)  
South African Civil Aviation Authority (SACAA)