UNIVERSITY OF KWAZULU-NATAL

Exploring Nurses' Experiences of In-service Training at a Hospital in Swaziland

KHAWULILE MAGAGULA

2017

EXPLORING NURSES' EXPERIENCES OF IN-SERVICE TRAINING AT A HOSPITAL IN SWAZILAND

KHAWULILE MAGAGULA

2017

EXPLORING NURSES' EXPERIENCES OF IN-SERVICE TRAINING AT A HOSPITAL IN SWAZILAND

Submitted to the College of Humanities

School of Education

University of KwaZulu-Natal

In fulfilment of the requirements for the degree of Master of Education

Khawulile Magagula

2017

Supervised by: Doctor Thoko Esther Mnisi

ABSTRACT

This study explores nurses' experiences of in-service training at a hospital in Swaziland. In-service training plays a vital role in the improvement and preservation of health personnel capabilities to offer excellent services and in further realising health coverage and health results worldwide. The study was prompted by that nurses' experience of in-service training is a topic that has not been fully explored in Swaziland and the personal rationale for the study was that researcher is a nurse by profession. The study applied a qualitative approach, the interpretivist paradigm and descriptive phenomenology. The sample comprised 13 nurses who were purposively selected from in and outpatient settings of the study hospital. Data was generated through in-depth interviews using an interview guide with open-ended questions and verified by a focus group discussion by a focus group guide. Colaizzi's (1978) method was used as a tool for data analysis. The theory of planned behavior was applied to view participants' data and reach a general description of nurses' experience of the in-service training. The study has unveiled participants' experience of in-service training, challenges of in-service training, and recommendations for improving in-service training. These themes responded to the 3 critical questions which guided the study: What are the experiences of nurses regarding in-service training in one hospital in Swaziland?; What are the current challenges in offering in-service training in one hospital in Swaziland and How can the provision of in-service programmes for nurses be improved in one hospital in Swaziland?

The study has shown that participants have experienced in-service training positively and negatively. Central to the experience is in-service training planning, design, implementation and post training follow up and application. In-service planning encompassed communicating in-service training to trainees, selecting participants among others. Implementation entailed types of in-service trainings, topics covered, facilitation strategies, training providers, effectiveness of in-service training, post training support, and benefits of in-service training. The study revealed multifaceted challenges on planning, logistics, delivery, continuity and sustainability of in-service training. These were linked to numerous causes such as shortage of staff, workload, high staff turnover, high morning hospital routine, conflicting trainings, funding challenges, shortage of equipment and supplies among others. Recommendations for improvement of in-service training include the need for proper organization and design of in-service training; proper implementation of in-service training; improving post training support and implementation; improving the work

setting; engaging management; donor support; upgrading the in-service infrastructure. The argument put forth is that in order to improve nurses' experience of in-service training to produce performance change and possibly better patient outcomes, efforts must address factors that influence the outcome of the experience. These are personal, significant others, internal organisational, and health systems factors.

DECLARATION

The research report for this dissertation was undertaken by Khawulile Magagula under the supervision of Doctor Thoko E. Mnisi in the School of Education, College of Humanities University of KwaZulu-Natal. This study represents original work done by the author and where work of others has been used acknowledgement was made. I declare that this dissertation has not been submitted for a degree at any other university.

_____

K. Magagula

January 2017

ETHICAL CLEARANCE CERTIFICATE

9 March 2015

Ms Khawulile Managula 214584582
School of Education
Edgewood Campus

Dear Ms Mangaula

Protocol reference number: HSS/0025/015M
Project title: Exploring nurses' experiences of In-service (IST) at a hospital in Swaziland

Full Approval – Expedited Application

In response to your application received on 7 January 2015, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol have been granted **FULL APPROVAL.**

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number.

PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

.....

Dr Shenuka Singh (Chair)
Humanities & Social Sciences Research Ethics Committee

/pm

Cc Supervisor: Dr Thoko Mnisi
Cc Academic Leader Research: Professor P Morojele
Cc School Administrator: Ms T Khumalo

ACKNOWLEDGEMENTS

My utmost adoration to God, who has shown me that indeed "…with God nothing is ever impossible…" (Luke 1:37). My greatest appreciation to Doctor Thoko Mnisi, my supervisor who patiently guided me and assisted me in a very profound way throughout this study. I have thus learned to nurture hope in others, even in their weakest point.

A special thanks to the nurses who participated in this study and their valuable contribution to this work.

I also wish to thank Matron Zwane who was supportive in granting me leave days when I requested which facilitated my studying the Master's degree to completion. Thank you also to her secretary Thembekile Kunene who has always been of great help. I also thank Bongiwe Lukhele and Mr Howard Mabuza for their invaluable assistance when I ventured into this project.

To Sandile Malaza. I will always be grateful to you for dedicating your valuable time, and patiently mentoring and assisting me.

My appreciation also to Sindie Simelane for being supportive throughout my studying and carrying the workload in the in-service department when I was not there without complaining. Thank you also to Mthokozisi Mahlangu for his support and always being available when I needed help. A special thanks to Wendy Gule-Dlamini who assisted me to conduct the pilot and actual focus group discussion.

To my mother Busisiwe Dlamini-Magagula and my late father. Thank you for raising me and seeing me through life. I attribute what I am today to you. To Ngcebo, Phumelela, Samukelo, Mphilo, Siya and Thatho. I bless God for you, and feel indeed blessed among women to have you.

I am grateful to my younger sister Thembekile Magagula-Msibi who introduced me to the opportunity to study. To Phumlile Magagula-Maziya and all my other siblings for their support in numerous ways.

To pastor and make Mabirizi, I am very thankful for your love, prayers, spiritual support and guidance for me, my children and family.

Finally, to sisi Fikile Nkosi and Sister Faith Fakudze for each being a true friend and sister to me, and make Sibongile Mamba-Dlamini for being a mother and spiritual mentor to me, my children and many others.

REFERENCING STYLE

This dissertation uses the American Psychological Association (APA) 6th style for referencing which is the University of KwaZulu-Natal requirement.

References in text have been cited as suggested by the APA 6th style as follows:

One work by one author

Aberson (2010) suggests that having a representative sample of reasonable size is critical for generating quality research findings.

Or

Having a representative sample of reasonable size is critical for generating quality research findings (Aberson, 2010).

One work by two authors

Marshall and Rossman (2006) argue that even well planned research studies will have limitations, flawless studies do not exist.

Or

Even well planned research studies will have limitations, flawless studies do not exist (Marshall,& Rossman, 2006).

One work by more than two and up to five authors

First time citation in text: Tzeng, Sue, Chiang, Kuan, and Lee (2010) undertook an interpretive phenomenological study on suicide survivors in Taiwan.

Subsequent citations in text: Tzeng et al. (2010) undertook an interpretive phenomenological study on suicide survivors in Taiwan.

Work by six or more authors

First and subsequent citation in text: Reutler et al. (2009) chose a typical sample of people from a district for an interview for the second stage of the study.

Or

A typical sample of people from a district was chosen for a telephone interview in the second stage of the study (Reutler et al., 2009).

Authors with same surname

In text: A study by A. V. Ntshangase and Ntshangase (2012) found that …

In the reference list

List all authors for each reference entry in the reference list, for example:

Hawkins, Y., Ussher, J., Gilbert, F., Perz, J., Sandoval, M., & Sundquist, K. (2009). Changes in sexuality and intimacy after the diagnosis and treatment of cancer. *Cancer Nursing*, 32, 271-280.

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

ABBREVIATIONS

AACN & AAMC	- American Association of Colleges of Nursing and the American Medical Colleges
AIDS	- Acquired Immunodeficiency Syndrome
ANCCCA	- American Nurses Credentialing Center's Commission on Accreditation
APA	- American Psychological Association
ART	- Antiretroviral therapy
BFHI	- Baby Friendly Hospital Initiative
EGPAF	- Elizabeth Glasier Paediatric AIDS Foundation
FGD	- Focus group discussion
HCI	- Health Care Improvement
HIV	- Human Immunodeficiency virus
HSSREC	- Humanities and Social Sciences Research Ethics Committee
HTC	- HIV Testing and Counselling
ICAP	- International Centre for AIDS Prevention
ICN	- International Council of Nursing
IMAI	- Integrated Management of Adolescent and Adult Illnesses
MNCH	- Maternal neonatal child health
MOH	- Ministry of Health
MOHSW	- Ministry of Health and Social Welfare
NARTIS	- Nurses Led ART Initiation
NCPDNM	- National Council for the Professional Development of Nursing and Midwifery
NGO	- Non-Governmental Organization
PEPFAR	- United States President's Emergency Plan for AIDS Relief
PIHTC	- Provider Initiated HIV Testing Counselling
PMTCT	- Prevention of mother to child transmission
SIMPA	- Swaziland Institute of Management and Public Administration

SNC	- Swaziland Nursing Council
SNHI	- Swaziland Nazarene Health Institutions
TB	- Tuberculosis
TPR	- Temperature, pulse, respirations
UNDP	- United Nations Development Programme
UNICEF	- United Nations International Childrens' Education Fund
URC	- University Research Co., LLC
USAID ASSIT	- United States Agency for International Development Applying Science to Strengthen and Improve Systems Project
WHO	- World Health Organization

CHAPTER ONE

ORIENTATION TO THE STUDY

1.1. INTRODUCTION

This chapter provides an introduction to the study which seeks to explore nurses' experiences of in-service training at a hospital in Swaziland. The chapter outlines the background of the study, rationale for the study, statement of the problem, research aims, research objectives, research questions, concept clarifications, research design and methodology, delimitation of the study, a summary of the chapter, and highlights of chapters 2 to 7.

1.2. BACKGROUND

In-service training plays a vital role in the improvement and preservation of health personnel capabilities to offer excellent services (Bailey et al., 2013; Bluestone et al., 2013; World Health Organization [WHO], 2014), and in realising health coverage worldwide (WHO, 2014). It has been hailed a valued technique to develop and scale up health worker competencies (United States Agency for International Development Applying Science to Strengthen and Improve Systems Project [USAID ASSIST Project], 2014).

In the nursing literature, in-service training is defined as systematic professional learning experiences intended to expand the knowledge, skills, and attributes of nurses and consequently enhance their contributions to quality health care (American Nurses Association & National Nursing Staff Development Organization, 2010). Moreover, in-service training assists nurse executives, nurse managers and nurses already in service to take up different assignments and varying roles in a complex and rapidly changing service setting (Booyens, 2008; Giri et al., 2012; Mizell, 2010). In-service training is commonly designed and offered by institutions or organisations for staff members – in the context of the nursing profession, it is offered by the hospital or health care organisations (Taylor, Lillis, LeMone, Lynn, & LeBON, 2011). It is an established by-product, and the backbone of continuing education in nursing and medicine, which supplements and sustains the concept of lifelong learning (American Association of Colleges of

Nursing & the Association of American Medical Colleges [AACN & AAMC], 2010). In the nursing profession, in-service training is both a personal and professional obligation for public safety and a requirement to uphold the integrity of the profession (International Council for Nurses [ICN], 2009; Swaziland Nursing Council [SNC], 2010).

In-service training is currently intensified globally as are the resources that contribute towards training by ministries of health and donor agencies. This is in an effort to improve health personnel capacities so that they can offer quality health care expertly, harmlessly and effectively (The Human Resource for Health Knowledge Hub, 2009; USAID Health Care Improvement [HCI] Project, 2013; University Research Co., LLC [URC], 2015). In-service training for health personnel is necessitated by the vigorous, continuous and increasing shifts in knowledge bases and skills (WHO, 2013). This arises from new evidence and tested best practices; amendments in statutes; changes in investigative and treatment approaches; fluctuations in demographics and in illness loads that demand in-service training for the practitioners (AACN & AAMC, 2010; Letlape, M.P. Koen, Coetzee, & Koen, 2014; Ministry of Health & Social Welfare [MOHSW], 2009; WHO, 2013). In the Swaziland health sector, in-service training is prioritised in the ministry's current agenda. Swaziland's efforts towards systematic and coordinated in-service training in the health sector began in 2006 when a quality improvement programme was introduced (Ministry of Health [MOH], 2012). This was followed by the appointment of full-time in-service coordinators in health care facilities. Moreover, health professionals are required to undertake in-service training as a pre-requisite for annual license renewals (MOHSW, 2007), which means that nurses have to participate in at least 10 hours of continuing professional development (SNC, 2011). The national in-service training policy of 2000 is also under review (Dlamini, 2014). However, the provision of health worker in-service training both globally and locally, presents challenges. The Swaziland MOH thus began an in-service training enhancement venture assisted by the USAID ASSIT Project in 2014 to tackle the national challenge of HIV and AIDS and tuberculosis to develop efficiency, proficiency and longevity in in-service training in the health sector (URC, 2015).

1.3. RATIONALE FOR THE STUDY

The researcher – a nurse by profession, was prompted to undertake this study after observing inconsistent and inadequate uptake of in-service training by nurses at a hospital in Swaziland where the researcher is working as an in-service coordinator. Poor attendance despite notifications, reminders, and follow-ups regarding in-service offerings marked the general response. The researcher, therefore wanted a logical explanation underpinning the existence of the above shortfall in nurses' in-service training at the study hospital, including likely solutions. The study aims to explore the experiences of nurses about in-service training at the hospital, and to hopefully, expose good aspects of the programmes as well as challenges and recommendations for improvement. The hope is that negative features of in-service training can be eliminated as a result of this study whilst positive aspects can be strengthened and improvements implemented.

The study hopes to give an in-depth description of nurses' experiences pertaining to in-service training at the study hospital, a subject that has not been given much attention globally and has not been studied at all in the Swaziland. The study also hopes to unearth reasons for the poor responses from nurses to in-service training offerings at the study hospital, and how this could be improved.

1.4. STATEMENT OF THE PROBLEM

Despite the importance of in-service training, the literature records implementation challenges (AACN &AAMC, 2010; Hughes, 2005; Letlape et al., 2014). For nurses, these include lack of access to training and barriers to attending training (Jaradeh & Hamdeh, 2010; National Council for the Professional Development of Nursing and Midwifery [NCPDNM], 2004); Richards, 2007, SNC, 2011; Yfantis, Tiniakou, & Yfanti, 2010). The literature also indicates that health worker in-service training is challenged by weak organisation, limited appraisal, and poor tracing mechanisms among other challenges (URC, 2015). Moreover, there is also a growing demand for learning development providers to produce practical outcomes which meet expectations and show a return on investments (D. L. Kirkpatrick & Kirkpatrick, 2010; Phillips, 2010). In the global health sector there is mounting pressure for providers of in-service training to show results and effectiveness in improving health care systems and patient outcomes (United States President's Emergency Plan for AIDS Relief [PEPFAR], n.d.), and to provide more viable in-service training (URC, 2015). Consequent to the above health worker in-service training is thus being prioritised

worldwide to improve effectiveness, efficiency and sustainability (Bailey et al., 2013; Burlew, Puckett, Bailey, Caffrey, & Brantley, 2014).

However, as mentioned before, the literature does not reflect much research undertaken on the experiences of nurses to in-service training in other countries including in Swaziland. Overseas studies focus on nurses' perceptions of continuing professional education (Hughes, 2005; Pool, Poell, & ten Cate, 2012; Yfantis et al., 2010). These studies report positive attitudes towards continuing professional development among nurses and challenges in implementing what was learned (Hughes, 2005), variations in perceptions among younger and older nurses (Pool et al., 2012), and that nurses appreciate continuing professional development as a component of lifetime education but are challenged in assessing its usefulness (Yfantis et al., 2012). A Jordan study investigated nurses' experiences of continuing professional development (Jaradeh & Hamdeh, 2010). This study indicates personal desires and nurse supervisors' needs as determinants of the choice of continuing professional development, whilst dedication to quality care was the main motivator (Jaradeh & Hamdeh, 2010). A few studies in South Africa have investigated in-service training as experienced by nurses (Norushe, Van Rooyen & Strumpher, 2004), their perceptions of continuing formal education (Richards, 2007), and have also explored in-service training needs for psychiatric nurses (Letlape et al., 2014). South Africa studies found that nurses; experienced training as insufficient and responded poorly towards the trainings (Norushe et al., 2004), endorse the necessity to train, similar to overseas studies identify challenges that hinder the execution of nurses' training and prevent nurses to embark on training (Letlape et al., 2014; Richards, 2007). These studies also concur with overseas studies on perceiving training as imperative for self and professional growth and upgrading the quality of patient care (Letlape et al., 2014; Richards, 2007). There is a suggestion to tackle challenges to training based on recommendations by nurses and their supervisors (Letlape et al., 2014). A Swaziland study focused on perceptions of learning needs and preferred teaching learning methods among nurses and midwives (SNC, 2011). The study highlights priority topics and barriers to continuing professional development, and shows that training can contribute to positive perceptions and an appreciation of maternal neonatal child health issues among nurses (SNC, 2011). This study explored the experiences of nurses about in-service training in a targeted Swaziland hospital in the Manzini region. It unveils evidence on nurses' lived experiences of in-service training, positive and negative aspects of the experience, challenges and possible solutions

from the Swaziland hospital. The study also adds on the few studies conducted on nurses' experiences of in-service training.

1.5. RESEARCH AIMS

The purpose of the study is to explore the experiences of nurses pertaining to in-service training at a hospital in Swaziland. The intention is to depict good aspects of nurses' in-service training programmes as well as to identify challenges and make recommendations for improvement.

1.6. RESEARCH OBJECTIVES

The objectives of the study are therefore to explore:

- The experiences of nurses regarding in-service training in one hospital in Swaziland.
- The current challenges in offering in-service training for nurses in one hospital in Swaziland.
- How in-service education programmes for nurses can be improved in one hospital in Swaziland.

1.7. RESEARCH QUESTIONS

Based on the objectives three critical questions are formulated:

- What are the experiences of nurses regarding in-service training in one hospital in Swaziland?
- What are the current challenges in offering in-service training in one hospital in Swaziland?
- How can the provision of in-service programmes for nurses be improved in one hospital in Swaziland?

1.8. SIGNIFICANCE OF THE STUDY

This study reveals nurses' experiences of in-service training. It intends to generate knowledge and contribute to nursing studies that can be evaluated and synthesised to reach conclusions about what may work or not work pertaining to nurses' in-service training. The study also intends to

contribute to increased knowledge and understanding of nurses' experiences of in-service training. Experiences of nurses pertaining to in-service training is a subject that has been studied to a limited extent globally, and has not been researched before in Swaziland. This study intends to close this gap. The study has also produced new knowledge on nurses' experiences of in-service training in Swaziland from the context of the one study hospital.

Moreover, in-service training educators and other providers for nurses' in-service training can use the evidence from this study to design more effective in-service training programmes. Findings from this study can further provide an evidence base to guide the development of pertinent policies and guidelines for nurses' in-service training offered by stakeholders. Policy making bodies may include the MOH, SNC, and Swaziland Democratic Nurses Union among others. Nurse managers and in-service training providers may also devise plans at facility and unit levels to address the identified challenges for future in-service training. In addition, nurses can possibly put to use what works and avoid what does not work in their self-development pursuits. This study lays the foundation for future studies that can be undertaken to validate its findings.

1.9. CONCEPT CLARIFICATION

Nurse refers to "A person who is qualified as a nurse and authorized to practice as such by the Swaziland Nursing Council" (SNC, 2010, p.6). Such a person possesses high level preparation in helping the unwell, elderly or wounded. The person is a competent professional academically and legally certified to work as a nurse (WHO, 2004). To function as a nurse, the person uses a body of knowledge and skills from physical sciences, humanities and social sciences as well as scientific skills which are required to satisfy the personal needs of patients and their relatives (Potter & Perry, 2009). Nurses render care to clients guided by nursing statutes, nursing standards of practice, scope of practice and a code of ethics (Potter & Perry, 2009; SNC, 2011). A nurse renders such care skilfully; with humanity, tenderness and esteem for every patient's self- worth and individuality. However, the body of nursing knowledge is constantly transforming alongside new findings and advancements (Potter & Perry, 2009). Therefore, the care which the patient/client is given is an outcome of on-going development including the individual and professional improvement of the nurse (NCPDNM, 2004). For this study, a nurse is a person who is trained as such, is registered with the SNC, holds a current license to practice nursing, and is employed at the study hospital.

In-service training refers to an "… instruction or training provided by a health care agency or institution. …[which] is held in the institution and is designed to increase the knowledge, skills, and competencies of nurses and other health care professionals employed by the institution" (Potter & Perry, 2009, p.8). In a hospital in-service training is a process by which people are trained in abilities and offered the required knowledge or outlook for empowerment to discharge their everyday jobs to the expected level in their current work, as well as in the assumption of superior and additionally challenging positions for the successful discharge of duties (Omar, 2014). In the Swaziland health sector in-service training is also offered by government programmes and donor agencies for health personnel ranging from a few days to a few weeks, or on a long-term basis whereby health professionals undertake longer and advanced preparation (URC, 2015). In-service training facilitates nursing competence. Through in-service training, nurses' abilities and know-how are upgraded to enhance their contributions to improved service. In-service training is essential for nurses to cope with difficulties and developments in the nursing field (Omar, 2014).

In this study, in-service training will refer to education and training offered to nurses by a hospital intended to improve their knowledge, attitudes and competence in order to provide high quality and safe care to clients and families who access the hospital.

Hospital – is "an institution the primary function of which is to provide inpatient diagnostic and therapeutic services for a variety of medical conditions, both surgical and non-surgical. Most hospitals provide outpatient services, particularly emergency care" (WHO, 2004, p.33). It further comprises structured medical, nursing and additional expert personnel, and functions 24 hours a day, 7 days of the week (WHO, 1987), and provides education to the health personnel (Dirckx, 1997). For this study, a hospital will refer to a health care facility that provides hospital services on a 24-hour basis to clients and families, has in- and out-patient departments, is staffed by qualified and licensed nurses, and offers in-service training to nurses.

1.10. DELIMITATION OF THE STUDY

This is a nursing study by virtue of studying nurses, but is located in the field of adult education since it seeks to understand nurses' experiences of in-service training. Descriptive phenomenology is a branch of psychology (Moustakas, 1994). The theory of planned behaviour is derived from

social psychology (Ajzen, 2012; Légaré et al., 2015) because the study intends to explore and gain an appreciation of communal behaviour, this being nurses' experiences of in-service training. The study is contextualised as research conducted in a referral hospital located in an urban setting in the hub of Swaziland in the Manzini region. Thirteen participants were recruited from the study hospital's in- and out-patient departments.

1.11. COURSE OF THE STUDY

This chapter has provided an introduction to the study to explore nurses' experiences of in-service training at a hospital in Swaziland. The chapter gave an introduction, background, rationale for the study, the problem statement, the research question, the research aim, the research objectives, the research questions, the significance of the study, concept clarification, a delimitation of the study, the course of the study, and synthesis.

Chapter 2 outlines a synopsis of the pertinent literature on nurses' in-service training reviewed by the researcher and covering indigenous, regional and global studies. Nurses' experiences of in-service training are discussed including challenges and potential improvement approaches. The theoretical framework which guided the data analysis and was identified during the literature review, is highlighted. The researcher wishes to state that studies which address nurses' experiences of in-service training are scarce.

Chapter 3 presents the research design and methodology in three phases. The first phase covers the research design, the setting, how the participants were selected, and the data generation and data analysis methods. The second part highlights the planning entailed in the data generation and data analysis. Here the researcher outlines bracketing activities, the pilot study, and the ethical considerations including other activities. The final phase covers the actual data generation, the data analysis, and the trustworthiness strategies employed in the study.

Chapter 4 presents the findings and discussions pertaining to the first research question.

Chapter 5 discusses the findings in response to the second research question.

Chapter 6 discusses the findings which respond to the third research question.

Chapter 7 presents the summary, conclusions, implications and recommendations for future research. The researcher indicates how the findings of the study will be disseminated and describes the limitations of the study.

1.12. SYNTHESIS

This study explores nurses' experiences of in-service training in a hospital in Swaziland. The purpose of the study was to gain an appreciation of the nurses' experiences, to uncover good elements in the programme, to identify challenges, and to make suggestions for improvement.

The following chapter investigates the local and global literature on nurses' experiences of in-service training, the challenges and possible solutions to improve this training. The chapter also outlines the study's theoretical framework.

CHAPTER 2

REVIEW OF LITERATURE

2.1. INTRODUCTION

The previous chapter gave an introduction and background to the study. This chapter presents a literature review on nurses' in-service training, based on global, regional and national studies identified by the researcher. The chapter begins with a brief overview of in-service training and continuing professional development. It is structured according to the three critical research questions which guide the study. A discussion of the challenges to offering in-service training to nurses follows and includes possible strategies to improve this training. Lastly, the theoretical framework applied to the study, is discussed.

2.2. OVERVIEW OF IN-SERVICE TRAINING AND CONTINUING PROFESSIONAL DEVELOPMENT

Definitions of in-service training and continuing professional development as found in the nursing literature are provided briefly due to the interrelatedness of both, and for the sake of clarity. This is because the interest was on studies which investigate nurses' experiences with the intention to fill the knowledge gap in Swaziland. In this study in-service training and continuing professional development will therefore be used interchangeably.

In-service training provides prospects to nurses to improve their understanding, expertise and outlook thereby empowering them to efficiently perform diverse responsibilities which include but are not limited to the provision of nursing care, management, teaching (WHO & JHPIEGO, 2005), research, and theory development (American Nurses' Credentialing Center, 2011). In-service training follows obtaining a nursing qualification as part of ongoing professional advancement (American Nurses' Credentialing Center, 2011; WHO & JHPIEGO, 2005). WHO (2013) defines continuing professional development as learning that occurs once one has obtained a qualification to sustain, develop and modify health personnel's understanding, aptitudes, outlook and performance to enable them to carefully and efficiently render clinical care on a continuous basis. The American Nurses' Credentialing Center (2011) concurs with WHO, adding that continuing

professional development is an essential aspect of lifetime education which assist nurses to grow and retain expertise, increase vocational nursing services and fulfil professional objectives. Over and above in-service training, continuing professional development can be undertaken through various means such as personal education and training, continuing education, and post-graduate education (WHO & JHPIEGO, 2005). Continuing professional development entails official, planned training activities provided by academic institutions, hospitals, nursing regulatory bodies, nursing professional associations, training and health care organisations (Potter & Perry, 2009), and other stakeholders.

From the above definitions it is clear that in-service training is a component of continuing professional education and that they both work towards the same purpose. They can be offered by a hospital or external organisations; they are lifetime activities for a professional nurse; and the ultimate aim is to benefit patients and families via the development of individual nurses and the profession as a whole.

2.3. LITERATURE ON EXPERIENCES OF NURSES REGARDING IN-SERVICE TRAINING

The researcher did an extensive review of literature on experiences of in-service training by nurses The literature broadly cover nurses' perceptions towards in-service training, the planning of in-service training, participation in in-service training, the content covered, teaching strategies, providers of in-service training, infrastructure and resources, support for in-service training, evaluation and post-training follow up, and the benefits of in-service training. This is discussed in details in the subsequent sections.

2.3.1. Nurses' perceptions towards in-service training

Studies conducted on nurses' perceptions towards in-service training and continuing professional development in Ireland, United Kingdom, Greece, Iran, and South Africa show various approaches in attitude and to in-service training. The studies reveal that attitude plays an important role in determining the success of in-service training (Hughes, 2005; Omar, 2014). Omar (2014) in Iran found that attitude influences enthusiasm and in this regard an optimistic attitude is important for successful participation in in-service training and for personal growth. An Ireland study found

that nurses perceive in-service training as a strategy for achieving and maintaining competence; nurses in this study were actively involved in continuing professional development undertakings including advanced scholarly activities (NCPDNM, 2004). The same study further reports that to reach an attitude of active involvement in in-service training/ continuing education nurses had to conquer many challenges. Similarly, Omar (2014) found that nurses have to acknowledge the need for on-going development for competency and professional development to occur.

Studies also reveal that pessimistic attitudes towards in-service training and leadership styles reduce impact (Hughes, 2005). These studies report that pessimism towards in-service training results from several factors. The causes include hardship in applying recent knowledge and not receiving guidance in in-service training. Also, few nurses recognising reflection as an inherent component to the education process and to care enhancement, recognising in-service training and continuing education as separate entities, and focusing on meeting registration requirements rather than perceiving it as a technique for professional improvement and the development of care (Hughes, 2005). The same study found that the management methods of nursing leaders and their receptiveness to transformation impacted on nurses' perceptions of the worth of in-service training and the latter's aptitudes to think. Hughes (2005) found that leadership style had substantial influence on inspiring younger nurses to alter performance following in-service training, and that supporting nurses to think back on the new knowledge gained from in-service training could modify practice. A Greek study by Yfantis et al. (2010) found that many nurses appreciate continuing professional development as a component of lifetime education. However, the same authors agree with Hughes (2005) that nurses do not perceive continuing professional development as a continuous practice of thinking and doing. For Yfantis et al. (2010) the latter might be due to the unavailability of proficient continuing professional development for nurses.

The literature further shows that nurses' perceptions of in-service training is influenced by factors such as age, formality, behaviour displayed by those who participate or do not participate in in-service training, purpose, and usefulness. For instance, a study done in the Netherlands by Pool et al. (2012) found different perceptions towards in-service training between older and younger nurses, which subsequently influenced level of focus, possibilities to leave the bedside, determination, and requirements for in-service training. The majority of nurses in this study perceived in-service training as a general variation of education activities with more emphasis on

non-formal learning, whilst a few nurses associated in-service training to official education (Pool et al., 2012). The nurses perceived non-formal learning activities to consist of ongoing learning, clinical teaching conferences, reading professional journals, learning from learners and other co-workers (Pool et al., 2012). Official education activities included participating in lessons or learning at a higher level in nursing (Pool et al., 2012).

Nurses who study on an on-going basis demonstrated the following behaviours: prepared to achieve deeper knowledge, registering in trainings, possessing an inherent longing to improve, critically reflective, instrumental in the improvement of the facility's department, apt to disseminate their knowledge willingly and invite more nurses to advancement sessions (Pool et al., 2012). The authors further argue that nurses who never engaged in on-going education were viewed as people who merely finish individually assigned duties without taking part in additional work. Some nurses performed perfectly in face-to-face patient care, despite not participating in any personal development activities. Scheckel (2009) concurs, pointing out that several studies report registered nurses function primarily similar in clinical areas irrespective of scholarly training, although Graf (2006) reports recent studies indicate that degree trained nurses are associated with better patient outcomes. On the issue of purpose, Jaradeh and Hamdeh (2010) in Jordan found that the nature of an in-service training event is subject to personal objectives together with the hospital nurse leaders' direct and sensed needs.

Closer to home, a study by Richards (2007) in South Africa reveals that the majority of nurses viewed continuing formal education as helpful to their individual and professional development and that it enhances quality of care for patients, but that obstacles hindered nurses from pursuing on-going official education ventures. Similarly, a Swaziland study by SNC (2011) shows that many nurses appreciate in-service trainings and further perceive that such trainings are beneficial.

The above discussions show the importance of attitude in determining the success of in-service training, including factors such as leadership support, and nurses' personal behaviour after undertaking in-service training which are among the elements that influence the realisation of in-service training. It is also clear that nurses view implementation of what is learned as an important aspect of in-service training. Moreover, nurses view in-service training as beneficial for their personal and professional growth and for the welfare of the client. The preceding discussion therefore suggests the significance of cultivating inspiring attitudes that encourage nurses to study

more efficiently and reinforcing a solid association between performance in in-service training (Omar, 2014).

2.3.2. Planning of in-service training

Very few studies report on the planning of nurses' in-service training. Studies report that 54% input was sought from nurses during in-service training planning, and 46% was personally driven (NCPDNM, 2004). A uniform criterion was used to decide on in-service training and continuing professional development offerings for both junior and mature nurses (Pool et al., 2012); 36.2% nurses were involved in selecting in-service training ventures, and 28.8% reported being partially involved (Jaradeh & Hamdeh, 2010). The above studies suggest minimal involvement of nurses in in-service training planning.

The literature also highlights the importance of considering the work setting during in-service planning since environmental elements may work as catalysts or impediments to the results and influence of the training (PEPFAR, n.d.). In this regard, Cervero and Gaines (2014) found that societal, governmental, institutional and financial aspects of the background within which educational methods are employed, affect the efficiency of in-service training. Trainers thus need to consider components of the work setting that may affect in-service training at all levels when planning a programme from unit to institutional level, including factors emanating from the external environment which may impact on a programme.

2.3.3. Participation in in-service training

Studies accessed by the researcher indicate a variation in nurses' participation in in-service training (Jaradeh & Hamdeh, 2010; NCPDNM, 2004; Richards, 2007; Yfantis et al., 2010). The reviewed studies are mainly quantitative in nature. They advanced reasons for undertaking in-service training and some of the reasons, which hinder nurses from participating.

Most of the literature reports lack of participation of nurses in in-service training (Richards, 2007; Yfantis et al., 2010), or minimal participation (NCPDNM, 2004; Yfantis et al., 2010), whilst few studies report liberal participation (Jaradeh & Hamdeh, 2010; SNC, 2011). A study of health worker in-service training in Ethiopia showed that beneficiaries were very often nurses, followed by health officers, then doctors, and infrequently information system or laboratory personnel, health extension workers, and midwives (Kebede, Gutema, Asres, Wuliji, & Lanford, 2014).

In a study by Richards (2007) in South Africa, some of the reasons for not participating in in-service training include shortage of role models in the workplace in terms of having nurse leaders who inspire staff and desire to be instrumental in cultivating an optimistic work atmosphere. Richards also reports inability to consider in-service training and off-duty arrangements; leaders prioritising staff levels rather than in-service training attendance and undesirable effects of personnel shortages such as workload on remaining nurses.

The literature suggests that nurses are driven by various reasons to pursue in-service trainings, which are personal, professional, or related to the organisation. Several studies show that they may participate in in-service training to attain personal growth and competence. Such reasons include personal improvement, to upgrade personal competence for direct patient care, to upgrade vocational knowledge and self- worth, to gain expertise in a particular field of speciality (Jaradeh & Hamdeh, 2010; NCPDNM, 2004; Pool et al., 2012; Richards, 2007); and to gain fresh knowledge and skills. Other personal reasons for pursuing in-service training were related to social status and self-esteem including increased remuneration and prestige (Pool et al., 2012). Richards (2007) concurs that the majority of the nurses were motivated by actual prospects for promotion and payment. This however, differs from the Ireland study (NCPDNM, 2004) and Netherlands study (Pool et al., 2012) which reported departing from bedside nursing or to leave the nursing profession as reasons to study. Jaradeh and Hamdeh (2010) and Pool et al. (2012) further report that advancing personal competence for patient care and augmenting the quality of nursing care were main drivers for nurses embarking on in-service training. Similarly, Graf (2006) in the United States concludes that nurses who have higher than associate degrees are driven by individual contentment and professional growth to undertake further studies rather than to increase their earnings. The literature also reveals other professional reasons for pursuing in-service training among nurses such as planning professional pathways and to accomplish professional desires. This means, achieving continuing development standards to be efficient in mentorship functions for both nurses and nursing students; and enhance the prestige of the profession and to network with other nurses (Hughes, 2005; Richards, 2007; Yfantisi et al., 2010).

2.3.4. Content covered

A few studies report on the content taught in nurses' in-service trainings. These studies suggest that training activities need to be designed with the definite purpose of achieving requirements for

particular leaners, and that the content for nurses in-service training need to be generated from findings of a training needs analysis (American Nurses Credentialing Center's Commission on Accreditation [ANCCCA], 2012).

The literature further shows that the topics offered to nurses and health care workers during in-service training encompass generic nursing topics (Yfantis et al., 2010). The same study suggests that 'real–life' incidents found in clinical areas should be exploited for skill oriented vocations like nursing. Quality improvement is another topic taught in official in-service training classes for health professionals in the United States, Canada, the United Kingdom (Health Care Foundation, 2012) and in Swaziland (URC-Swaziland, 2014). However, the content taught in quality improvement differs from region to region (Health Care Foundation, 2012). Management of Human immunodeficiency virus (HIV) and Acquired immunodeficiency syndrome (AIDS) training is offered often to nurses, nurse midwives and health workers in Ethiopia and Swaziland; family planning was also offered (Kebede et al., 2014; SNC, 2011; URC-Swaziland, 2014. In addition, prevention of mother to child transmission, infection control (SNC, 2011); tuberculosis and multi-drug resistant tuberculosis (URC-Swaziland, 2014). Other topics included are maternal and child health (SNC, 2011); communication skills (Kebede et al., 2014; URC-Swaziland, 2014); orientation of new nurses (Norushe et al., 2004); monitoring and evaluation; and radiology at a basic level (URC-Swaziland, 2014). Studies further highlight important courses in human resources for health that are not catered for such as human resource management, injustice and violence, social work and care (Kebede, Asres, Gutema, & Wuliji, 2012); and health economics and financing (URC-Swaziland, 2014).

What can be drawn from the above literature is that quality improvement is offered across continents despite disparities observed in the content offered. HIV & AIDS, and family planning and communication skills seem to be common topics offered in Ethiopia and Swaziland. The literature further highlights the importance of providing hands-on topics or in-service training based on true clinical scenarios which are useful in practice professions like nursing.

2.3.5. Teaching and learning approaches

According to Scheckel (2009) instruction or teaching are educational and learning approaches and practices which educators and trainees employ to attain the outcomes of a syllabus. For successful

learning, effective planning and harmonisation of instruction is essential (WHO & JHPIEGO, 2005). Efficient teaching approaches in in-service training is thus crucial to produce better education outcomes (Bluestone et al., 2013).

The literature indicates that suitable instruction methods for in-service training are derived from training needs analysis data which informs the training gap, the intended outcomes, the training objectives and the curriculum (ANCCCA, 2012). It is recommended that teaching methods which involve the trainee need to be established, built on adult education values and awareness of the trainees' favoured learning method for the specific education event (Potter & Perry, 2009).

Delivery approaches applied in nurses and health personnel in-service training include distance education, online units (Health Care Foundation, 2012; URC-Swaziland, 2014), published materials, professional development workshops (Health Care Foundation, 2012), work-based education, full-time classrooms, part-time classrooms, distance learning, and e-learning (URC-Swaziland, 2014).

Several studies show that passive teaching methods, mainly lectures, are widely used in nurses and health personnel in-service training (Health Care Foundation, 2012; SNC, 2011; WHO, 2013) although URC- Swaziland (2014) found that lectures were the second most applied approach. Other studies highlight various methods such as interactive methods, self -directed and methods such as collaborative and on-the-job, simulation and role play, laboratory exercises, class presentations by participants clinical teaching conferences, and seminars (Health Care Foundation, 2012; MOHSW, 2009; Pool et al., 2012; Yfantis et al., 2010). Other methods includes peer learning - different workmates, being taught by scholars, group teaching and education through practice. Self-directed learning methods include reading published material, reading professional journals (Health Care Foundation, 2012; Pool et al., 2012; URC-Swaziland, 2014), research, and personal projects (Jaradeh & Hamdeh, 2010; MOHSW, 2009). Additional teaching methods offered in the literature are problem based learning by conducting tangible projects to develop skills and internet sources (Health Care Foundation, 2012; URC-Swaziland, 2014), meetings, supportive supervision, preceptorship (MOHSW, 2009), and case-based learning (URC-Swaziland, 2014).

Favoured teaching approaches for nurse midwives in Swaziland, according to a study, were group discussions, lectures, case studies, clinical onsite training and demonstrations, while less approved methods were modules or self-paced instruction (SNC, 2011). Over and above the discussed

teaching methods, Pool et al. (2012) emphasise the importance of dedicating time to rehearsing new knowledge or education through experience.

The above discussion identifies a wide range of teaching methods applied in nurse and health worker in-service training programmes such as didactic, interactive, self-directed, simulated, problem based with the emphasis on interactive involvement, and most importantly reflection on and applying what was learned for success.

2.3.6. Providers of in-service training

Providers of in-service training include donor partners, MOH programmes, non-governmental organisations (NGOs), academic institutions, and hospitals. In a study by Kebede et al. (2012), the majority of the providers of in-service training were domestic and global NGOs as well as donor partners. Providers of in-service training in Swaziland include foreign partner organisations, MOH progammes, local NGOs, hospitals, academic institutions, professional associations, multilateral organisations (SNC, 2011; URC-Swaziland, 2014), and local private profit making organisations (URC-Swaziland, 2014).

2.3.7. Infrastructure and resources

Availability and accessibility of learning facilities and resources is critical for the success of in-service training. Few of the studies that were accessed by the researcher reported on their resources; they show limited resources for in-service training, and the fact that providers have more access to learning resources than learners (Kebede et al., 2014; URC-Swaziland, 2014).

Only Liberia is reported to have 2 training centres specifically developed and equipped for basic life support training for both theory and practice (MOHSW, 2009). In a Greek the study venues for in-service training sessions included centres for vocational training and hospitals (Yfantis et al., 2010), whilst an Ethiopian study reports that one provider had a fully-fledged conference room which could accommodate over 50 people and 2 providers possessed projectors and speakers (Kebede et al., 2014). Accessibility to learning resources studies indicate that trainers had more access compared to learners (Kebede et al., 2014; URC-Swaziland, 2014). For instance, in an Ethiopian study most of the trainers had access to computers and Internet facilities including current reference materials (Kebede et al., 2014). In a Swaziland study, most trainers had access

to computers with internet access compared to the learners and this was useful in accessing current reference materials (URC-Swaziland, 2014).

The above literature suggests a lack of infrastructural and resource support for nursing and health work in-service training and favourable access to education resources for trainers rather than trainees.

2.3.8. Support for in-service training

A few studies report on the assistance provided to nurses to undertake in-service training/ professional development pursuits. Two studies that report on support for in-service training; in Ireland institutions offered in-service training to mainly nurses, as well as policy support, financial and affirmative support towards study leave, but this support did not cover contract employees (NCPDNM, 2004). A Jordan study reported that of majority of the nurses who participated in in-service training in 2008, studied through personal effort, while a few studied through the in-service training/ staff development department (Jaradeh & Hamdeh, 2010). From the above it can be said that support from hospitals and government sponsorships were minimal compared to personally initiated and personally financed in-service training undertakings.

2.3.9. Evaluation of in-service training

Few studies that discuss experience on in-service training evaluation report on the difficulty in illustrating results and effectiveness of in-service training ventures in terms of progress in health service provision, and direct progress in people's health (Eaton et al., 2011; Health Care Foundation, 2012).

The literature further indicates that in-service effectiveness can be objectively appraised and a commonly used approach is the Kirkpatrick model (1994). This model measures trainee reaction to the learning activity, trainee acquisition of knowledge, skills and attitudes, trainee behaviour, results or the impact of the performance modification on real measures such as the quality of patient care, efficiency of services, absences from work, employee retention, reduction in accidents, and decrease in expenditure (Kirkpatrick, 2010).

The few studies that measure health workers and nurses' in-service training conclude that in-service training seems to be more beneficial in attainment and maintenance of knowledge,

attitudes, and aptitudes than in performance conduct and service provision (Marinopoulos et al., 2007). Légaré et al. (2015) confirm that the majority of continuing development events are not commonly planned to advance provider performance modification, but emphasises recalling and understanding facts. Similarly, nursing studies report that recently employed nurses need additional knowledge about evidence-based practice among other skills (Health Care Foundation, 2012); most nurses felt that they obtained growth in knowledge, some obtained growth in skills and a few obtained growth in performance (Jaradeh & Hamdeh, 2010); nurses obtained higher scores in knowledge questions and were challenged on application questions (SNC, 2011).

The above studies suggest that evaluation of health workers' and nurses' in-service training programmes is inadequate. The literature shows that training tends to focus more on knowledge acquisition and attitude changes than on performance changes and improvements in patient outcomes. This may not work well for a practice-based profession that seeks to achieve improvements in patient health. Therefore, in-service training evaluation for nurses require more research to determine evaluation methods that can produce tangible results regarding expected patient health outcomes, expected organisational outcomes, and expected nurse performances.

2.3.10. Post training follow up and support

A study by Yfantis et al. (2010) found that most nurses felt they were not assisted in putting into practice recently acquired information; an insignificant number reported having received support. All the participants reported that there was no refresher or follow-up training after the last course that had completed. This study shows that post-training assistance that is very poor or non-existent and needs to be strengthened.

2.3.11. Benefits of in-service training

There is a plethora of literature on the benefits experienced by nurses in in-service training. The benefits include personal development, professional development, discipline based benefits, and benefits to the organisation.

Personal development ranges from assisting nurses in organising their professional development to personal growth in terms of knowledge and expertise development in their field (Hughes, 2005; NCPDNM, 2004; Rahimaghaee, DehghanNayer, & Mohammadi, 2010; SNC, 2011). The

development includes imparting self-assurance; promoting an extra positive outlook (Rahimaghaee et al., 2010; SNC, 2011), upgrading service provision through improvement of junior nurses and information sharing with other workmates (Hughes, 2005). Such benefits indirectly improve the nurses psychologically and socially, which includes perceiving the patient fully, and increasing dedication to the job (Rahimaghaee et al., 2010).

Professional development benefits include reflecting and working by a few nurses; to assist in the accomplishment of professional desires; and that professional development is a method of lifetime education; (Yfantis et al., 2010). Contrary to this study, Hughes (2005) did not find reflection as a main gain of in-service training. Other benefits are discipline based such as for psychiatric nurses were career benefits which include the provision of quality care, inspiring employees to advance their education, aptitude to operate autonomously, improved employee inspiration, better interpersonal relations, social benefits such as esteem from others, learning how to deal with staff, positive work environment with minimal clashes (Letlape et al., 2014). Psychological gains were increased self-assurance and better enablement to cope with tension and worry.

However, a study by Pool et al. (2012) acknowledges the value of in-service training but argues that it may not be beneficial when one has reached a higher level of expertise. Pool et al. (2012) found that once mature nurses possess several years of practice and achieve a 'ceiling' in courses or high rank in proficiency, official training might offer minimal extra worth. These authors further assert that in such instances, growth occurs by non-official education ventures like daily work practices. Seifert (1983) refers to overlearning, a concept in transfer learning that refers to instances where no instant growth is obtained from more practice.

In-service training is also beneficial to the organisation or employer. Benefits to the organisation include assistance in employee retention (NCPDNM, 2004); job retention; and fulfilment of numerous patient needs (Yfantis et al., 2010). However, in a study by Hughes (2005) the contribution towards insightful service provision was not recognised as a key profit in in-service training; nurses experienced challenges in putting into practice what they learned from in-service training.

2.4. LITERATURE PERTAINING TO IN-SERVICE TRAINING CHALLENGES

Like most programmes, in-service training comes with challenges which vary from personal and physical to structural barriers. In-service training challenges cut across and beyond the above referred levels which may hinder the results of in-service training (Richards, 2007).

Personal barriers might be based on the person's outlook regarding him or herself as a trainee while physical barriers are conditions that prevail at whatever point in the person's existence which may inhibit them from successfully participating in in-service training; and structural barriers may emanate from the work environment (Richards, 2007) or beyond the organisational setting. Barriers of in-service training affect the achievement of organisational and patient outcomes as a whole. Challenges of in-service training identified in the literature are presented below in order of personal level, organisational, training planning, delivery, and post-training challenges.

2.4.1. Personal level challenges

Personal circumstances and attitudes identified in the literature which may hinder the success of in-service training include not meeting admission requirements, family obligations, financial limitations, inability to reflect, language challenges, lack of interest, and negative attitudes. PEPFAR (n.d.) reports that participants may not be receptive to training because they do not possess the right experiential and educational backgrounds. Some studies such as Hughes (2005); Jaradeh and Hamdeh (2010); NCPDNM (2004) point out family obligations as a limiting factor for nurses' engagement in in-service training. Another study found that childcare responsibilities hindered nurses from participating in in-service training offerings (Richards, 2007). Some studies also report that lack of finances was a major challenge, which prevented nurses from engaging in training or pursuing advanced education (Graf, 2006; NCPDNM, 2004; Richards, 2007). Hughes (2005) further reports that nurses who lack the capacity to reflect may not be able to change their practices or improve their work following in-service training. Reflection is a means of critical thinking whereby nurses examine their attitudes and comprehension of knowledge of an educational experience, and then develops the capacity to implement the concept in clinical areas (Potter & Perry, 2009). Reflection is an essential aspect of modifying performance (Hughes,

2005). Challenges with English as the main medium of teaching hinders some second language speakers from participating in in-service training (Richards, 2007).

Attitude may hinder some participants from attending in-service training or even applying the learned knowledge in the workplace (PEPFAR, n.d.). Personal attitude challenges might be due to lack of interest, readiness and capacity to pursue additional training (NCPDNM, 2004). Mature nurses may oppose receiving training from less qualified and junior nurses, while supervisors may disregard previous knowledge and competence in certain nurses (Richards, 2007; Norushe et al., 2004). Nurses attending in-service training for the wrong reasons such as to get an allowance (Giri et al., 2012) may not implement the application of learned knowledge.

2.4.2. Organisational barriers

The literature reports several organisational barriers such as workload, shortage of resources, insufficient support from the organisation, inadequate leadership style, and lack of support.

2.4.2.1. Workload/work related barriers

Under workload barriers, studies report that shift work and exhaustion diminishes enthusiasm for in-service training (Hughes, 2005). Overwork and nurses who were working night duty face further hindrances in attending in-service training since the majority of the training ventures are implemented during the course of the day (Jaradeh & Hamdeh,2010). Some nurses cannot participate in in-service training sessions because the clinics are very busy (Yfantis et al., 2010). The job roles and corresponding time difficulties were reported as barriers resulting in some nurses starting a study programme but never completing it (Richards, 2007). Pellico, Brewer and Kovner (2009) report high patient to nurse ratios and physical burdens of nursing as additional causes, which contribute to new nurses' frustration and dissatisfaction.

2.4.2.2. Shortage of resources

Studies report inadequate personnel, time and financial resources among other challenges (Jaradeh & Hamdeh, 2010; Richards, 2007). Inadequate resources are a barrier to attending in-service trainings on maternal neonatal and child health courses (SNC, 2011). Kovner and Brewer (2013) in the United States found that a big percentage of recently licensed nurses reported lack of supplies

to perform their work, which was likely to be 50-60% in each shift. Studies further report that the majority of providers of in-service training were global and domestic donors, which is a barrier in terms of sustainability (Kebede et al., 2014; URC, 2015).

Over and above these challenges, the literature reveals that available employees might also be inadequately trained for assigned positions in service delivery (Rycus & Hughes, 2000; SNC, 2011). There could be lack of training, knowledge and practice in management for employees at managerial level and delayed provision of orientation to new employees (Rycus & Hughes, 2000); and new nurses might be ill-equipped to implement all the required clinical nursing skills (Pellico et al., 2009).

2.4.2.3. Insufficient support from the organisation

Inadequate support from the organisational structure was reported to be amongst primary barriers to in-service training (NCPDNM, 2004; Richards, 2007). Studies report that delegation of nurses in private practice by company owners for in-service training posed extra obstacles in attending in-service training (Hughes, 2005). The main organisational obstacles perceived by nurses include terms stipulated for study leave, absence of support from employers in terms of funding, difficulties of schooling whilst employed, lack of acknowledgement from employer, insufficient prospects for promotion/upward mobility, no accommodation from systems in terms of manpower/promotion following on in-service training (Richards, 2007). Other organisational barriers include absence of policies and procedures that support service delivery for specific in-service training programmes (SNC, 2011); and lack of efforts to support /build/ own training infrastructures (URC-Swaziland, 2014).

2.4.2.4. Leadership style and lack of support

Leadership style and the type of assistance rendered by nurse managers toward in-service training to nurses in professional development pursuits is reported to be crucial for the success of in-service training, and might be a barrier if not rendered adequately (Hughes, 2005; IntraHealth Inc., 2012). The literature highlights inadequate assistance from nurse managers and lack of illustration of customary practices and guidelines to nurses causing discontent and deficiency in doing particular tasks (Norushe et al., 2004); absence of role models in the workplace; unwillingness of expert

nurses to disseminate the information they possess; dictatorial, uninvolved methods of leadership contribute to unsupportive environments (Richards, 2007).

2.4.3. Challenges in training design and delivery

Challenges identified in the literature include lack of trainee involvement in planning in-service trainings, poor curriculum design, inadequate training programmes marked by lack of skilled in-service trainers, and the use of ineffective training methods.

2.4.3.1. Poor planning and design

Rycus and Hughes (2000) report that the inability to correctly, determine personal training requirements rates amongst the factors that weaken the excellence, efficiency, and significance of in-service training. The literature indicates lack of participation during the planning phase as the main challenge in training design, and includes lack of trainee involvement in identifying requirements and organising their advancement (Giri et al., 2012; Jaradeh & Hamdeh, 2010; Norushe et al., 2004). This leads to the possibility of nurses not willing to participate and the lack of post training application at the work place (Giri et al., 2012). Studies also highlight inefficiently organised trainings, lack of standards that guide curriculum design contributing to a lack of consistency in subject matter and syllabi, which are important for accomplishing results in an institution (Giri et al., 2012; USAID ASSIST Project, 2014; (URC-Swaziland, 2014; Wuliji, 2014).

Poor organisation also includes lack of communication about courses offered to trainees (Norushe et al., 2004; Richards, 2007; SNC, 2011). Absence of information about training schedules or course content contributes to nurses not completing the programmes or not attending at all (Richards, 2007; SNC, 2011).

Inadequate logistical arrangements such as venue locations may hinder accessibility; distant venues may hinder trainee admission to courses, decrease participation and increase transport costs and accommodation expenses (Rycus & Hughes, 2000). Yfantis et al. (2010) cite barriers to in-service training, which consisted in nurses discovering that courses were fully booked before they could register.

2.4.3.2. Inadequate training delivery

Studies report that some nurses' or health workers' in-service training programmes were provided in a disorganised manner (Norushe et al., 2004). This ranges from poorly coordinated, hardly ever measured, often replicated to that training providers tend to overburden and cripple training systems leading to service disruptions (Giri et al., 2012; USAID ASSIST Project, 2014; URC-Swaziland, 2014; Wuliji, 2014), and ineffective augmenting of skills. Timing challenges include prolonged teaching periods affecting attention, sessions in the afternoon or after work sessions, weekends or during off-duty times (Omar, 2014).

The literature further reflects an inadequate supply of well-trained in-service training educators (WHO, 2013; WHO & JHPIEGO, 2005; Yfantis et al., 2010). Health care trainers often possess inadequate skills and enthusiasm to integrate best practices in clinical teaching (WHO, 2013); hardly apply theories for behaviour change in planning learning activities (Lėgarė et al., 2015); and are short of efficient managerial attributes (Norushe et al., 2004). There is also lack of official criteria and quality regulation procedures for trainers and teaching syllabi (Rycus & Hughes, 2000).

Studies show that teaching methods frequently used in health worker in-service training are didactic, passive or informative thus bearing small advantage (AACN & AAMC, 2010; Bluestone et al., 2013; Health Care Foundation, 2012; USAID ASSIT Project, 2014). These teaching methods are not effective in producing desired performance changes in health workers and health results for patients (Bloom, 2005; Bluestone et al., 2013).

2.4.4. Post training challenges

Kirkpatrick (2010) reports that the ability to implement knowledge, skills, and attitudes acquired from an in-service training in the workplace is crucial in determining practical outcomes of the training. However, a few studies that report on post-training support reveal poor transfer of knowledge and expertise on the job and poor support from management (Hughes, 2005; Vellios, 2010). Hughes (2005) found that nurses were unable to effect transformation or were indifferent after participating in an in-service training event, mainly due to dictatorial styles of leadership, inadequate assistance in applying learned information from managers and workmates, the attitudes of other trained nurses, and opposition from members of other health care teams.

Lack of monitoring and evaluation mechanisms and the absence of official systems to endorse reporting on training may further contribute to the lack of post-training application at the work place (Rycus & Hughes, 2000). WHO (2013) confirms that under-resourced nations are short of modern information gathering structures for nurses'/health workers' in-service training plus the expertise to evaluate and use monitoring data for advisory, planning, predicting, regulating and strategising health personnel approaches. MOH (2012) and URC-Swaziland (2014) further verify a shortage of information on health workers' in-service training plus the absence of a recording structure. There is also a lack of continuity in pre-service training which poses a challenge to the sustainability of in-service training (URC-Swaziland, 2014).

2.5. LITERATURE ON IMPROVEMENT OF NURSING IN-SERVICE TRAINING

Recommendations for improving the provision of in-service training for nurses include strategies to improve training planning and design, improve training delivery and post-training support, address staff shortages and work environment issues, and strengthen existing in-service infrastructures.

2.5.1. Improve in-service training planning and design

Systematic planning of nurses' in-service training planning lays the foundation for successful implementation, monitoring, evaluation and support (United Nations Development Programme [UNDP], 2009). This is also necessary for achieving the desired behavioural performances from nurses, which will contribute to the achievement of health results in patients. Planning and design activities include conducting training needs analyses, training plan development, development of standard curricula, integration of evidence based training methods and transfer of learning activities (UNDP, 2009).

2.5.1.1. Conduct a training needs analysis

Studies recommend that effective in-service training should integrate training needs assessments that involve target groups and health personnel should be individualised and should be directed by and respond to the needs of health personnel (Institute of Medicine, 2011; Jaradeh & Hamdeh,

2010),). In this way, in-service training could encourage reflection, self-assessment and successful participation (Eaton et al., 2011).

A training needs analysis is a crucial precondition for an efficient education and improvement undertaking. It examines and determines education requirements for the individual worker, section, or institution to assist the institution to function efficiently (Chartered Management Institute, 2006). It safeguards the main concerns of the institution, prevents replication of work, and assist in channelling assets where they are most required (Chartered Management Institute, 2006). Rycus and Hughes (2000) further recommend generating a training needs appraisal based on job task analysis and competencies for competency based in-service training.

2.5.1.2. Curriculum design, material development and other logistical activities

The literature suggests that in-service training for nurses should be based on curricula developed for each course offered and are periodically revised to accommodate new developments and matters that influence content and instruction (Ministry of Education & Training, 2011).

A nursing curriculum should be competency based, centred towards achieving patients and community health needs, and primarily be intended to build nurses' knowledge, skills, and practices pertinent to the changing requirements of people (WHO, 2013). It should also be founded on nursing professional standards and competencies for nursing practice (Scheckel, 2009). Subject matter derived from the curriculum needs to be prepared by specialists in each topic (ANCCCA; 2012; Ministry of Education & Training, 2011) and founded on training needs analysis findings (ANCCCA, 2012; Rycus & Hughes. 2000).

An evidence-based evaluation model should be built in that measures learner reaction, knowledge, skills and attitude gain, behaviour change, and impact outcomes at patient and institutional levels (Kirkpatrick, 1994; PEPFAR, n.d.). It is important to cost the evaluation component and include it in the financial plan and to disseminate evaluation outcomes to relevant stakeholders (USAID HCI Project, 2013).

2.5.1.3. Integration of recent evidence based teaching methods and transfer of learning activities

It is also crucial to integrate recent evidence-based teaching methods and to transfer of learning activities. Studies suggest that the selection of instructional strategies should be based on existing evidence, and target provider performance (Légaré et al., 2015). This is because studies show that health workers' in-service training activities tend to focus on knowledge acquisition (Bluestone et al., 2013; USAID ASSIST Project, 2014) rather than promoting performance and health results (Marinopoulos et al., 2007). In addition, Bluestone et al. (2013) report that instruction incorporated in a clinical setting develops knowledge, skills, attitudes and behaviours whereas lecture room instruction which only develops growth in knowledge.

Numerous additional beneficial teaching approaches are listed in the literature such as point of care learning, self-directed learning, problem based learning and team based learning (Bluestone et al., 2013; WHO, 2013). The use of theories that advance performance change is also recommended, for example socio-cognitive theories like the theory of planned behaviour (Légaré et al., 2015), experiential learning theory by Kolb (1984), and social learning theory by Bandura (1971).

According to seminal theorists, transfer of learning is important in ensuring that learning goes beyond the training room and is implemented in service delivery (Gass, 1985; Seifert, 1983). In the context of in-service training for nurses, this means that each training session needs to be designed and offered so that it has a lasting effect on enabling nurses to successfully apply the learning in the work place to achieve patient results, or even in other life situations. Transfer of learning activities should be developed prior to implementation of in-service training as part of training planning (Gass, 1985).

2.5.1.4. Design data generation reporting and monitoring system

Monitoring is a continuous procedure of reporting back to stakeholders on advancement gained in attaining stakeholder goals and objectives that assists in guiding actions and decisions (UNDP, 2009). Vigilant monitoring is important to capture required data (UNDP, 2009). What is crucial here is the design of a training data base that captures important elements about each nurses' in-

service training programme at hospital, regional and national levels as approved by relevant stakeholders (USAID HCI Project, 2013; WHO, 2013), the training of personnel on analysis and the use of training data in planning, and evaluations (WHO, 2013).

2.5.1.5. Training plan development

Miller and Osinski (2002) report that training plan development is informed by training needs analysis data, ranked training needs, the number of workers to be trained, the curriculum, the trainers, and the accessibility of assets and facilities. The literature also recommends that planning should be in line with the national human resources health plan and the health sector plan so that it responds to priority needs in the health sector at community and national levels (USAID HCI Project, 2013; WHO, 2013). It should further correspond to guidelines, policies, statutes and rules pertaining to the standard scope of practice for the particular health professionals (USAID HCI Project, 2013), and address training needs in a timely manner.

2.5.1.6. Strengthen coordination

Coordination is important in addressing challenges related to the disruption of services and duplication resulting from poorly coordinated in-service training offerings (URC-Swaziland, 2014). The literature asserts that this can be achieved by creating collaboration between pertinent stakeholders at national ministerial levels, partners or donor supporters, NGOs, and regional and facility levels (USAID HCI Project, 2013). Cooperation between health care institutions, in-service trainers, governing bodies, vocational associations, in-service training programmes and nurses' pre-service institutions is essential to ensure continuity with pre-service training and to address the poor preparation of new nurses (USAID HCI Project, 2013; WHO, 2013).

2.5.2. Improve training delivery

The literature indicates that successful training delivery can be accomplished by targeting the correct trainees at the correct time. Over and above that, using correct evidence-based curricula and teaching approaches, transferring of learning activities guided by training needs analyses is important (Rycus & Hughes, 2000; USAID HCI Project, 2013). This should be followed by monitoring and evaluation, and implementing prior communication to learners of course aims, objectives and teaching strategies (USAID HCI Project, 2013).

2.5.3. Post training support

Post-training support and skills building is essential to ensure continuity of learning, the application of what was learned from the in-service training, manifestation of the desired behaviour at service delivery, and achievement of results in improvement of health outcomes (The ACQUIRE Project, 2008). According to USAID HCI Project (2013) assistance should occur prior to, throughout, and following in-service training. The literature advances numerous post-support activities that include but are not limited to mentorship and supportive supervision (Intra Health Inc., 2012); distribution of assets, supplies, education materials, and needed technology to trainees; maintaining contact with trainees prior to and after training; and offering on-going updates to managers and hospital directors (USAID HCI Project, 2013). The use of combined education methods and more vigorous support in post training applications are reported to enhance the realisation of desired outcomes (Everett, 2010).

2.5.4. Address staff shortage and work environment issues

The literature recommends addressing systems issues that cause nursing challenges, strengthening support for in-service training, offering proper orientation to new nurses, and development of nurse managers in leadership and other skills. Regarding systems, studies recommend paying attention to matters that contribute to staff shortages and other nursing concerns. These include reviewing nurses' service conditions; improving retention packages and designing professional growth ladders with equivalent remuneration (Graf, 2006; Pellico et al., 2009); and introducing quality indicators of nursing care (Kovner & Brewer, 2013). Measures that strengthen in-service training include instilling life-long learning from pre-service throughout the working life of health employees (AACN & AAMC, 2010); assisting nurses in their pursuits of professional development Graf, 2006; Pellico et al., 2009); and offering policy support and dedicated leadership which is enlightened about the importance of in-service training (WHO,2013). Offering evidence based/ effective orientation programs for new nurses offered over a period of time to address performance challenges among new nurse graduates (Pellico et al., 2009) and providing concentrated leadership education for nurse managers (Kleinman, 2004).

2.5.5. Strengthen existing in-service infrastructure

Some scholars suggest: allocating a budget for in-service training activities, developing in-service structures to efficiently run sustainable training activities, and providing necessary in-service training policies and guidelines (USAID HCI Project, 2013). Budget provisions should come from ministerial to health facility levels to cater for the necessary human, equipment, supplies and other resources needed for effective of in-service training (USAID HCI Project, 2013). An in-service infrastructure needs to: be fully capacitated to effectively execute all in-service system functions; effectively liaise with regional and ministerial levels for support and be line with national efforts; be staffed with well qualified personnel to efficiently run the department (ANCCCA, 2012; USAID HCI Project, 2013; WHO, 2013). Kirkpatrick (2010) further recommends the nomination of a multidisciplinary consultative committee comprising training personnel and other experts from the organisation. Relevant in-service training standards, procedures, policies, and guidelines need to be developed and regularly revised (PEPFAR, n.d.), including research into the impact of implementing teaching strategies and learning outcomes (Bluestone et al., 2013; Légaré et al., 2015; Marinopoulos et al., 2007).

The preceding sections discussed several studies on nurses' and health workers' in-service training and provided a general understanding of the training including experiences, challenges and recommendations. However, only a few studies have examined nurses' experiences of in-service training in other context and scanty studies if at all any studies on nurses' experiences of in-service training have been undertaken in Swaziland. Most overseas studies tend to focus on general health workers' in-service training, while the nursing studies focus more on perceptions of nurses towards in-service training. This study intends to bridge this knowledge gap in the literature mainly in Swaziland, although such a gap seems to also apply in Africa and in the international nursing community in general. In the subsequent section a discussion of the theoretical framework used in this study is done.

2.6. THEORETICAL FRAMEWORK

The researcher has applied the theory of planned behaviour by Ajzen (1988) to understand and explain nurses' experiences of in-service training in the study (Ajzen, 2012). The theory of

planned behaviour was developed based on the theory of reasoned action, coined by Ajzen and Fishbein in 1980 (Ajzen, 2012; Rise, Sheeran, & Hukkelberg, 2010; Southey, 2011). It is a theory of social psychology that began as a key structure for comprehending, foretelling, and modifying people's collective conduct and every form of communally important action (Ajzen, 2012). It focuses on how people's activities are directed (Ajzen, 2012). It also offers a model that can be applied to guide the design of effective in-service training programmes for nurses at the study hospital to produce desired behaviour and possibly achieve better patient outcomes (Ajzen, 2012; Casper; 2007). The researcher therefore, found the theory of planned behaviour suitable for this study for the above reasons.

The theory of planned behaviour is centred on intentions, attitudes, subjective norms and perceived behaviour control which it purports, govern human behaviour (Ajzen, 2012). Intention is the intellectual depiction of an individuals' willingness to carry out certain behaviours. It foretells behaviour and is a product of attitudes, subjective norms, and perceived behaviour control. Attitude is an individual's general assessment of behaviour in terms of positive and negative results obtained from performing it. Subjective norms are an individual's personal approximation of societal persuasion to implement anticipated behaviour and is influenced by the preference of significant people, and the presence or absence of support. Perceived behavioural control is the degree to which an individual considers him or herself to be competent to perform a certain behaviour including envisaged challenges (Ajzen, 2012; Rise et al., 2010). It is governed by the influence of internal and environmental aspects that may prevent execution of the behaviour (Ajzen, 2012; Casper, 2007). This may include challenges like inadequate capability, time, situational and institutional challenges and unintended habits (Ajzen, 2012; Casper, 2007). The theory of planned behaviour also asserts that the intention to carry out a particular behaviour can be enhanced when individuals' attitudes are more positive, including the subjective norms and perceived control (Ajzen, 2012; Casper, 2007). The theory of planned behaviour tallies with this study in that it offers an understanding and clarification of the personal elements, significant others, and internal and external organisational factors that direct nurses' experiences of in-service training. It also suggests that improving personal elements, organisational and health systems factors, once identified, can produce improved experiences of in-service training for nurses in this study. The theory of planned behaviour as applied in the study is shown in the next Figure 2.1:

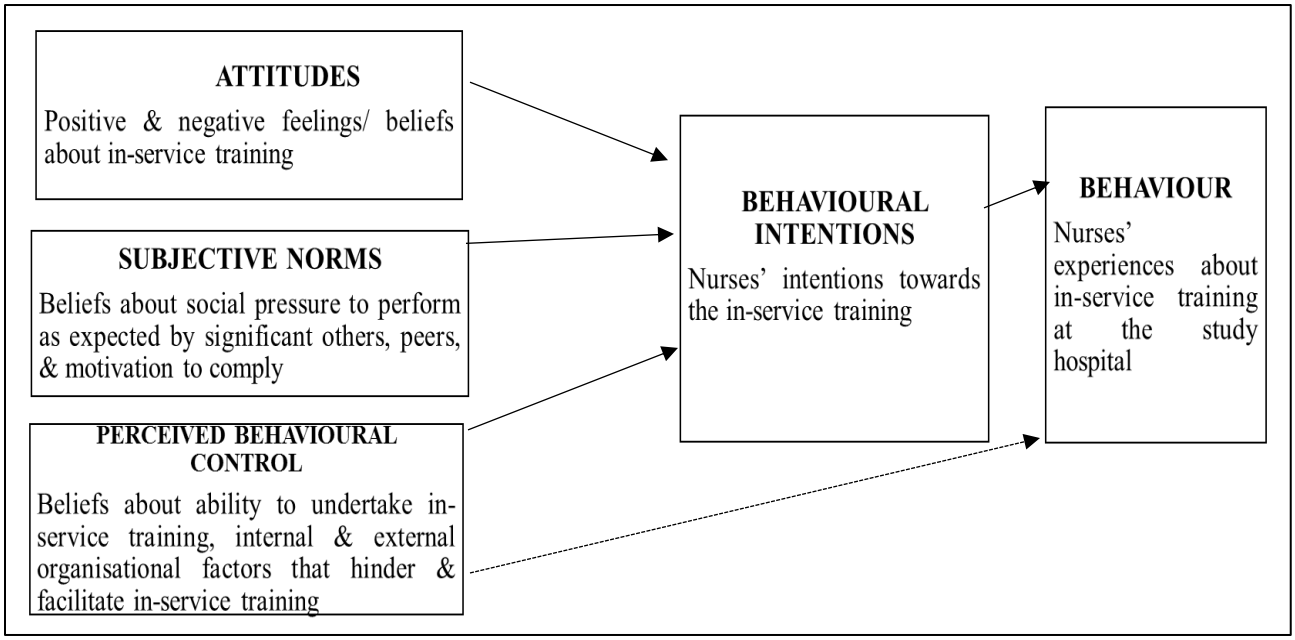


Figure 2.1: Theory of Planned Behaviour (Ajzen, 1991). Adapted from "Theory of Planned Behaviour" n.d., p.12.

2.7. SYNTHESIS

The preceding chapter provided an in-depth review of the literature regarding in-service training in health care with particular focus on nurses' in-service training. The literature covered the experiences of nurses, their challenges, and suggested recommendations that might improve the provision of and effectiveness of training at the hospital. The theoretical framework that guides the study was also discussed. The next chapter provides a detailed discussion of the design and methodology of the study.

CHAPTER 3

RESEARCH DESIGN AND METHODOLOGY

3.1. INTRODUCTION

The preceding chapter provided a detailed discussion of the literature on in-service training for nurses and health workers including the theoretical framework applied in this study. This chapter presents the methodology and data generation in three phases as Motalingoane-Khau (2010) did. Part 1 outlines the research design and methodology, part 2 discusses the activities the researcher undertook in preparation for the fieldwork, and part 3 deliberates on the actual data generation and production.

3.2. AIMS OF THE RESEARCH

The study was conducted to explore the experiences of nurses regarding in-service training in one hospital in Swaziland. The intention was to explore good aspects of nurses' in-service training programmes as well as challenges and to arrive at recommendations for improvement.

3.3. RESEARCH QUESTIONS

- What are the experiences of nurses regarding in-service training in one hospital in Swaziland?
- What are the current challenges in offering in-service training in one hospital in Swaziland?
- How can the provision of in-service programmes for nurses be improved in one hospital in Swaziland?

3.4. PART ONE: RESEARCH DESIGN AND METHODOLOGY

3.4.1. Research design

The researcher opted for a qualitative approach, an interpretivist paradigm and a descriptive phenomenological design for this study.

3.4.1.1. Qualitative research

Qualitative research concentrates on studying people, assemblies, gatherings, developments, or institutions (Marshall & Rossman. 2006). It is a method of discovering and appreciating the explanation persons or gatherings assign to a societal or mankind challenge (Creswell, 2014). Qualitative research seeks a multifaceted, in-depth appreciation of a topic (Marshall & Rossman, 2010). The researcher strives to grasp the participants' meanings pertaining to a matter instead of the meaning that the researcher may transport into the study; it advances a universal description that entails numerous viewpoints, different aspects, and outlines the bigger depiction in a condition (Marshall & Rossman, 2010). Qualitative researchers receive biased and personal accounts from participants as correct representations of their lived encounters, and discovers and learns the truth from these subjective occurrences, narratives and expressions (Nieuwenhuis, 2007). Qualitative research is particularly appropriate for exposing the surprising, discovering unknown situations, or providing whole accounts ". . . of complex circumstances that are unexplored in the literature" (Marshall & Rossman, 2006, p.7). According to Marshall and Rossman (2010) the final report of a qualitative study consists of the participants' verbatim responses, the researcher's personal effort towards bias prevention in the study and what the study adds to research. For all these characteristic of qualitative research, the researcher opted to use it as it was seen suitable for exploring nurses' experiences of in-service training.

3.4.1.2. Research paradigm

A paradigm is an assemblage of principles and directives that guide researchers in certain fields of study on the problem or topic of study, approach, methodology and analysis of findings (Bryman & Bell, 2011). For Nieuwenhuis (2007) a paradigm functions as a set of guiding values to understand physical existence. Guba and Lincoln (1994) suggest that paradigms carry significant outcomes for the actual execution of a study, including explanation of results and election of strategies. Emphasising the importance of a clear relationship between the moral foundations of a study and its methodology Lopez and Willis (2004) assert that an approach that lacks consideration of its theoretical roots can result in a study with unclear aims, arrangement and results.

Interpretivism was the selected paradigm for this study based on the researchers' observation of inconsistent and inadequate uptake of in-service training by nurses at a hospital in Swaziland where the researcher is employed as an in-service coordinator. The researcher's observations and

interest to undertake a study informed the research questions which in turn informed the choice of an interpretivist approach for this study. Interpretivism therefore, fitted the purpose of this study since the researcher wanted to provide understanding of the experience of in-service training from the standpoint and interpretation of the nurses in the study (Nieuwenhuis, 2007). Interpretivism assumes that there are numerous aspects to physical existence which are collectively created (Nieuwenhuis, 2007; Pickard, 2007), by people's deliberate acts (Van Rensburg et al., 2010), and that reality is all-inclusive (Pickard, 2007). A person therefore has multi-faceted, numerous worlds rather than one physical world (Pickard, 2007). For interpretivists reality always fluctuates (Nieuwenhuis, 2007; Pickard, 2007; Tuli, 2010), and is based on time and setting (Nieuwenhuis, 2007; Pickard, 2007). Interpretivists further suggest that social reality is deeply significant for appreciating and explaining generated meanings (Nieuwenhuis, 2007). This is because people's behaviour is influenced by background (Nieuwenhuis, 2007).

Regarding methodology, a qualitative approach is assumed to generate knowledge for an interpretitivist study (Pickard, 2007; Tuli, 2010). The methodology used in this study is discussed in detail in the next section. The emphasis in this paragraph is on the relationship between the researcher and the participants and how the researcher in an interpretivist paradigm gathers information. This could be by interacting with participants (Pickard, 2007) or by means of collective conversations in community settings (Tuli, 2010). Through verbal dialogue the researcher conducts in-depth examinations and gains understanding of the world that is narrated by individual participants (Pickard, 2007). This means the researcher generates knowledge for the study by direct personal contact with participants as opposed to watching, experimentation, control, and use of quantitative methods as in positivism (Pickard, 2007). Quality enhancement through trustworthiness and credibility is important in interpretivism, instead of reliability and objectivity which is adopted in positivism (Tuli, 2010). Finally, the findings of an interpretivist study can only be applied to the participants and context of a particular study and cannot be generalised as is the case of positivist (Nieuwenhuis, 2007; Pickard, 2007). However, transference of results is determined by the appropriateness of the settings (Pickard, 2007). The researcher understood that the quality of the study could be measured by trustworthiness, that the results could only apply to the participants and setting of the study, and that they cannot be generalised to the rest of the nurses in hospitals in Swaziland.

3.4.2. Research methodology

Research methodology refers to the methodical gathering and examining of information to respond to research questions (Grove, Burns, & Gray, 2013), or the stages, techniques and approaches for generating and scrutinising data in research (Polit & Beck, 2012). It is basically concerned with the procedures of generating information and analysing it to derive meaning. According to Guba and Lincoln (1994) research methods need to conform to a prearranged research strategy.

3.4.2.1. Descriptive phenomenology

Edmund Husserl (1900; 1970) founded phenomenology. It is a qualitative research design entrenched in philosophy and psychology (Polit & Beck, 2012). Phenomenology focuses on research that is based on understanding meanings (Moustakas, 1994). It is concerned with awareness, human life or the essence of existence. It centres on people and their world instead of the study of objects and the natural world (Giorgi, 2005). Descriptive phenomenology, also referred to as Husserlian phenomenology (Lopez & Willis, 2004; Tan, Wilson & Olver, 2009) is dedicated to the description of experiences (Moustakas, 1994) of individuals' daily existence or ". . .'things' as people experience them" (Polit & Beck, 2012, p. 495). These things comprise listening, looking, trusting, recalling, opting, appraising, and performing (Polit & Beck, 2012). The purpose of phenomenology is to establish the essence of an experience according to the individuals who have undergone it (Moustakas, 1994), or to obtain detailed appreciation of people's lived encounters (Chan, Fung, Chien, 2013). This approach is particularly helpful when a phenomenon is inadequately explained or understood (Polit & Beck, 2012). Husserl, the founder of phenomenology believed that personal accounts are essential in appreciating people's motivations as their activities are determined by their views of reality (Giorgi, 2005; Lopez & Willis, 2004). In this study the accounts of nurses' experiences are going to be understood through phenomenology.

Important features in phenomenology include meaning, consciousness, intentionality, phenomenological reduction and physiognomy as asserted by Giorgi (2005). For phenomenologists meaning is the specific manner in which an entity is encountered or "…is in the act of experiencing it, and not in the object itself" (Moustakas, 1994, p.2). Consciousness and intentionality underpins learning human behaviour and understanding the meaning of that

behaviour. Consciousness is where human knowledge is embedded, whilst intentionality involves the external form of an entity including internal /cognitive perception according to remembrance, appearance, and meaning (Moustakas, 1994). Phenomenological reduction or transcendental subjectivity (Lopez & Willis, 2004) is a strategy of ensuring neutrality by separating previous experiences regarding an encounter so that when it is brought to the researcher's awareness, it is received with objectivity (Giorgi, 2005). This is achieved through bracketing which is the adoption of an objective outlook (Lopez & Willis, 2004). An objective outlook on the part of the researcher is important to understand the critical lived encounters of the study population (Lopez & Willis, 2004).

Physiognomy is communication that emanates from the person undergoing an experience which allows learning from it (Giorgi, 2005). It refers to the experiencer's emotive, non-spoken expressions and entails an in-depth description of the more cherished components of the experience not openly available to the investigator (Giorgi, 2005). This implies the use of face-to-face interactive data generation techniques by the researcher that permit open and free sharing and allows for the observation of non-verbal cues in the participant.

The above points to the need for the researcher to engage in continuous bracketing and to use purposive sampling to obtain desired and varied participants. It is crucial to apply person and method triangulation to obtain multiple data generation points and perspectives about the encounter of in-service training from participants. Likewise, to review the data and to think about it repeatedly to grasp the entire meaning in its different contexts.

To learn the in-depth features of the narratives, the researcher reviews and analyses the descriptive accounts (Giorgi, 2005), and needs to recognise the elements found in each encounter which are shared by everyone that lives the encounter, and which are referred to as essences or eidetic structures (Giorgi, 2005; Lopez & Willis, 2004). This is necessary to reach a general or universal description, and for the lived encounter to be taken as science (Giorgi, 2005; Lopez & Willis, 2004). Throughout the data analysis, the researcher uses additional phenomenological principles such as "intuiting, analysing, and describing data" (Polit & Beck, 2012, p. 495).

Descriptive phenomenology was thus a suitable approach for the researcher to reveal the resemblances, forms, generalities, and answers in respect of the experience of in-service training by nurses in this study (Wojnar & Swanson, 2007). Nurses' experience of in-service training in Swaziland is inadequately explained or understood due to the limited research on the topic. Following is a discussion of the research setting.

3.4.3. Research setting

This study was conducted in a hospital in Swaziland. The facility is a regional and second referral hospital which provides primary health care, curative, and rehabilitation services. It comprises both in- and out-patient departments. The hospital is located in the Manzini region which is also referred to as the hub of Swaziland, in the city of Manzini. Of the four regions in Swaziland, Manzini is the most populated, with a population count of 360,228 (MOH, 2009), and multicultural (Swaziland Nazarene Health Institutions [SNHI], n.d). The study hospital mainly caters for the Manzini population, but also treats clients beyond the region and Swaziland's boundaries. It also serves as a teaching hospital for nursing, medical, and allied health scholars. The hospital is one of the six hospitals in the country where the MOH in cooperation with the Southern African Human Capacity Development and Council for Health Services Accreditation for Southern Africa introduced a quality assurance program in 2006 (MOH, 2012). It was purposively selected for this study because of its long experience in in-service training, having started a full-time in-service training programme for its personnel in 2007. The researcher is familiar with the setting since she is currently employed at the study hospital which also facilitated obtaining entry and authorisation to conduct the study.

The study hospital has a bed capacity for 350 in-patients and its staff comprises 238 nursing personnel, 34 medical officers, 45 allied health workers and 216 support staff (SNHI, n.d). The nursing personnel comprises 2 matrons, 25 nursing sisters, 160 staff nurses, 44 nursing assistants and 6 coordinators of quality improvement. The hospital setting and the nature of the nursing job requires nurses to work shifts so that patient care is provided 24 hours a day. Nurses assume day, afternoon, evening and night shifts. A nurse may be in a department for a month, months, a year, or years before being assigned to another department, except for nurses with specialised training. According to the MOH (2009) the nurse to patient ratio in the country is 28 per 10 000, and 1.8 per 10 000 for doctors, which indicates inadequate staffing levels throughout the teams of service

providers. The hospital's 2011 statistics show that 236, 042 patients were seen in the out-patient department, and that there were 54,640 in-patients, 12,679 admissions and 8338 deliveries which is approximately one delivery per hour (SNHI, n.d).

The study involved nurses from the following departments in the hospital: nursing management, quality improvement, the eye clinic, the wellness clinic, the outpatient department, the private out-patient department, the maternal and child health clinic, the children's ward, the male surgical ward, the male medical ward, the maternity-labour ward, the post-natal ward, special care nursery, and the private ward.

3.4.4. Selecting the participants

The researcher elected purposive sampling using a maximum variation method to select eligible nurses for the study. It is a sampling strategy commonly applied in interpretivism, qualitative research (Pickard, 2007; Polit & Beck, 2012) and phenomenology (Polit & Beck, 2014).

The liberty to make a deliberate choice in identifying participants for a study made purposive sampling a suitable strategy (Polit & Beck, 2014). This is because a prerequisite in choosing participants in a phenomenological study is for every participant to have had prior encounters of the occurrence, and the capability to communicate how it was to have gone through the encounter (Polit & Beck, 2014). Nurses who were selected for the study were therefore employed at the study hospital and had undergone in-service training. The inclusion criteria was that nurses should: (i) have participated in in-service trainings at the hospital between 2012 and 2014 (ii) have been employed at the hospital for more than six months (iii) be registered with the SNC with a current license, and (iv) be willing to participate in the study. The researcher purposely excluded nurses who did not possess the above characteristics. These were nurses who (i) had been at the hospital for less than six months, had attended an in-service training, were registered with SNC and had current licenses (ii) had participated in in-service trainings between 2012 and 2014, were employed at the hospital for more than six months, and did not have current licenses.

Through purposive sampling the researcher intentionally elected particular nurses, features, occasions, or events to be part of the investigation (Grove et al., 2013). The researcher further sought to secure nurses who were likely to have deeper knowledge about the phenomenon under study, to produce detailed elaborations on the topic (Sampson, 2012). The nurses also needed to

be expressive, insightful, and prepared to speak to the researcher in detail (Polit & Beck, 2012). This deliberate selection assisted the researcher in appreciating the experience of in-service training by nurses at the hospital of study, its benefits, challenges and possible improvement interventions (Creswell, 2014). Through the use of maximum variation, the researcher also ensured that nurses were from the different nursing cadres and departments of the hospital were selected to accommodate diversity in backgrounds and other aspects and to obtain multiple or dissimilar perspectives of the experience of in-service training (Polit & Beck, 2012).

The researcher personally identified willing nurses to participate in the study from different departments after obtaining permission from the matrons at administrative level and from nursing sisters in the wards. Physical follow-up visits and telephonic calls were made to secure and confirm appointments for personal interviews and focus group discussion (FGD).

The sample included 13 nurses, comprising a matron, four nursing sisters, five staff nurses, a quality coordinator and 2 nursing assistants. Of these nurses, one was not available on the day of interview but turned up for FGD. So, from this sample 12 nurses participated in the interview, 9 nurses managed to attend the FGD, the 9th nurse being the one who was not interviewed, and 4 nurses who were interviewed could not participate in the FGD.

The demographic data of the sample is shown in the 2 tables below. Table 3.1 illustrates the biographic data, and Table 3.2 shows the participants' designations and departments.

Age (years)	No. of participants	Males	Females	Working years	No. of participants	Qualifications	No. of participants
20-29	1	1	0	0-5	2	Certificate in nursing	2
30-39	7	2	5	6-11	5	General nursing diploma	1
40-49	4	0	4	12-17	3	General nursing & midwifery	3
50-59	1	0	1	18-23	2	Speciality ophthalmic/paediatric	2
				24-29	1	Bachelor's degree	5
Total	**13**	**3**	**10**	**Total**	**13**	**Total**	**13**

Table 3.1 Participants' Biographic Data

Designation	No. of participants	Departments
Matron	1	Nursing administration
Nursing sister	4	Eye clinic/ Wellness, Children's' ward, Male medical ward, Labour ward
Staff nurse	5	Out-patient, Private out-patient, Male surgical ward, Special care nursery, Private ward
Nursing assistant	2	Maternal & child health clinic, Post-natal ward
Quality coordinator	1	Quality improvement
Total	**13**	**13**

Table 3.2: Participants' designations and departments

Securing participants for both the interview and FGD was challenging because of the busy nature of the departments and the fact that nurses work in different shifts as mentioned earlier. This presented even more uncertainty for attendance in the FGD.

Phenomenological studies usually comprise small samples, for example 10 people (Polit & Beck, 2014). Limited sample size is also characteristic of qualitative research and phenomenology study (Polit & Beck, 2012). The sample size of 13 people achieved in this study was acceptable to the researcher, since the originally planned sample size was 10. The researcher did not aim for representation, but aimed to produce adequate rich information that would reveal the forms, classifications, and aspects of the experience of in-service training by nurses at the study hospital.

3.4.5. Research methods

In line with descriptive phenomenology, which follows an interpretivist approach in obtaining information, the researcher applied person-to-person communication strategies to unlock meanings of what the nurses had undergone in in-service training at the hospital (Wojnar & Swanson, 2007). Face to face, interactive methods permit engaging with and observing participants and setting (Wojnar & Swanson, 2007), gathering rich data, and greater appreciation of phenomenon under study (Giorgi, 2005; Polit and Beck, 2012). The researcher therefore, used face-to-face interviews (Chan, et al., 2013; Moustakas, 1994; Shosha, 2012) as the main data generation strategy, which were corroborated by a FGD. The FGD served to feedback, comment on, and confirm data collected form interviews. Triangulation in the form of person and methods was thus applied. Person triangulation was used to obtain diverse viewpoints of the experience of in-service training by selecting nurses from different nursing cadres and departments (Polit & Beck, 2012), which is important to obtain a multifaceted and comprehensive understanding (Giorgi, 2005; Moustakas, 1994). Method triangulation by engaging FGD was used for confirmation (Maree & Westhuizen, 2007). The data generation methods are discussed in detail below.

3.4.5.1. In-depth interview

An interview is a two-way discussion in which an investigator questions an interviewee to obtain information about the interviewee's thoughts, "beliefs, views, opinions and behaviours"

(Nieuwenhuis, 2007, p. 87). An in-depth interview strives to stimulate learning regarding personal experiences and perspectives on a particular subject (DiCicco-Bloom & Crabtree, 2006). It allows the researcher to constantly generate rich descriptive information that assists to appreciate the informant's construction of facts and societal reality (Munhall, 2007; Nieuwenhuis, 2007). In-depth interviews were deemed suitable for in-depth appreciation of the context and meaning of nurses' daily encounters with in-service training at the study hospital. Again, descriptive phenomenology requires face-to-face encounters with participants (Wojnar & Swanson, 2007).

The researcher therefore used an interview guide with open-ended questions based on the study's objectives (Chan et al., 2013). Throughout the interview the researcher applied phenomenological principles that permit a truthful appreciation of the nurses' accounts, such as bracketing (Chan et al., 2013; Finlay, 2009; Tufford & Newman, 2010), intuiting, focused listening, intense analytical thinking and effort to empathise with the participants (Wojnar & Swanson, 2007).

Out of the 13 participants, 12 nurses were interviewed. The interviews lasted around one and a half hours at most, were audio recorded by cell phone, and documented in notes which recorded non-verbal aspects of the interview. The voice recorded interviews were then transcribed in preparation for analysis. The researcher checked data for completeness before leaving the field by listening to the audio recordings. The data was kept in a safe and private place. The interviews were conducted in a quiet and conducive setting at 5 of the participants' work settings, the hospital conference room for another 5, and the hospital's lounge or an empty room in a private ward of the hospital for the remaining 2 participants.

3.4.5.2. Focus group discussion

An FGD is a form of group interview that enables communication between the researcher and research participants so that rich data can be generated (Bryman, 2004). FGD is a method of dialogue that involves several members with the facilitator focusing on properly delineated issues. Emphasis is placed on interactions between members and the shared production of meanings (Bryman, 2004). The emphasis on communication between group members and collective generation of information is a unique feature of FGDs (Kirtzinger, 1994). In FGDs questions are not directed at a particular person; the researcher asks a question and the group members can

deliberate with each other before answering. The purpose of a FGD is to ascertain common standpoints (Nieuwenhuis, 2007).

FGDs are tool through which thoughts can be clarified (Kirtzinger, 1994). Interactions between participants can produce agreement, lead to the identification of group standards, bring out participants' points of view and main concerns, enable appreciation, and assist in communicating thoughts and encounters that may not be exposed in interviews (Kirtzinger, 1994). FGDs can expose rich in-depth facts developed from individual members' thoughts and remarks including profound understanding about members' opinions, outlook on and encounters with particular subjects (Elliot & Associates, 2005; Nieuwenhuis, 2007).

While most authors are not specific about the number of participants to be included in a group, Marshall and Rossman (2010) recommend 7 to 10, while Kitzinger (1994) recommends between 8 and 12 participants as an ideal composition. Kelly (2008) recommends a smaller group and argues that participants are likely to have a lot to say, and might become emotionally involved in a topic.

One FGD session with nurses at the hospital of study was done as a method triangulation to test agreement with and articulation of individual interview responses, and gain a better appreciation of their experience of in-service training. The FGD involved 9 participants who were willing and able to attend. The researcher invited the same participants who were individually interviewed to enable participants to feedback, comment on and confirm the data obtained from the interviews, one of the participants who could not be available for the individual interview because of working a night shift and exhaustion, managed to participate in the FGD. The group comprised 3 nursing sisters, 3 staff nurses, 2 nursing assistants and a coordinator of quality improvement. The group managed to have an open dialogue and share their opinions without intimidation (Polit & Beck, 2012). The researcher secured one of the hospital's conference rooms from the management of the hospital. The venue was conducive to the purpose, comfortable, quiet, easy to reach, and convenient for audio-recording (Polit & Beck, 2012). The researcher moderated the discussion, guiding it using a focus group guide and ensured participation from every member (Polit & Beck, 2012). The researcher had a research assistant responsible for recording the proceedings of the

group including non-verbal aspects. The discussion lasted for approximately 2 hours. It was voice recorded using a cellular phone and later transcribed in preparation for analysis.

3.5. PART 2: PREPARING FOR THE FIELD WORK

3.5.1. Bracketing activities

A phenomenological study can be defined as such based on an in-depth description of the lived encounter and the assumption of an open phenomenological outlook (Finlay, 2009) which is achieved through bracketing, by continually examining the researcher's influence, and by removing preferences and presumptions which might affect the study. Bracketing helps the researcher to maintain a neutral and open state in respect of the participants' realities, referred to as transcendental subjectivity, during the entire study (Lopez & Willis, 2004; Wojnar & Swanson, 2007). Bracketing assists in managing the researcher's human nature, which unavoidably affects the development of the study (Chan et al., 2013). This is necessary because in a research which studies human experience, the researcher functions as the study instrument which serves the purpose of appreciating and describing the complications that are associated with people's existence and their interactive dealings (Pickard, 2007). In phenomenology bracketing also offers a valuable procedural method to prove validity (Chan et al., 2013). Bracketing activities need to be properly organised prior to undertaking data gathering and analysis (Chan et al., 2013). Preparatory activities for bracketing included mental assessment, decisions about the literature review, bracketing the interview, reflexivity and other activities which are discussed below.

3.5.1.1. Researcher's mental assessment

Mental assessment involved engaging in thinking activities to personally examine if the researcher was appropriate for undertaking phenomenological research (Chan et al., 2013). This involves, whether the researcher was sufficiently modest to study senior, peer and younger nurses' encounters regarding in-service training; and whether she could prepare herself to assume an outlook of deliberate inexperience regarding the nurses' in-service training (Chan et al., 2013). These authors further suggest that once the researcher could confirm the first 2 questions, she can proceeded to adopt phenomenology as methodology for the study. Next, the researcher quizzed herself on the types of fresh knowledge that could be produced following the study. In this case,

the researcher was curious and open to discover the truth as well as possible solutions to her observations which satisfied a justification for the researcher to proceed with phenomenology.

3.5.1.2. Decision regarding literature review

In phenomenology, the issue of when to start a literature review including the extent and depth of the literature review is still uncertain, thus it is advisable to adhere to the gate keeper's policy (Chan et al., 2013; Tufford & Newman, 2010). Further to adhering to readings, the researcher followed the guidance of her study supervisor, in line with the expectations of the University of KwaZulu-Natal, College of Humanities, School of Education.

3.5.1.3. Bracketing interview

In line with a phenomenological approach, the researcher went through a bracketing interview prior to data gathering and analysis (Polit & Beck, 2012; Tufford & Newman 2010; Chan et al., 2013).

The main purpose of the bracketing interview was for the researcher to confront the upcoming task of data generation and analysis with a non-biased and open mind to learn and understand the indispensable lived experiences of nurses about in-service training (Lopez & Willis, 2004). Underlying this purpose, the researcher also wanted to learn her personal response to the in-service training that is offered to nurses at the hospital. Also, uncover personal biasness and suppositions including conferred benefits for embarking on the study and the manner in which the latter could influence interviews and the focus group discussion; and render her reflexivity open to trustworthiness in the study as recommended by (De Cruz, 2010). The researcher further wanted to unveil themes that could prevent her from listening to the participants, or cause sensitive reactions shutting out additional examination; reveal overlooked encounters to enhance her transparency and involvement with the nurses' encounters; and advance her ability to appreciate the lived experiences of in-service training (Tufford & Newman; 2010).

The bracketing interview was an interesting activity during which the researcher responded to the participants' interview guide, being interviewed by an independent researcher. It was undertaken before pilot testing and lasted for about an hour. It helped the researcher to feel how it feels to be the interviewed; to separate coordinator and trainee roles in terms of her experience of in-service

training, a challenge that the researcher was not conscious of and which was brought to the fore in the interview. Furthermore, it helped to clarify her role as researcher and a neutral person in the study; to redirect her focus from exploring a broad experience of in-service training for the entire hospital staff to a specific focus on the selected nurses in line with the study's purpose; and to confront her own standpoint regarding in-service training at the hospital.

3.5.1.4. Reflexivity and reflexive notes

Reflexivity is a procedure of thinking critically about oneself and examining and recording one's beliefs, former life encounters and understandings that may impact on data gathering and analysis (Polit & Beck, 2012). It is the main exercise that assists to determine possible biases that may emerge during the course of a study. It involves detailed personal questioning and thinking to be properly situated for intensely inquiry and to understand the phenomenon being researched from the participants' perspectives (Polit & Beck, 2012). The researcher maintained a reflexive diary to document personal views, emotions, insights, and former life encounters and understandings regarding the events being studied including observations and misunderstandings (Wojnar & Swanson, 2007). These were discussed with an experienced researcher and bracketed. The researcher began active reflexivity soon after the bracketing interview and maintained this throughout the data generation, analysis and writing up of the findings. During the data generation reflexivity helped the researcher to engage deeply with the participants and the raw data as suggested by Tufford and Newman (2010).

Additional activities for maintaining a neutral and open attitude included designing open ended interview and FGD guides based on the study objectives in preparation for data generation (Chan et al., 2013). The adoption of Colaizzi's method to guide the data analysis, adopting the theory of panned behaviour as a disciplinary approach towards understanding and organising the data during analysis was a plan to maintain neutrality (Ajzen, 2012; Giorgi, 2005; Peeler et al., 2013; Polit & Beck, 2012).

3.5.2. Piloting data generation tools

According to Grove et al. (2013) a pilot study refers to a minor model of the main research undertaken to improve data gathering and analysis approaches. The researcher pilot tested the

interview and focus group guides with four participants who were from the outpatient departments of the hospital and the quality improvement department.

The researcher updated the following questions in the interview guide, which were not clear or readily understood: “What was your role in these?” to read as “How have you been involved in the in-service trainings?”; “What enhances and retards these experiences?” was separated into 2 questions to read as “What enhances or makes these experiences better or successful?” and “What retards or makes these experiences worse or unsuccessful?” The think back question was also improved to indicate the years or period to think back on, and included a pause in parenthesis, to alert the interviewer of the need to let the participant reflect for a moment. The researcher further created more spaces for note taking after each question and for follow-up questions. Finally, the researcher added the SNC registration number and the current license number under the demographic data.

3.5.3. Ethical considerations

Maintenance of ethical values is important in research that studies individuals (Israel & Hay, 2006; Polit & Beck, 2012). This is done to protect study participants by reducing threats of damage or uneasiness and by augmenting respect; guarantee trust with the research participants by just and respectful conduct; safeguard the truthfulness of the study by keeping to proper conduct; meet institutional and professional requirements; and manage upcoming moral challenges (Israel & Hay, 2006).

In the above regard, the research first obtained approval to embark on the study from the University of KwaZulu-Natal Humanities and Social Sciences Research Ethics Committee (HSSREC) after submitting a proposal to do the research. The ethical clearance certificate is shown (see page vi). The researcher also obtained permission to conduct the study from the study hospital (see Appendix A). Authorisation was sought and granted at ministerial level in Swaziland from the Swaziland Ethics and Scientifics Committee (see Appendix B). The researcher also used informed consent and a consent form as a procedure for safeguarding protection for the participant in the study (see Appendix C). A schedule indicating the anticipated period for piloting and data generation and the possible departments to be involved, was submitted to the nursing department of the study hospital (see Appendix D).

3.5.4. Managing power differentials

It was also essential that the researcher deliberately addresses power differentials during the study, in light of her background, position occupied at study hospital, and familiarity with the study facility and participants. In this regard the researcher observed ethical considerations, trustworthiness, and bias management strategies entailed in phenomenology. The researcher obtained ethical clearance to conduct the study from concerned gatekeepers. These being the University of KwaZulu-Natal HSSREC, Swaziland Ethics and Scientifics Committee at ministerial level in Swaziland, and from hospital authorities as elaborated in Section 3.5.3 above. Each participant participated in the study through informed consent and signing of a consent form to ensure voluntary participation by participants in the study and to safeguard them from any discomfort or harm as also discussed in Section 3.5.3 above. The researcher further engaged quality enhancement strategies, namely ensuring credibility, transferability, dependability, and confirmability which is discussed at length in Section 3.8 under trustworthiness. For bias management the researcher engaged phenomenology principles throughout the study. This was to maintain a neutral attitude and eliminate influence emanating from the researcher's background. Strategies include bracketing activities that entail mental assessment and preparation of the researcher, conducting a bracketing interview, engaging in reflexivity, intuiting, reflecting, and applying Colaizzi'strategy during data analysis. Colaizzi's strategy, which is elaborated in Section 3.7 under data analysis allowed the researcher to confirm findings with participants.

3.5.5. Securing assistance for focus group discussion

The researcher negotiated with another nurse who has just completed her Master's degree to assist in the FGD as a scribe. The nurse readily agreed to assist the researcher, and was available during the pilot phase as well as in the main FGD. The researcher further oriented the nurse on the study and the focus group guide. This nurse was very helpful in assisting the researcher with some of the logistics such as the venue arrangement, registration of the participants, consent signing, serving of refreshments, and debriefing the participants after the FGD.

3.5.6. Securing venues for interviews and focus group discussion

As already reported under ethical considerations, the researcher first wrote a request letter and obtained verbal permission from the hospital management to use one of the hospital's conference rooms for conducting interviews and the FGD. The researcher further made advance booking arrangements with the responsible office at the hospital to use the venue for the duration of the data generation, and further followed up on the availability of the venue up to the day of each activity. Whenever suitable, interviews were conducted in the nurses' departments instead of the hospital conference room. On three occasions the hospital conference room was occupied although booked in advance; for the pilot FGD, and for 2 of the main interviews. Alternative accommodation was secured in the private ward section of the hospital and in another hospital conference room, which was unfortunately not very conducive for interviewing and audio recording.

3.5.7. Finding participants

The researcher personally approached the participants she deemed fit for the study from their workstations in the different departments of the hospital to secure appointments for the individual interviews and FGD. Physical and telephonic follow-ups were also necessary up to the day of interviews and FGD. Recruitment of the participants required more time and scrutiny since each participant who consented to being interviewed also needed to be present for the focus group discussion. The researcher ended up interviewing 12 participants, and out of these, 8, managed to participate in the FGD. The ninth participant in the FGD could not be available for the interview on the appointed date, but turned up for the focus group discussion.

3.5.8. Photocopying and other activities

The researcher used the hospital's photocopying facility to photocopy the interview guides and consent forms for both the pilot and main studies. The hospital administration granted verbal consent to the researcher to use this facility. The researcher further had a cell-phone ready and checked for proper functioning, and charged it in advance in preparation for voice recordings.

3.6. PART THREE: IN THE FIELD

In this section the researcher discusses the activities that took place in the field, during the actual data generation.

The researcher approached authorities at the hospital once approval of the study was granted by the Swaziland Scientifics Ethics Committee to finalise logistics about entering the facility, conducting a pilot study, generating data and using some of its venues. This included submitting a schedule for piloting and data generation, booking the study hospital's conference room to secure a place for interviews and the FGD, and visiting the relevant departments to locate the participants. The researcher then proceeded to conduct the pilot study, individual interviews and FGD - a process that lasted over three weeks. Informed consent was sought from each participant and signed for participation in both the in-depth interviews and the FGD. Consent forms, interview notes, and the cell phone for audio-recording the interviews were all kept confidential and safe. The researcher maintained a phenomenological stance, through bracketing, reflexivity, keeping a journal, intuiting, and adopting an impartial and open attitude towards the participants' narrations of their experience and their world. This was crucial for truthful and in-depth learning about the experiences as lived by the participants.

3.6.1. In-depth interviews

Each interview session began with an exchange of greetings, an introduction of the researcher and purpose of the study, thanking the participants for agreeing to participate and contributing to the study, informing them about their rights as outlined in the consent form, clarifying any questions, and signing the consent form. The researcher used an interview guide with open-ended questions to direct the interviews (see Appendix E). These were conducted in a convenient venue in the hospital or at the nurses' workstations. The interviews lasted from 42 minutes to 1 hour and 25 minutes. The longest interview was 1 hour and 57 minutes. Demographic data was recorded at the end of each interview session. Each interview was also voice recorded using a cell-phone, and labelled by number from Participant 1 (P1) to Participant 12 (P12). The researcher recorded notes for each interview on the interview guide and documented reflexive notes.

3.6.2. Focus group discussion

The FGD was conducted to confirm the interview responses from nine participants. A focus group guide (see Appendix F) was used to direct the discussion. The participants' interactions, responses and agreements were observed and noted, and the session lasted for around 2 hours. It was held at the hospital's conference room. The researcher facilitated the session, being assisted by a recorder who documented the proceedings and non-verbal observations of the interactions. The FGD was also voice recorded by cell phone and later transcribed. The participants used a code for identification, instead of personal names, such as P1, P2 up to P9 for protection, anonymity and confidentiality. This enabled the researcher to distinguish between responses during analysis.

3.7. DATA ANALYSIS

The data analysis occurred simultaneously with the data generation, which according to Grove et al. (2013), is a common feature of qualitative studies. The aim of the analysis was to describe the actual exhaustive structure of the lived experiences of nurses in in-service training at the study hospital, in such a manner that any other person that has undergone the same training would recognise their personal encounters from the exhaustive description (Wojnar & Swanson, 2007).

Here, the researcher adopted Colaizzi's (1978) method of descriptive phenomenological analysis. This method favours a universal understanding of the entire transcript and setting (Polit & Beck, 2012), singling out main themes and descriptions of the vital context of the experience (Polit & Beck, 2014). Colaizzi's method allows the researcher to maintain close interaction with the data or to familiarise him or herself with the data, while maintaining interactions with the participants by going back to them to confirm the findings (Polit & Beck, 2012). It thus permits the researcher to arrive at a more accurate description of the experience since it is informed or narrated by the participants. The researcher followed the 7 steps suggested in Colaizzi's method of descriptive analysis as outlined by Polit and Beck (2012), and Wojnar and Swanson, (2007). The first step entails repeated reading of all the transcripts to be acquainted with the experience and to get an understanding of the entire description. This step is assisted by the phenomenological principle of dwelling with the data by repeated reading, ongoing and repetitive writing of transcripts and notes, remembering observations and experiences, and listening to the audio recordings (Grove et al., 2013). The second step requires revising the transcripts and individually pulling out significant

statements (see example in Appendix G) that accurately relate to experiences (Peeler et al., 2013). In step 3 the researcher derives meanings from significant statements (see example in Appendix H). Step 4 requires the researcher to assemble the meanings into clusters of themes that are shared by all participants (see example in Appendix I) and any disagreement in the clusters of themes is recorded and not overlooked (Polit & Beck, 2012). In the fifth step the researcher incorporates the findings into a thorough description of the lived experiences that are being studied (Polit & Beck, 2012). At this stage the researcher deliberately enforces order and organisation on the meanings by linking meanings, insights and descriptions of ideas (Wojnar & Swanson, 2007) to achieve a general understanding of the phenomenon.

As already mentioned, the researcher selected the theory of planned behaviour to impose clarity, order and organisation on the data, and to view and describe the nurses' ordinary meanings of their lived experiences of in-service education from a disciplinary and objective stand-point. This is required in phenomenology for the lived encounter to be considered science (Giorgi, 2005; Lopez & Willis, 2004). This process which is referred to as eidetic reduction in phenomenological language, is necessary because meanings of lived experiences of "…natural attitude, which is the attitude of everyday life…never serve as a genuine scientific expression" and need to be converted by the researcher into a disciplinary perspective "…in order to meet scientific criteria" (Giorgi, 2005, p. 80-81). In the sixth step the researcher articulates a clear comprehensive description of the lived experiences of the phenomenon under study based on the pronunciations by participants in as explicit a statement of identification as possible (Polit & Beck, 2012). In the seventh and final step the researcher checks the findings with the participants as a way of confirming that they agree with the thick description (Polit & Beck, 2012; Shosha, 2012). Feedback from participants is then integrated into the final thick description of the phenomenon which should be inclusive so that any other person who has lived through the encounter can recognise their own experience (Wojnar & Swanson, 2007).

The researcher practised and maintained principles of bracketing, reflexivity and intuiting throughout data analysis. This allowed her to interact with the data in a neutral and open-minded way to gain a deeper and elaborate appreciation of the encounter including its multiple dimensions of manifestation in the participants' lived world (Nieuwenhuis, 2007). In addition, the researcher checked each step in Colaizzi's method of analysis with an independent researcher, and finally

with her study supervisor for assistance and elimination of bias. Descriptive phenomenological analysis and its processes therefore facilitate achieving the purpose of qualitative research, interpretivism, and phenomenology.

3.8. TRUSTWORTHINESS

For trustworthiness in this study, the researcher adopted quality appraisal criteria, which are advanced by Lincoln & Guba (1985) because the study is founded on the qualitative genre and an interpretivist paradigm. Lincoln and Guba's trustworthiness criteria entail credibility, transferability, dependability, and confirmability.

The researcher took credibility measure to ensure trustworthiness of the findings of the study. These include employing triangulation by using different methods in the data generation, selecting nurses from different cadres and departments of the study hospital, verifying thick descriptions with participants and the study supervisor, and including disclosure of the researcher's professional background as a nurse and in-service coordinator at the study hospital. Clear details about the study such as the methodology, sample, data generation methods, setting, and transcripts were given to ensure transferability. To ensure dependability of the results, the research provided detailed and comprehensive information about the research design, data generation, and data analysis. Confirmability was ensured by employing bias reducing strategies throughout the data generation, analysis and reporting the findings. The researcher also maintained an audit trail which is a clear description and record of every step of the study from proposal writing up to reporting the findings; voice recorded the interviews and FGD and kept records of these including the transcripts.

3.9. SYNTHESIS

This chapter discussed the theoretic foundations that guided the choice of the study's design and methodology. The researcher illustrated how this was accomplished by adhering to interpretivism, the paradigm adopted for the study. The researcher further elaborated on descriptive phenomenology, and how this was applied in the study to learn and describe the nurses' lived experiences of in-service training. In the next chapter the research findings are thematically presented.

CHAPTER FOUR

FINDINGS AND DISCUSSIONS OF NURSES' EXPERIENCES OF IN-SERVICE TRAINING

4.1. INTRODUCTION

The preceding chapter provided a detailed discussion of the design and methodology of the study. This chapter discusses the findings relevant to the first research question: "What are the experiences of nurses regarding in-service training in one hospital in Swaziland?" The findings are presented thematically and under each theme there are sub-themes. Three themes emerged from participants' data from the first research question and they are: organisation of in-service training, implementation of in-service training, and benefits of in-service training as indicated in Table 4.1.

4.2. FINDINGS AND DISCUSSIONS

The next Table 4.1, below summarises the themes and sub-themes that emerged from the data under the first research question.

THEMES	CATEGORIES
Theme 1: Organisation of in-service training	• Planning of in-service training • Notification about in-service training • Selection/delegation of nurses for in-service training • Documentation of in-service training

Theme 2: Implementation of in-service training	• Types of in-service training
	• Topics covered
	• Facilitation strategies
	  • Use of audio-visuals
	  • Practical activities
	  • Reflective methods
	• Providers of in-service
	• Effectiveness of in-service training
	• Post training support

Theme 3: Benefits of in-service training	• Personal level benefits • Hospital/institutional level benefits • Nursing profession benefits

Table 4.1: Themes and categories regarding nurses' experiences of in-service training

4.2.1. Theme 1: Organisation of in-service training

This theme discusses the experiences of in-service training that emerged from the study pertaining to the organisation of the training. Here participants spoke about planning, notification, selection and delegation of nurses, and documentation of in-service training.

4.2.1.1. Planning of in-service training

A few participants in the study expressed that in-service trainings were often organised, planned, and carefully worked out before the actual training sessions. This was articulated in statements like:

> *…I think they were organised, the people who were training us and ...they told us earlier Kutsi (that) they were coming so we were able to prepare ourselves kutsi (that) someone was going [to attend], so I was ready* (Participant 1).

A few participants had a different view and indicated that certain trainings were disorganised:

> *No we were not told, we were not told [requirements for NARTIS]* (Participants 6).

The results suggest that most of the participants who made reference to organising in-service training concurred that the planning was fairly executed. This is in line with some of the best ethics for effective in-service training (American Institute for Research and Academy for Educational Development, 2011). Several studies affirm that intensive organising, arrangement and supervision of events should occur well in advance of in-service programme implementation (Gusdorf, 2009; Rycus & Hughes, 2000). This includes but is not limited to pre-arranging the syllabus and planning (Sava, 2012). The results show that a few participants related poor planning of in-service training. Karagiorgi and Symeou (2007) emphasise that organisation of in-service training should be relevant with greater trainee participation. The fact that most participants never commented on the way the in-service is organised is a paradox in itself. This may point to the fact that there is still a lot to be done to make in-service training significant, known, and acknowledged.

4.2.1.2. Notification about in-service training

Some participants who commented on in-service training notification referred to the mediums of notification and the content of the notices as recounted below:

...sometimes the memos, are there in the wards. '... an in-service is starting at what time' (Participant 7).

...And ... you are told as to, there are these topics available so you'll be organizing who will be going for those trainings. ...so I got a message. ... Yes, from my phone through WhatsApp (Participant 4).

And we... have specific topics that are being given...like you know we'll be going on such and such a day, date for such. ...the message is passed on from one to another, by the time it comes to me maybe it's distorted or the telephonic ones mostly... Better even the written one the invite because with that everything is more clear (sic) written down... (Participant 10).

The above comments show that the participants were informed about in-service training through memoranda, mobile phones by WhatsApp, telephonically and verbally. The content of the notices covered topics, dates and times of in-service courses. This corresponds to Sava's (2012) observation that existing networks for communicating a training programme are varied and widespread, differing but not limited to fliers and websites including electronic devices. Similarly, Seidenberg et al. (2012) found that the use of automated notices from mobile handsets to notify health agencies and care providers about HIV test outcomes, considerably shortened the intervals between test collection and reporting of outcomes. However, Moorhead et al. (2013) and the National Archives (2013) pronounce that several communication mediums have both advantages and disadvantages. This suggests a need to monitor the effectiveness of each in-service communication medium that is used (Moorhead et al., 2013).

The findings also suggest that the participants were informed in advance about in-service trainings to some extent. This tallies with another best principle in health worker in-service training, which stipulates that trainers should clearly communicate to trainees among other things aims, objectives, and expectations of the course (USAID HCI Project, 2013; Jehanzeb & Bashir, 2013). The results highlight the need to use different communication methods and to include details of the trainings as part of the process. However, the study also indicates that in-service notification was challenged, which is further discussed in Chapter 5.

4.2.1.3. Selection/delegation of nurses for in-service training

A few participants commented on the different criteria used to select nurses for in-service training. They mentioned two methods; one being that senior nurse managers or matrons simply assign

nurses for external and internal trainings and that a nursing sister selects nurses on a rotational basis. The participants responsible for selection revealed this:

> *The matron who receive the message … that there is workshop going on somewhere… They pool a leg… for one to go there. …Well the hospital based is the in charge in the department who is supposed to …send someone to the in-service. … So, it will … depend on … how she feels like if the ward is so, so, so bad she won't send anyone. … But if the she feels 'Ah we are fine' then that is when she can … send someone to attend the workshop* (Participant 10).

> *Yes we do try to make a comprehensive list of nurses that need to go to the workshops* (Participant 3).

The issue of selection caused a bit of stir as many participants alluded to the challenges in delegation of nurses for in-service training, which are further discussed in the next chapter. However, the findings show that there are certain criteria and practices in delegating nurses for in-service training in the hospital. This practice however contradicts the position taken by the by United Nations Educational Scientific and Cultural Organization (2004) and Management Sciences for Health (2012) which stipulate that the choice and primacy of trainees in a training programme should be determined by a training needs analysis. Gusdorf (2009) elaborates that a training needs analysis should be in line with an organisation's study of its strengths, opportunities, weaknesses and threats so that in-service training enhances personnel knowledge, skills and aptitudes, and the realisation of the institution's strategic designs. The United Nations Educational Scientific and Cultural Organisation (2004) further states that in-service training needs to conform to the requirements of a distinct programme in which the appointment of trainees are based on predetermined standards. Clearly, the current practice of delegating nurses for in-service training in this study seems to lack consideration of the essential features, such as a training needs assessment, and the organisation's strategic plans.

4.2.1.4. Documentation of in-service training

Several participants opted not to comment on the documentation of in-service training, whilst some participants alluded to documentation of in-service training at national and hospital levels respectively. By documentation, participants were referring to the keeping of attendance registers and logbooks. They elaborated:

I'm just thinking about this eh the new register from the Ministry. Where… we write eh our names, and then…there's also a date whereby you … write when you will feedback… your department on what you have learned" (Participant 5).

Because now… we have this book from … Nursing Council… (Participant 6).

So the institution has also developed a certain booklet, but they've only issued it out to doctors because they do not have it in surplus so… they will further give out to nurses (Participant 11).

The findings indicate that a documentation system exists at national level as well as at the study hospital for recording certain trainee biographical information and in-service trainings undertaken by nurses and other personnel. This could be seen as a mechanism for monitoring and evaluating for in-service training at national and facility levels. Fort, Ng, and Nicholson (2015) and the WHO (2013) concur that structures for gathering data in human resources for health practices should be developed prior to in-service training for effective monitoring and evaluation. Such data may include the number of trainees who participated in a course, plus formative evaluation outcomes (Fort et al., 2015). In addition, the same authors approve this practice as an essential element to reinforce personnel in the health sector. In the same vein, WHO (2013) emphasises that information gathering for the various indicators of in-service training occurs best when undertaken by the institutions concerned such as the providers of the training, professional regulatory organisations, and employers. However, the country's Human Resource for Health Strategic Plans reported that there was shortage of information on in-service training due to the absence of recording structures and an information pool (MOH, 2012). This was also observed by the URC-Swaziland (2014) who in an assessment of health worker in-service training, found that trainees can hardly be traced.

4.2.2. Implementation of in-service training

This theme elaborates on the participants' experiences regarding the implementation of in-service training in the study. The participants related the types of in-service training that were on offer, topics covered, the facilitation strategies, the effectiveness of in-service training, the providers of the training, and post training support.

4.2.2.1. Types of in-service training

Several participants divulged that in-service trainings broadly comprise of short- and long-term in-service trainings. Short-term in-service training encompasses internal trainings, which are implemented in-house at the hospital level and in the departments and external trainings which are done outside the hospital.

About internal trainings, some participants said:

> *And I think with the trainings around the hospital… The participation… is much better because like the in-house one more people are able to attend than when you have to leave the institution and go outside* (Participant 10).

> *Otherwise, no they are just lovely… more especially now because you find that other departments they are just presenting … So, we have learned a lot…Kutsi (that) in the different departments what are they really doing* (Participant 6).

Many participants revealed that external residential in-service trainings were most preferred, refreshing, and conducive to learning, whilst a few opted not to comment on the matter. This was corroborated in the FGD.

> *Yah, we had to go to Motshane Lodge, which is very, very far. … And in a remote area. … You are far away from everywhere. …No shops around, you know you're just grounded {laughing}…But for the in-service per se it's very, very good because you cannot even run away to town. You learn very, very well* (Participant 3).

> *Yes, they are more enjoyable because maybe even the extension of hours if maybe the workshop was supposed to start at eight … If maybe a speaker is not there … So you can always extend to later hours because we're in a different environment where everybody's sleeping there* (Participant 11).

> *When it's outside people they say 'Wow, I want to go there,' you know {smiling and even laughing} but when it's the hospital venue 'Ah'... And the refreshments are there. {all participants laugh loud, 'Wow' said one of the participant}* (Participant 7 FGD).

Although some participants agreed that internal in-service trainings were useful in many respects, several participants pointed out that the setting was inappropriate for learning:

> *…I remember there was one …eh in-service we attended there, people were now…standing at the door they wanted to use the… room which we were using. … Us, we haven't finished. … Because we were given … nine to elven, but you know that issues arises as…they give you information … They were like 'Time, time you have to get out.' So, at the end of the day, you are cut in between, you… are not yet finished with what you want to ask* (Participant 7).

A few participants spoke about long-term training which comprises both full-time and part-time courses; and that full-time courses were more suitable. This was expressed as follows:

> *…it's better when it's full-time. …Yes when it's full time. …Because you know that, that somebody is having study leave and someone will be put to be in that department. …Like replacing. … Like bo (these) two years or more than two years, let me say one to three years. …Yah, part-time it's better when it's full-time* (Participant 4).

The preceding accounts show the good aspects of both internal and external in-service trainings. Document reports from the study hospital confirm in-house training activities in the form of general in-service training as well as continuing medical education, and further verify external in-service trainings (SNHI, 2012, 2013 & 2014). The Action for the Rights of Children (2005) agrees that internal in-service training is convenient and economical for training many people based on specific requirements of groups, including the construction of generic knowledge and a variety of needed expertise, knowledge, and attitudes.

However, some participants recounted some of the negative elements of internal in-service training versus external training, such as poor venues and a lack of refreshments, which may end up hindering learning. The KPMG Consulting Barents Group (2001) assert that the trainer needs to ascertain that the amenities satisfy the desires of mature students. They emphasise that adults need suitable amenities to encourage learning, and further need to access without effort refreshments and restrooms, as they can be easily distressed. This might suggest that the setting and services provided on-site did not satisfy the nurses' requirements, which might contribute to detesting local venues. The results indicate that internal in-service training has both positive and negative aspects. What also is exposed is the positive elements about full-time training which is supported by study leave and staff replacements. The URC (2015) verifies long-term training as a type of training offered in health worker in-service training in Swaziland, which is financially supported by the government.

4.2.2.2. Topics covered

In-service topics undertaken predominantly cover HIV & AIDS related courses, followed by maternal neonatal and child health (MNCH), quality management and medical-surgical topics, emergency/intensive care, general patient care, and other unclassified topics.

Many participants stated that they participated in a wide range of HIV and AIDS related trainings, while several said they were taught about topics. The FGD also confirmed trainings in the latter category. Some of the participants articulated:

> *Eh okay, mostly they are … related to I would say HIV and AIDS…* (Participant11).
>
> *…yes, oh now I remember also… breastfeeding…It was in twenty fourteen* (Participant 1).
>
> *I attended a workshop on breastfeeding though it was not the first time…* (Participant 6 FGD).

Numerous participants stated that they were trained on quality management related courses. Other participants' revealed that they were studying medical-surgical topics, which was confirmed in the FGD.

> *External workshops, I attended eh QI workshop where we were …taught about quality improvement, the quality improvement projects, team building* (Participant 5).
>
> *I also went for a training on diabetic, management of diabetes. … I also did eh um management of fractures* (Participant 7).
>
> *There's one I attended last year it was at Manzini, it was about diabetes mellitus* (Participant 4 FGD).

Several participants reported that they were trained in courses related to emergency/ intensive care, general patient care and other topics, which was also confirmed by the document analysis data set.

> *I can remember only the year it's two thousand and fourteen resuscitations…Yes it was eh around four hours…* (Participant 9).
>
> *We had an in-service on blood transfusion. … You know… Plotting of TPR sheet…That one was also late last year. … Twenty fourteen.* (Participant 12).
>
> *And eh psychological care and support. …Ah, twenty fifteen …We went to see …a hospital in Durban…it was just…experience exchange* (Participant 10).

The document analysis concur that several trainings associated with the above topics were undertaken (In-service Department, 2013; 2014; SNHI, 2013). These findings tally with an Ethiopian study by Kebede et al. (2012) and the Swaziland literature (MOH, 2010; SNC, 2011) which states that the majority of health care workers are trained on HIV topics. HIV and AIDS is one of Swaziland's main health concerns together with prevention of mother to child transmission

(PMTCT) and tuberculosis [TB] (MOH, 2010; SNC, 2011). Quality management trainings are congruent with the ministerial vision to offer quality health care services in the country (MOH, 2012). On another note, Eckman and Comerford (2012) report that surgical courses address critical or continuing diseases in adult clients including client reactions to real or possible challenges in health. This shows that in-service training caters for epidemic diseases as the need arise while also advancing on important topics such as the resuscitation for nurses, basic life support for nurses, advanced life support for doctors, nursing critically ill patients in surgical wards, blood transfusion, and temperature, pulse, respirations (TPR) among other trainings (In-service Department, 2013; In-service Department [first & third quarter], 2014).

4.2.2.3. Facilitation strategies

Facilitation strategies experienced by participants in this study include the lecture method, and several active involvements strategies/ mixed methods. The participants further revealed the teaching strategies they liked:

Most participants referred to being taught by lecture, while some participants reported being taught through combined lecture.

> *... Okay, mostly it was eh lecture…* (Participant 5).
>
> *Lecturing … Group discussions. … Case studies* (Participant 2).
>
> *We were participating; sometimes we were a patient, or a nurse role-playing* (Participant 1).

The FGD confirmed the use of lectures and active involvement strategies.

> *A lecture, discussions…* (Participant 7 FGD).
>
> *Participation…By sometimes role-playing* (Participant 9 FGD).

The study suggests that lectures were the commonest teaching method used by trainers in in-service trainings offered in the study. This is verified by reports at the study hospital which indicate the use of mixed facilitation methods, mainly lectures, but also discussions (BFHI Training Report, 2014), participatory lectures, power point presentations, group discussions, and other presentations (Quality Assurance Department, 2012 & 2014). The literature suggests that lectures and presentations are beneficial when giving data, facts or clarification to an audience that requires the

information (Action for the Rights of Children, 2005). This study confirms the practice and the views of other researchers that health worker training tends to rely on lectures or passive methods (Bluestone et al., 2013; Jaradeh & Hamdeh, 2010; MOHSW, 2009). The literature reports several advantages of contemporary lecturing such as the integration of trainee activities, which makes the education process lively and enhances learning (D. Kaur; Singh, Seema, Mahajan, & Kaur, 2011). Studies by Bluestone et al. (2013), Cervero and Gaines, 2014; concur on the effectiveness of combined learning methods in health worker education.

Use of audio-visuals

Several participants referred to the use of audio-visuals to support learning during in-service training which was confirmed by the FGD.

> *It's through … discussion we were discussing… lecturing… and sometimes we'll see some videos* (Participant 9).

> *Um ours it was a lecture and power point presentation and we were also issued with eh hand-outs… and also a video but we couldn't see some of the words because it was from the print and the sound was so low* (Participant 4 FGD).

The above accounts indicate how audio-visuals assist learning when used with other teaching methods, while also showing a possible negative aspect of audio-visuals. The study hospital's BFHI Report (2014) confirms the use of videos with other teaching strategies such as lectures and discussions in BFHI training. Several authors concur that audio-visuals make instruction more effective (Awasthi, 2014), make education lasting (Ashver & Igyuve, 2013; Awasthi, 2014), promote learner involvement, and spread experience (Ashver & Igyuve, 2013). Similar to this study, Valva (2009) found that printed materials are valuable knowledge sources, which enable personal study and offer trainees the prospect to expand their understanding of the courses. On the negative side, Management Sciences for Health (2012) found that videos of low quality might cloud trainees.

Practical activities

Nearly all the participants further indicated that they were taught through practice, and experimenting in classroom settings, the clinical area, and other environments. Almost all the participants reported practising in classrooms.

> *We were…demonstrating here, we were doing it vele (actually) demonstrating even to ourselves. …So that I got that experience okay…You first do it on a doll* (Participant 9).

> *We had a lecture then the following two days we had a clinic. …So the doctors came to see the patients in actual fact. So we were able to … see… the things they were talking about …now because we were seeing the patients, 'These are veins that are thin, this is the whiteness we are talking about'* (Participant 10).

> *…I don't know how, which category this one falls like eh the one for QI, there were plays we were doing during team building {laughing}. …Whoa, the games were so funny {Laughing}* (Participant 5).

The above comments show that the participants were taught through practical activities in class, in the clinical area and away from the clinical area through various clinical and non-clinical oriented practical activities and games. This parallels assertions by the AACN and AAMC (2010) and Scheckel (2009) who report that active out-of-classroom, clinical or work-based learning is effective in accomplishing behaviour change and patient outcomes in health worker education. The International HIV/AIDS Alliance (2003) reported that games and exercises are valuable in promoting team building, assisting trainees to reflect on issues, tackling challenges in teams, and stimulating innovative and imaginative reasoning. The results therefore suggest the need to strengthen clinical and work-based education in nurses' in-service training to promote changes in performance and to achieve patient results. The results also indicate the importance of integrating teaching strategies that promote creativity, construct teams, and foster problem solving among teams in nurses' in-service training.

Reflective methods

Some participants stated that they were taught through reflective strategies.

> *And some of them… will be, people who are more experienced in that area will be sharing as to how do they tackle some of the issues that were are coming with. …So experience sharing* (Participant 4).

The above comment suggests that over and above the highlighted teaching methods, facilitators also improved the learning experience of trainees by engaging knowledgeable peers through sharing their experiences, through visits or learning on the job by observing experienced practitioners. In reflective learning it is crucial to consider, question, and assess one's professional practice in order to constantly advance performance (Ferraro, 2000; Surgenor, 2011).

Some participants confirmed that they liked the teaching strategies and related fond memories about their in-service training. This included practical work, audio recordings, demonstrations, return demonstrations, animated videos, and exercises/ games.

> *…maybe demonstrate on one of us using those machines … how to do that and that. …The real thing! … Once I see I don't forget. … But I see well okay, but if I haven't seen this thing it's easy to forget it* (Participant 9).

> *They made us look at some photos, you know a video of eh kids being operated, that went well. We were excited. …So what went well is the mere fact that we could see things practically, and you know take a closer look at our dental clinic* (Participant 3).

The above comments suggest that the participants preferred active involvement through various strategies like demonstrations, videos, exercises, practical work or audios for various reasons. Parallel to the above findings, Prince (2004) reports that learner involvement can substantially increase remembrance of facts with numerous benefits. Ode (2014) further states that educationalists have realised students learn best by performing, or when they undertake direct experiences in the topic being taught. The same author found that audio-visuals render intangible concepts more real to trainees; they considerably influence instruction and education by heightening attentiveness and enthusiasm, and increasing learning. Demonstrations are one of the favoured teaching approaches for nurse midwives in Swaziland including group discussions, lectures, case studies and clinical on-site training (SNC, 2011). Less approved teaching methods were modules or self-paced instruction (SNC, 2011).

4.2.2.4. *Providers of in-service training*

The participants further divulged that the providers of in-service training were international donor partners; international faith-based and other organisations; government, programs and departments hospital level providers.

Almost all the participants stated that international donor partners were providers of in-service training in the study. These donor partners included the Elizabeth Glasier Paediatric AIDS Foundation (EGPAF), the International Center for AIDS Prevention (ICAP). Some participants commented:

> *… Um, family planning I think it was EGPAF … with the government. … But most of these things were from ICAP in collaboration with government Ministry of Health* (Participant 6).

> *It was UNICEF together with the quality office of this institution… ISO it was National Quality ISO it was National Quality…with PEPFAR* (Participant 12).

Few participants referred to international faith based and other organisations.

> *It was an in-house training organised by the Bethany First Church* (Participant 3).

> *The others were maternal care and midwifery that one was supported by Medical, Taipei Medical University* (Participant 6).

> *Another one, I don't know that company which eh supplies iv[intravenous] fluids, Franchase, something like that, le (this) the one about enteral feeding* (Participant 4).

Many participants stated that the government through the MOH programmes and departments provided in-service training at the hospital.

> *Mm, mostly we get the trainings from through our mother ministry, Ministry of Health, well as an extension arm of government (*Participant 3).

> *… it was offered by the Swaziland Blood Bank. …Yes so we had the workshop there we visited the Blood Bank… in Mbabane* (Participant 11).

Many participants cited providers at general hospital level, with a few out of these specifically referring to management, departments, and personnel.

> *It was through our hospital. … the hospital management* (Participant 8).

> *It was eh the hospital staff, especially the doctors … other anaesthetists. … From theatre [resuscitation training]* (Participant 9).

The above suggest that the EGPAF was a dominant sponsor and that international donor partners worked in collaboration with the government through the MOH. Reports at the study hospital confirm that numerous international donor partners provided trainings. These included but were not limited to the EGPAF, the ICAP and PEPFAR (SNC, 2011). Kebede et al. (2012); SNC (2011); URC- Swaziland (2014) confirm that academia is represented among in-service providers to the health sector, as well as some private profit-making organisations.

Documents at the study hospital verified that the Bethany First Mission Church of the Nazarene was a provider of numerous trainings, for example on ophthalmology (In-service Department [first quarter], 2012). The MOH through the Swaziland Institute of Management Public and Administration (SIMPA) offered a six weeks course for retiring staff (Nazarene Health News [third edition], 2013; SNHI, 2014). The Swaziland National Blood Transfusion Services conducted several trainings on quality and safe blood transfusion for clinicians (Nazarene Health News [third edition], 2013).

Documents further confirmed numerous training conducted by the in-service department such as BFHI trainings (BFHI Report, 2014); and staff orientations offered by human resources and other departments (Nazarene Health News, 2012, 2013 & 2014). The quality improvement team offered quality improvement training to hospital staff sponsored by UNICEF/URC (Quality Assurance Department, 2014; SNHI, 2014). The Resuscitation Committee provided training on resuscitation (In-service Department [second quarter], 2013; SNHI, 2013). The ICU together with the surgical department conducted surgical training for nurses (In-service Department [first quarter], 2014). Medicine and pharmacy, among other departments offered presentations on different topics (SNHI, 2014). The SNC (2011) confirmed that the study hospital was a provider of in-service training to nurse midwives in the country. The above, taken together shows that Swaziland collaborates with a number of service providers internationally and nationally to keep the nurses abreast through in-service training.

4.2.2.5. Effectiveness of in-service training

Nearly all the participants in the study further stated that in-service training was a positive and desired programme and the nurses displayed eagerness about in-service training.

> *In this facility, in-service training is the most desirable thing to happen to nurses, and most of them are motivated, they each one of them want to attend in-service* (Participant 3).

> *Okay, my experience I think it's a good one… Because with in-service I have learned a lot* (Participant 6).

In addition, all the participants in the study felt that the trainings were useful, relevant, and that they applied the knowledge they gained:

> *…so we find it very much informative as eh part of the institution as workers in the institution* (Participant 11).

> *And I came back to implement that information because I am dealing with newborn [babies] here* (Participant 2).

Several participants further stated that the facilitation was excellent and the setting for the training favourable. The latter was more noticeable where the training took place in external hotel settings:

> *Okay…with the positives …the facilitator he was just giving us information, it's like he had researched very well the information that he gave us was just excellent. … Even the environment where we were it was good. There were no disturbances* (Participant 2).

The FGD confirmed that facilitation was excellent and that the external setting was suitable:

> *I attended a nice one it was an in-service training on documentation …So it was really on point the presentation was very good. We … started with a… pre-test which we did very bad! … but after the… presentation …there were only two who got one question wrong. All of us we got everything correct. It was really on point* (Participant 4 FGD).

> *Yes, so okay both the venue uh they were so good, it was in a hotel with nice food* (Participant 5 FGD).

The positive responses from participants towards the programme in this study clearly indicate the nurses' appreciation for in-service training, as well as the need for such training. The study hospital showed that all the topics were gainful (Quality Assurance Department, 2012). The above comments are in line with the NCPDNM (2004) which reported that nurses feel motivated about in-service training. Studies in Ireland (NCPDNM, 2004), Netherlands (Pool et al., 2012), South Africa (Letlape et al., 2014; Richards, 2007), and Swaziland (SNC, 2011) attest that in-service training is valuable. On the contrary, Norushe et al. (2004) found that nurses responded negatively about in-service training for various reasons.

The study also indicates the importance of facilitation, setting, and other logistical issues in in-service training. It also shows that facilitators in this study were seen as equipped instructors who effectively played their part as trainers by conveying the intended information to the participants whilst securing a setting and taking an approach that enhances successful adult education (BC Recreation and Parks Association, 2014; Hamza, 2012; Kamp, 2011). Action for the Rights of Children (2005) concurs that it is important for the trainer to ascertain that the learning setting is appropriate and that it contributes to learning. While the setting can affect approaches, it should

be easy to access, be adequate for the number of participants, and permit for a sitting plan that enables interaction during the sessions (Kamp, 2011). In conclusion, although the in-service trainings in the study was effective, there were negative aspects that needed to be addressed as the participants' verbatim are indicated in the following section.

Many participants also commented that the trainings were accessible; several had participated in many trainings although not to the desired extent. One participant expressed it as follows:

> *…there were lot of eh workshops that maybe I've attended even… though not to my satisfaction. ... It happens that ... you find that there're lot of workshops that you hear about maybe the institution ... sends ... people ... So you find yourself not being able to be part of the major group that attends* (Participant 11).

The findings show that training was offered and that nurses participated however not to the satisfaction of everyone because of time and staff shortages. Baker (2011) is of the opinion that in-service training access occurs when trainees benefit from the in service programme at suitable times, and when the training is required by the institution and the trainees. An example could be that when there is an outbreak and the institution and the nurses are required to equip themselves for it; compelling need gives trainees access.

4.2.2.6. *Post training support and activities*

When asked 'what form of support was offered after training?' Several participants responded that post-training support was inadequate, which is discussed in detail under challenges of in-service training. This section discusses the training topics, which were supported, and the post-training activities, which took place as narrated by the participants in the study.

Several participants spoke about training areas which were supported after in-service training. These included HIV and AIDS programmes, blood transfusion, preceptorship, resuscitation, and psychological care and support.

> *Okay with IMAI, and NARTIS… they also come to our facilities… to see how we are faring…* (Participant 6).

> *Um like the one on preceptorship…So we were like we would love the lecturers to come and visit the students when they are in the hospital. So, you see them coming. … Supporting*

us as to 'Do you have any problem with the students? … With the resuscitation one we would see the equipment coming. (Participant 4).

The participants further stated that several post-training activities were offered by in-service providers, which include monitoring of trainees, provision of mentorship, couching and feedback, provision of equipment and materials, and reporting back.

Several participants spoke about post-training monitoring, and indicated reasons for conducting it.

You trained us on doing HTC. Are you really following up …
…to see how we are faring, any challenges and when there are challenges they try to deal with those challenges. …Like …the tools that we are using, the registers sometimes, it's difficult to grasp everything … during a one-week workshop (Participant 6).

The study also found that monitoring was done through the use of guidelines, regular departmental audits, physical visits and other means.

Okay, there are guidelines. We see to it that everything is according to the guidelines. … That are … are derived from government or the government gives us the guidelines. …Then we tend … to monitor by having audits …general audits periodically … in every department (Participant 3).

A few participants reported that they were supported through mentorship, coaching on the job, and feedback.

The couching at times they come to the facility. Like … if I were to make mention of … PMTCT. … We have … mentor mothers. … Or regional mentor mothers, they come to the facility…to see that everything is done according to what has been …laid in the standard (Participant 3).

The above comments relate some of the activities offered to trainees as post- training measures. The study thus affirms the aims of the MOH (2010), namely that the ministry endeavours to prepare health workers through training among other means, and to guarantee the supply of needed guidelines to health care institutions to help health workers manage diseases and health disorders. This was also supported by the study hospital's Quality Assurance Department (2014) report, which stated that general audits were conducted by the quality improvement steering team on a monthly basis to monitor quality assurance. The findings also indicate some of the areas that were supported post training by providers of in-service training, and the document analyses set verify that post-training monitoring and support was given by EGPAF and the Clinton HIV/AIDS

Initiative to assist the facility in institutionalising and continuing with HTC activities (Nazarene Health News, 2012). The documented reports also allude to 2-day feedback meetings after six weeks of attachment in PIHTC trainings (Nazarene Health News, 2012; 2014).

Regarding the supply of equipment, material and other forms of support, some of the participants had this to report:

> *…we had an …issue of lack of the …blood giving sets. … Since that workshop was done in the institution …I haven't found myself without a blood giving set. … They are always readily available* (Participant 11).

Reporting back, a few participants spoke about policy, follow-up, and forums for reporting back after attending in-service training.

> *But if somebody went there, the rule is to come back and tell them in their departmental meeting that 'Oh, I went for in-service, this was said. These are the changes. This has to be applied'* (Participant 10).

Some participants alluded that where post training support was offered, it was very helpful.

> *…Oh, it was good I think because I for now I think I'll be able to continue without the assistance. I'll be able to continue helping those who come although [if] I find that they need help… or if I feel we are not reaching the goal I'm able to refer them … further… To a psychologist or to the doctor* (Participant 10).

The above comments show that various methods were applied in the study to tie education to job performance for improved education results, such as follow-up by supervisors, coordinators and providers; plus mentorship and reporting back; and provision of tools and materials (The ACQUIRE Project, 2008). It is clear that the different forms of post-training support provided to trainees assisted them to develop expertise, knowledge and experience. The study therefore clearly confirms the need for post-training support in nurses' in-service training.

4.2.3. Benefits of in-service training

The participants were asked "how did you benefit from the in-service education sessions attended in this facility?" and they came up with benefits in 3 key areas, namely personal level, Hospital/institutional level and nursing profession level.

4.2.3.1. Personal level benefits

Here participants reported benefits at personal level, which included knowledge and skills development, self-assessment, psychological benefits such as increased self-confidence, and socialising.

Under knowledge and skills development, the participants mentioned that they gained a clearer appreciation of concepts, got updated with new knowledge, were reminded of previous knowledge, and developed general and speciality skills. This was also confirmed by the FGD.

> *And some of the things that we knew about, they were more clear. … if you have questions you…tend to know now as to how are you going to go about some of the things you're not sure of. … Yes, you know when the things you are working, actually you are seeing each and every day. Then it's being explained as to how it is happening, you know. … Things become more (sic) clear to you* (Participant 4).

> *We learn many things. … Something that we didn't learn from the school [college]. … In the in-service … we continue learning* (Participant 8).

> *And then we were also assisted with other skills in difficult deliveries like, in shoulder dystocia. … Some skills were taught, and then they also taught us about ema (these) external … manoeuvres… They are very important, because these are the things that I come across on … on daily basis* (Participant 2).

> *Update with current information* (Participant FGD).

> *You also gain new skills that you were not able to do when you, when you came to the profession, like not even, like PIHTC now I can prick {demonstrating with both hands and the rest of the participants laughing} positive and negative. So, new skills are being achieved* (Participant 7 FGD).

Some participants further reported self-assessment as a gain.

> *Yah, it did go well, especially the one for… HIV and AIDS … I think I was far behind. … regarding the statistics… I discovered a lot of information … So you find yourself that 'No I myself and as a department is not in par with maybe the generalised knowledge'* (Participant 11).

The participants also reported having psychological benefit such as increased self–confidence, understanding people's conduct better and feeling personally refreshed after burnout.

> *…Yah. I'm confident, really I am. … another thing now I can work anywhere. … Anywhere without any problem. … Yah, because I'm familiar with a lot of things. … And I'm hands on, everyday I'm doing that thing* (Participant 6).

> *… you know when you attend a workshop you… get to be away from work. … So being away from work …Looking at things in a different perspective… now. It gives you a picture kutsi (that)… no I can still do better. … Yah, so that's what… I've realized myself. … Even if in that setting or myself I've got burn out, there are… times when I had burnout I just attended one workshop. … So … you get to find different experiences… So you tell yourself that 'Ah no when I get back to work I think I'll be able to function. … Yah, much better than before* (Participant 11).

Some participants reported socialising as another benefit.

> *…so you sometimes get the chance to be with other people. Socialise during your break time … and when you are out. ……some of the workshops you find …that you are broke and after the workshop they will be giving you some bit of finances. …For transport, you know. …So you learn … other things, social things. … Which are more even out of what you've come for. …we… had to go out and use the i-nangu (this thing), … it was my first time …to see someone riding a horse. …So I said 'wow,' …the next time I went there I … rode in that horse {laughing}…So you see. …Some of the things…* (Participant 4).

The participants mentioned several gains from in-service training such as improved understanding of their work and how to better perform simple and complex tasks as a result of the knowledge and skills they were received or were reminded of during the in-service training. Hughes (2005) and the USAID ASSIST Project (2014) concur that in-service training is vital in the provision of current information and expertise. It enriches or refreshes knowledge and skills learned in the past, ensures on-going competence and affirm that expertise development (Giri et al., 2012; NCPDNM, 2004; Rahimaghee et al., 2010). The above accounts by participants show how in-service training can serve as a personal and performance enhancement. Pool et al. (2012) however argue that official training may offer minimal additional benefit for mature nurses who have numerous years of practice and have reached a ceiling in learning or significant proficiency.

The participants also felt that they were able to determine or realise knowledge deficits at a personal level or for their units prior to or during participation in the training. Eaton et al. (2011) report that the medical literature stresses the benefits of tracking and supervising in-service training particularly through conducting individual advancement plans and yearly assessments. However, in this study it is not clear whether self-assessment was targeted or planned or whether it occurred haphazardly as a result of being exposed to courses and attending in-service training.

The findings show improved employee inspiration as a benefit of in-service training, and increased ability to cope with tension and worry. Rahimaghaee et al. (2010) in Iran and Letlape et al. (2014) in South Africa agree that self-assurance is one of the benefits of in-service training and class this under skills development. They class the benefits of perceiving the patient fully and enhanced dedication to the job regardless of work conditions, under psychosocial development. Letlape et al. (2014) consider self–confidence a psychological benefit of in-service training. In addition, the same authors reported aptitude to operate autonomously as a career benefit of in-service training. While the findings also consider socialisation as a benefit of in-service training, Saldana (2013) highlights the need to consider the extent of the socialising role of the education system. The author contends that the learning system should not be more focused on the upkeep of social aspects than the trainee's intellectual growth.

4.2.3.2. Hospital/institutional level benefits

The benefits of in-service at the level of the hospital also tie with the benefits obtained by the various departments within the hospital and the patients. This section presents the benefits of in-service training at the hospital level.

Several participants in the study mentioned hospital level benefits and improvements in the study facility's systems, staff performance and service delivery.

> *Yah because … the laboratory department is being upgraded and some of the procedures they are being improved. … there's now a functional blood department. … There's a person assigned now with blood. So if you are collecting blood … there's always a person there during the day. … To issue out the blood unlike previous, you'll just go to the fridge and collect the blood on your own.*
> (Participant 11).

> *Um, okay, eh this facility has benefited a lot from in-service. First of all it eh standardizes the performance. … You know after having undergone in-service training even the one whose performance was … substandard it then tends to… conform to the standard. … You know so, there'll be no one who is substandard because of in-service* (Participant 3).

A few participants claimed department level benefits such as improvement in the quality of care, and stress-free jobs due to the provision of new equipment, plus contentment.

> *…we used to make sure that a pint of blood will last … whole of it, all of it will last on*

a patient. … But now I know it should be strictly four hours. … After that I usually advocate for it to be thrown away. … Because it's no more of use to the patient (Participant 11).

There are also some equipment, which were offered in some of the in-service …, new equipment … which was helpful to us. …I can take Hb with an Hb meter in the ward, without… fighting people from laboratory. … I can use my cooler box just to go and collect my blood without fighting with anyone,' you see.' …It's something which is very good and makes your life easy … you work easy (Participant 7).

Some participants revealed patient and national level benefits such as reduction in disease incidence, morbidity and mortality.

Uh … something that is very, very positive … about this malaria training. … Is the mere fact that…it seems like we are eliminating it …in the country, the cases of malaria are reduced drastically. …That is something positive that is something we happened to like very much. …Malaria is on the decline … by the day (Participant 3).

It's good for the children. … They will benefit … since we see that last year we lost many of the under two … years olds because of this diarrhoea. … They are few who are not breastfeeding … which means they understand the importance of breast, breastfeeding … than this formula feeding (Participant 8).

The preceding comments suggest improvements in the study facility's infrastructure, procedures, personnel, and services for both personnel and clients plus service delivery. In line with the above results, Giri et al. (2012) agree that in-service training is necessary for successful health care systems. Damirchi, Kazemian, Hafezian, Kani, and Gholizadeh (2014) concur that in-service training has an influence in raising the quality of performance. The NCPDNM (2004) in Ireland concurs that in-service training improves quality of care offered to patients. However, Hughes (2005) argues that insightful service provision was not recognised as a key profit of in-service training. Jaradeh and Hamdeh (2010) agree with this and report that in-service training in clinical conduct is inferior to development in knowledge and expertise. The participants' voices are vital to record and share the worth, usefulness and effect of in-service training as the intellectual voices so far differ on the benefits of in-service.

4.2.3.3. Nursing profession benefits

A few participants referred to nursing professions benefits such as reflecting and influencing change in practice, self-development and meeting regulatory requirements.

Okay, there wasn't much it was only just me thinking back in the hospital 'How are we going to do it?' ... So it was like 'Mm, in our hospital setting ...the confidentiality, privacy how are you going to do it.' Then I started looking back ... 'Okay there I am, let me see how in that... out-patient department doing it so.' ... So I had to come back then start. Okay share with the staff, then see how best we could because it was just like we had to do it. ... So we had to change a few things. ... so that we accommodate ... eh this PIH thing testing. ... We changed we are able to do it. ... Mm, it is being done for every patient. ... Who comes in the hospital (Participant 10).

...It's a positive initiative done by the nursing council ... To encourage nurses to learn they have to have CPD points ... or continuous professional development the minimum being ten hours, which is equal to ten points. ...Without these ten points you are not allowed to renew your license in the country (Participant 3).

The study shows that in addition to achieving self-improvement, the participants were able to reflect and provide additional essential patient services and meet the statutory requirements of annual license renewals. McClure (2013) suggests that reflection is a vital component in education, as recognised by participants in the study. A study by Yfantis et al. (2010) found that in-service training helps nurses to reflect and work which a few participants also reported. The supposed regulatory gains of in-service training include enhancing patient care (Hughes, 2005), guaranteeing competent performance, meeting societal anticipations, and being updated on developments in patient care (Eaton et al., 2011). The study therefore seems to indicate that in-service training with the regulatory backing might be gainful but needs further study. It is also clear that there are pros and cons to the mandatory stipulations of in-service training in nursing.

4.3. SYNTHESIS

This chapter discussed the findings of the study pertaining to the first research question on nurses' experiences of in-service training and the three themes that emerged under this question. The findings have shown that nurses' experience of in-service training revolves around in-service training organisation, implementation, and benefits. The study has so far also shown that nurses have positive intentions towards in-service trainings and have a desire to participate. Under in-service organisation, the participants affirmed that they had experienced planning, notifications, selection/delegation of nurses, and documentation. At the implementation phase, participants have experienced different types of in-service trainings and topics, instruction methods and teaching strategies that the participants liked, and provision of post-training support. This chapter has

further shown that there were positive aspects in each phase of the experience, which can be continued and negative elements, which need to be improved. The participants mentioned numerous benefits, which cut across personal, departmental, institutional, patient and nursing profession levels.

CHAPTER 5

FINDINGS AND DISCUSSIONS ON CHALLENGES OF IN-SERVICE TRAINING

5.1. INTRODUCTION

The previous chapter presented findings relating to nurses' experiences of in-service training, in response to the first research question. This chapter discusses the findings regarding the challenges, which participants experienced during in-service training. This is in response to the second research question, namely "What are the challenges of in-service training in one hospital in Swaziland?" Three themes emerged from the participants' responses and frame the discussion of this chapter, namely challenges in planning and attendance, in-service delivery, continuity and sustainability.

5.2. FINDINGS AND DISCUSSIONS

The findings are presented according to the themes that emerged, which are displayed in the next table (Table 5.1) together with their categories.

THEMES	CATEGORIES

Theme 1: Challenges in planning and attendance	• *Workload as a barrier to attend in-service training*
	• *High morning hospital routine*
	• *Parallel and conflicting training plan*
	• *Poor logistics and lack of good practice*
	  • *Poor notifications*
	  • *Bias selection criteria*
	  • *Poor means of transport to the venue*
	• *Funding challenges*

Theme *2:* In-service delivery challenges	• *Poor delivery mode of in-service training* • *Uncompromising concurrent programmes* • *Delayed start, poor attendance and inadequate learning* • *Poor planning and resource allocation*

Theme 3: Challenges of continuity and sustainability	• *Post training challenges*
	  • *Lack of post training support*
	  • *Poor dissemination of information*
	• *Lack of sustainability of invested learning*
	• *Disabling organisational structural support and environment*
	• *Superficial pre-service knowledge*
	• *Poor in-service infrastructure*

Table 5.1: Themes and categories relating to challenges of in-service training

5.2.1. Challenges in planning and attendance

The study revealed that the provision of in-service training was coupled with challenges: logistics, planning, delivery mode, and lack of support from the organisational structure. These factors are linked to staff shortages, workload, limited opportunities for junior nurses, and exclusion of support staff.

5.2.1.1. Workload as a barrier to attend in-service training

Many participants raised the challenge of inability to attend in-service training, which was primarily caused by staff shortages, high workload and burnout. Excerpts from the interviews corroborated by the FGD, are given below:

> *But you find that we are unable to attend. … Reason being that eh the wards we are understaffed. So we find ourselves being unable to attend even important workshops. …that's the first challenge that maybe you find yourself not being able to attend those workshops. … So sometimes we are a busy department, so we find ourselves not being able to send people to workshops. …On the burnout …Like I've mentioned before that you find yourself unable to attend even a single workshop. …Eh even unable to maybe sometimes go for leave. …So you find yourself you are at work most of the time* (Participant 11).

> *…I've realised that we have a lot of in-service trainings that are happening in the hospital but our attendance meaning the nursing side is not a very good one* (Participant 6 FGD).

> *Yes, the attendance is poor but I've noticed that most of the time eh it's shortage of staff. You find that there is an in-service training but …there is … shortage of staff* (Participant 9 FGD).

In the preceding accounts, the participants mainly blame staff shortages, which cause high workloads and burnout, for failing to participate in in-service training. The document analysis verified challenges caused by staff shortages (Quality Assurance, 2014; SNHI, 2012 & 2014), plus employee loss through demise (SNHI, 2012, 2013 & 2014), high staff turnover, high workload, and working under pressure (Quality Assurance, 2014).

Similar studies conducted in Greece (Yfantis et al., 2010) and South Africa (Richards, 2007) also report poor participation of nurses in in-service training. Yumkella (2005) argues that personnel scarcity might be attributed to flaws in a health organisation's training, education, employment and retention procedures. Considerable increase in the work- load for nurses or health workers in sub-Saharan Africa is also attributed to the growing HIV and AIDS burden which poses risks and dangers to health care providers as well (WHO, 2006).

Other studies report nurse shortages as a global concern and a major challenge in first world countries (Campbell, Collins-McNeilc & Khayile, 2012). Larger proportion of nurses and doctors per population serve in developed as opposed to under-resourced developing countries (Tawfik &

Kinoti, 2006). In well-resourced countries high work burdens, extreme tension and exhaustion, poor relationships between administration and medical personnel, inferior work circumstances, and poor administration are the main causes for nurses to want to abandon the profession (Holland, Allen & Cooper, 2012).

5.2.1.2. High morning hospital routine

Another hindrance to in-service training is a demanding morning routine, which affects participation in on-site trainings. Participants had the following to say:

> *… and then in hospitals there are routines. …For an example they will say the in-service should be between eight and nine AM. … There's a high routine between eight and nine there are doctors' rounds, there's medication, so definitely you cannot release people to attend that in-service. That is the wrong… timing altogether…* (Participant 2).

The FGD confirmed demanding morning routines in the hospital:

> *I think the other thing that contributes to that it's because of the time. Because eh normally it happens in the morning where you find that the routine in the ward it's where mostly we are very busy in the ward. So we don't attend because of that. …Yes, because our main priority is the patient. So in the morning we are very busy with the patient. …So that time is not conducive for that* (Participant 5 FGD).

In the above accounts, participants clearly identify the challenges, which prevent nurses from attending in-service training. The heavy workload that routinely occurs in the morning throughout the study renders morning time completely unsuitable for in-service attendance. Some studies concur on this challenge however also point out the unwillingness and disinterest on the part of nurses to participate in the trainings (Jaradeh & Hamdeh, 2010; Norushe et al., 2004; SNC, 2011).

5.2.1.3. Parallel and conflicting training plan

The in-service training that was offered internally often coincided with the externally offered training that made it difficult for staff members to attend. Specific topics were also often conflicting. The participants had this to say:

> *Okay the other thing you find that there are in-service in the hospital. …I will say internally, and then you will hear that there is a workshop …outside. … So they come at the same time. … it's not only the hospital per se, … even outside you'll find that the Ministry of Health has … called its own workshop, maybe EGPAF has also scheduled another workshop …and another programme maybe, TB programme has also scheduled*

another workshop. …So you find that we are not able to attend some of the workshops because they come at the same time (Participant 2).

In think …the challenge can be … maybe the topics…like say …breastfeeding. They will say 'Ah, the breastfeeding is for those… nurses working in the Maternity ward. … 'Ah this topic is not for our department … it's for … medical.' … So, they don't have interest of those topics. …So they refuse to come (Participant 8).

Reports at the study hospital attest to numerous concurrent or conflicting trainings on-site and those offered by ministerial and donor/partner levels in the midst of staff shortages further limiting participation (In-service Department [first quarter], 2012 & [third quarter], 2014), and also to making deferrals in trainings (In-service Department, 2014). Studies by Giri et al. (2014) in Kenya and URC-Swaziland (2014) verify the challenges of poor coordination of health worker in-service trainings. Coordination is a central challenge that cuts across hospital, district, ministerial and donor community levels (URC-Swaziland, 2014).

5.2.1.4. Poor logistics and lack of good practice

A number of participants indicated that late notification, lack of a clear selection criteria, lack of an in-service plan and lack of specific trainings were other contributing factors to not attending training.

Poor notifications

The participants revealed that notifications were given on short notice:

…My experience… we usually do not get the information on time. … that we are going to attend this, we've been chosen to attend this particular workshop. …or this in-service training. … So the information is not disseminated on time (Participant 12).

The FGD substantiated poor notification about in-service training as a challenge:

Okay, another thing the communication uh is not very good, because you are just using memos. …Sometimes you see a memo sometimes you don't see a memo. And some of the topics if you read it you don't understand. …You don't even know what is written, you don't know what you are going to talk about in that in-service (Participant 5 FGD).

Yes, it is true that sometimes the memo won't reach us on time. They are delayed somewhere. Then we see it the very day of the meeting or you see it in the late afternoon that there is a meeting in the next day. …yes as we have said before that maybe sometimes it's the communication problem …. it's so difficult to attend a workshop whereby you don't know what is being said or what is going to be said there. You just go then when you are there you are told 'Oh we are talking we are discussing about this.' (Participant 6 FGD).

The above comments emphasise the lack of sound planning of in-service training in the study, which was marked by poor notifications and poor trainee attendance. The findings indicate a lack of trainees' and managers' involvement before training plus lack of prior and timely communication (JHPIEGO, 2003). It is also imperative to reinforce management assistance to apply what is learned. Trainee involvement heightens trainees' preparedness for the course and increases course profits (Aguinis & Kraiger, 2009).

Bias selection criteria

Several participants attested to poor identification of trainees, limited opportunities for junior nurses to attend in-the training, and the exclusion of support staff.

> *…you'll find that on a…certain topic … there are people who are not really hands on …fine in this hospital there is that change over that happens monthly. …But maybe because of … the staffing… and the sponsors phela* (*isn't it) would want to have lama (the) participants. … So you find that they'll be picking anybody …just to fill up* (Participant 2).

> *Eh you find that these in-services … most of the time … are done by the supervisors. You see as junior nurses … you don't get that much time … to do it* (Participant 9).

> *… Like the ones that are specific, you cannot take an NA to a workshop which is specific for midwives. So you find that in most cases the NA's they … are left behind* (Participant 5).

> *But the support staff is being left behind. … Yes, their in-service … they rarely happen* (Participant 6).

The preceding accounts indicate the absence of a uniform way of selecting nurses for in-service training. Participation in training is based on, but not limited to supervisors' personal preferences and favour, meeting donor expectations, and hospital change-overs resulting in poor attendance and the exclusion of junior and deserving nurses. Favouritism in supervisors is cited as one of the challenges in some of the departments of the study hospital (Quality Assurance, 2014). On the other hand, the above comments suggest a lack of implementing performance requirements, namely ascertaining that training will address the shortfall in performance, identifying the knowledge and skills required to enhance performance, appreciating organisational needs (Hart et al., 2012; JHPIEGO, 2003; IntraHealth International Inc., 2012), and guidance in the selection of trainees (IntraHealth International, n.d.). Other studies agree with this study about the challenges of trainings that are not based on existing needs (Giri et al., 2012; Jaradeh & Hamdeh, 2010;

USAID ASSIST Project, 2014), that result in irrelevant participation in in-service training and lack training schedules (Richards, 2007).

In the above comments, the participants also attest to the existence of prejudice and negative treatment of junior nurses by supervisors particularly the nursing assistant (NA) cadre, and the fact that the latter do not meet the training requirements for some courses thus contributing to minimal chances in participation in in-service training. Prejudice and negative treatment of junior nurses indicate deficient leadership on the part of responsible managers (WHO, 2006; WHO & JHPIEGO, 2005). Prejudice and negativity also foster a negative work environment that threatens the success of in-service training and nurses' performance (Deussom, Jaskiewicz, Adams & Tulenko, 2012; WHO, 2014). The literature further concurs that it is necessary for trainees to possess at least procedural education to offer services in line with the courses offered (The ACQUIRE Project, 2008), or within their scope of practice (SNC, 2011).

Poor means of transport to venue

Closely related to the poor logistics was the poor transport system which affected attendance at external trainings.

> *...sometimes we usually have difficulties in finding transport ... to attend those especially the outside workshops and other things. ... Transport becomes a problem. ...sometimes ...you request transport. ...You wait at the gate, like they say transport can't pick me at eight. They come at half past eight so that you are, by that you are losing the start of sessions ...where you're going to* (Participant 12).

The data analysis confirms that transport delays to external trainings in the mornings caused some content to be excluded to catch up on time (Quality Assurance, 2014). This suggests inadequate resources for logistical preparations, and The ACQUIRE Project (2008) recommends that transport arrangements should be catered for during the planning phases of in-service training. Organising workshops without considering means of transport shows a lack of dedication and good practice on the part of organisers.

5.2.1.5. Funding challenges

Some participants further mentioned lack of funding as a severe challenge to in-service training. This was voiced as follows:

Maybe the resources, to some of them there will be no resources for continuing with the in-service. … Yes, if maybe … some of the thing[s] need money…to do it, you find there is no money, so it's delaying the in-service (Participant 8).

The above comment suggests that shortage of funds affects in-service training in numerous ways. Studies indicate that health worker in-service training is predominantly financed by donors thus posing a threat to continuity (URC- Swaziland, 2014; Kebede et al., 2012). Funding is an essential tool for projects like in-service training.

5.2.2. In-service delivery challenges

This theme discusses three categories, that is, poor delivery mode of in-service training; uncompromising concurrent programmes; delayed start, poor attendance and inadequate learning; poor planning and resource allocation.

5.2.2.1. Poor delivery mode of in-service training

Several participants referred to poor facilitation, time constraints, bulky materials, lack of equipment to practice, and disturbances due to poor logistical planning.

Some participants elaborated on poor facilitation as follows:

…sometimes it would be like someone facilitating something that he is not experienced in. … So you'll be like you want to ask something and then he will not be having more information because the person is not in that area. …Sometimes maybe he's not audible enough, or he can't explain some of the things. … because it's also important that… you'll be able to learn (Participant 4).

Several participants stated that a large amount of content was given in a limited time frame, and this was confirmed in the FGD:

…what I've noticed is that maybe the time… is so limited. Because you find that they are just one hour with a lot of information. …Maybe the presenter has a lot of information, but because of the time, he or she will break down some of the things or leave some of the things out (Participant 6).

There's one I attended last year it was at Ezulwini, it was about diabetes mellitus. There were so many presenters and the information was too much!! … It was only four hours and everyone came out confused {all laughing loud}. Okay because the time was so limited and by the time people started asking questions the time was up and they wanted to use their auditorium. So we came out confused eeish!, eeish! It was… a bad experience (Participant 4 FGD).

A few participants highlighted the challenge presented by lack of equipment needed for demonstrations and practice.

> *…you find that …some of this equipment we need to use are not here. …some of the equipment we need for resuscitation were not there, so we couldn't even use them to demonstrate on us. It was a bit of a challenge …for some of us there. …The eye care … offered by these people … there were no … those equipment we use. …they just taught us. … 'The eye is like this, you have to do this when you have that.' Okay we wanted to see the visual thing (*Participant 9).

The above comments attest to poor prior organisation in the selection of facilitators, time allocation, and availability of learning equipment. These findings tally with those of The ACQUIRE Project (2008). There was also poor resource planning and allocation in terms of time and equipment for teaching and learning, poor proficiency in facilitators marked by inability to tackle challenges efficiently, and poor time management. The aforementioned factors are not exceptional to the context of the study see also JHPIEGO (2003). The above factors resulted in an unsuitable learning setting, and hindered in-depth learning and the ability to rehearse intellectual and practical abilities adequately by observing and doing and obtaining guidance on conduct - as also mentioned by WHO and JHPIEGO (2005).

5.2.2.2. Uncompromising concurrent programmes

Some participants mentioned family commitments, being away due to night duty or off- duty, as other challenges to participating in in-service training.

> *So I've had someone saying 'I didn't attend that workshop because I had to take my child to school, and also attending the workshop, so who is going to take my child to school'* (Participant 4).

> *… with the night duty part. … I'm sometimes on night. … you find that I can't be there. … Because I'm assigned to perform night* (Participant 10).

Other studies concur on challenges presented by family obligations/family life (Jaradeh & Hamdeh, 2010), child care responsibilities (Richards, 2007), societal errands, and being on holiday or travelling (Jaradeh & Hamdeh, 2010).

5.2.2.3. Delayed start, poor attendance and inadequate learning

Some participants related delayed sessions at training levels, few participants complained about inadequate learning due to interruptions.

> *…you find kuthi (that) they are saying 'You are going the … fourteen of you' at the end of the day, you are five. …you are waiting for others …to come. …So the facilitator has to go back again and start calling the wards. …'Guys we said nine O'clock…and then it takes thirty more minutes, to one hour for people to come. …Dragging the time, now the facilitator will come 'Pree, pree, pree now fast forward.' … Eh and then at the end of the day you're left like 'Okay, what did I hear here. …I didn't understand anything.' You try to ask a question. 'Ah, no, no the time, the time (*Participant 7).

The participants also mentioned that interruptions were common in trainings, which disrupts learning.

> *Whereas when you are here … sometimes you're disturbed by your work commitment. …Sometimes they call you. … You have to do this, so you miss most of the information* (Participant 12).

These factors arise from work demands leading to delays and recalling trainees back to work, which might be due to poor supervisor involvement and support (IntraHealth Technical Leadership Department, 2013). Requiring trainees to return to work could also be due to personnel scarcity or managers not arranging for trainee replacement (The ACQUIRE Project, 2008). The research suggests that lack of prior and proper arrangements may lead to poor enthusiasm in trainees (Hart et al., 2012).

5.2.2.4. Poor planning and resource allocation

Some participants mentioned service disruption because of the high number of nurses required for internal trainings and poor regulation of and support for long-term trainings.

> *Now the challenge emanates from the fact that eh you know if you take a lot of nurses away from the service area the departments can no longer function well with a lot of nurses away whereas if it's something that nurses have to attend to in a different venue …they request for quite a few spaces for nurses* (Participant 3).

> *You find that … it's not well planned. So people will be all writing exams. … And then you will be left working … Short staffed. …So it's a challenge because the hospital …. it's not financially okay to say 'I'm going to assist this group to go … to school, then you guys you will wait' and then you know. …with the part-time one you know that this person will be working, so you try to change the hours. … So that… someone will be comfortable somehow* (Participant 4).

The above challenge was validated by the FGD.

> *… another problem that I want to raise is on the training plan for part-time training whereby everyone will be… going to write exams and there's shortage. … In the department. … Yes. So I don't know if we can make arrangements (Participant 7 FGD).*
>
> *I'll still go back to … P9's point of eh shortage of staff or nurses in the hospital, because if there was enough staff in the hospital there wouldn't be that much of a problem with people doing eh studies on their own…So … I find it very much unfair to stop someone who is saying 'I need to study on my own, because this is the time I felt it's proper for me to pay for myself since two years when I finish my studies I need to start this project.'* (Participant 2 FGD).

The preceding comments indicate that much as on-site training is desirable it upsets service provision. The participants therefore emphasise that poor planning and resource allocations may result from a lack of appropriate policies (WHO, 2014). Staff shortages and lack of managerial support is mentioned once more as a cause for the above challenge. Reports from the study hospital confirm that part-time education lacks proper control leading to interrupted activities in the units during examination particularly when a number of personnel in a department study the same course concurrently (Report on leave and claim form review, 2014). It also indicates poor budgetary considerations and allocation towards long-term training (Cox, Farrell, Ng, Burlew, & Pacquė-Margolis, 2013). Jaradeh and Hamdeh (2010) report that nurses study through personal effort. On the contrary a study in Ireland reported support in terms of policy, finance, study leave, supervisor support among other forms of support (NCPDNM, 2004) and this is the commonly held view or what one would expect for the success of the in-service training.

5.2.3. Challenges of continuity and sustainability

This theme presents the challenges that hinder the continuity and sustainability of in-service in this study. Broadly, the post training, which makes it impossible to implement and sustain what the trainees benefited from the training. The challenges are presented under each category out of the 4 categories: post training challenges; lack of sustainability of invested learning; disabling organisational structural support and environment; superficial pre-service knowledge and poor in-service infrastructure.

5.2.3.1. Post training challenges

Post-training challenges mentioned by the participants were inadequate post- training support, lack of post-training reporting, lack of application of new knowledge, lack of behavioural change, shortage of working tools and materials, lack of teamwork, and resistance from staff.

Lack of post training support

Several participants mentioned that post-training support was inadequate:

> *Okay, I can't say that much support…When it comes to the training, I go for training then I'll come back there's not that follow up maybe from the hospital. Kutsi (that is) once a training, how was it … share with us, there is not that much support. …I think for all as for my experience* (Participant 1).

The FGD confirmed the above:

> *But what I have noticed with these facilitators or whoever is responsible there is no follow up. …They don't come and say 'Okay we said PMTCT, you are supposed to test a patient like this, like this. Let me see how you are testing your patients or how many have you tested or are you having all the equipment.' They don't do follow up, there's no follow up* (Participant 4 FGD).

The comments above point to a gap in offering post-training support to trainees by the providers of in-service training in the study. The ACQUIRE Project (2008) and JHPIEGO (2003) agree that post-training follow-up is an essential but usually ignored component of education. Similar sentiments are echoed by Caffarella (2002), Egan (2013), and Merriam and Leahy (2005) who conclude that transmitting knowledge from the training room to the job setting has confounded adult educators and instructors for years. This is in agreement with Yfantis et al. (2010) who report that nurses are not assisted in putting into practice recently learned information. Haddock (2015) and Pool et al. (2012) emphasise the significance of devoting time to post-training follow-up and providing prospects to apply knowledge.

Poor dissemination of information

Several participants attributed poor post-training support to a number of causes, for example lack of time, lack of support, absence, not benefiting from a training, and incompetence.

> *In return when they come like the supervisors, sometimes they don't share those … information with us. … So as to equip us with the information they got from that particular in-service. …You go to an in-service you come back, there's no time even to share. …So that will be your own information that you are using absolutely there's no … support. … You find that the challenge you are not always there. … other nurses are not there ... but a little bit I tried to compress it and share it. …Because …I did it for five days but I shared it on (sic) thirty minutes. …So how can you cope with five days to thirty minutes* (Participant 9).

> *So you find that someone is not coming to share the information. …Okay, some people, you find that … naturally they are not uh competent… if I can say. …Or sometimes they are just lazy. … Or they just don't feel like… doing it. …For some they feel ah now I'm old, I just want to go home* (Participant 6).

The FGD verified poor post-training reporting and further revealed other causes like lack of departmental meetings, staff shortages, work overload and burnout.

> *There's a gap there because people are sent for workshops, they come back and they don't report to staff in the department* (Participant 1 FGD).

> *Some departments don't have departmental meetings, so that is another point that when or where is this person going to share this information. …Because if the … supervisor is quiet everybody will be quiet. …but that department doesn't know because the one who attended was not given the chance! … to say what was said there* (Participant 6 FGD).

> *It's challenging …. Because … of the workload people …are… not interested even to know kutsi (that) what did you learn from the in-service. Because vele (the truth is) they are tired, no one will even ask you because of the workload. … Mine (I) nje (for instance) in my department when I come in the morning there's already resuscitation, there's no time to report* (Participant 9 FGD).

The above comments underline several factors that hinder post training reporting in the study such as lack of supervisor support, lack of time, bulkiness of content for external versus internal trainings, personnel shortages, and burnout. The participants' emphasised the overwhelming environment confronted by nurses at the study hospital, which is the case for countless health care employees around the world particularly in sub-Saharan Africa where staff scarcity and its impacts are highest (WHO, 2006). A number of reports underscore the crucial role of the manager in backing up and participating in post-training reporting which is essential for planning and successful applications of new knowledge (Hart et al., 2012; IntraHealth International, n.d.). Regardless of the underlying causes, absence of reporting back after training adds to poor application of the information gained from in-service training (Rycus & Hughes, 2000).

5.2.3.2. Lack of sustainability of invested learning

Several participants confirmed lack of or difficulty in post training implementation, lack of continuity, lack of sustainability of invested learning, lack of application of new knowledge, negative behaviours, and disillusioned personnel.

Some participants cited overwork and lack of teamwork as causes for non-application. The FGD verified this pointing to shortage of staff as the cause.

> *Yaah! sometimes it's very difficult to implement some of the things that we learned there. …We are overworked here, you find that sometimes it's difficult to do some projects.* (Participant 2).

> *Sometimes …we would want to do the right thing, us who attended the workshop. But we are working as a team. … So we cannot do it on our own we need all the team members to be on board and they don't understand you at all. … You try to explain 'no they don't understand.' …So it becomes a real challenge really, because even … the QI projects that we do, you find that they… end up failing. …Because some people they don't… do what they are supposed to do in order to, for us all to improve the quality care* (Participant 5).

> *another thing about the shortage you find that that person has learned something new and she wants to practice or he wants to practice, in the department. He can't do it. because of the shortage. …Like this PMTCT, HTC you know you want to do better than the others but you can't because of the shortage* (Participant 7 FGD).

Participants who mentioned lack of continuity felt it was attributable to lack of follow-up, shortage of equipment, overwork, and high staff turnover with resultant loss of knowledge and skills. The FGD confirmed staff shortages, high staff turnover and its consequences as causes of lack of continuity.

> *There was no follow up and even now we are still doing that very wrong thing. … Which they told us not to do because we don't have the… equipment, we don't have the… things which they say we should have, you see. ……Now you come, you've got the knowledge to do it. But how to do it … there's no equipment … there's no stationery… there's no this and that. …And if there're equipment which needs to be purchased. … to get a glucometer …we have to go for three months running to other wards asking for a glucometer…(*Participant 7).

> *…There is high staff turnover you find that those who have been trained they're leaving the… place and they'll be replaced by maybe newly qualified nurses. … So the skilled personnel is just moving out* (Participant 2).

> *…shortage of staff has really crippled …the institution and the learning process of the institution. … nurses have been trained. But those trained nurses acquire knowledge and seeing that they are working under very stressful situations whereby …there's not enough staff. … they tend to leave the institution with the information that has been provided to them…The institution brings very new nurses who do not have the …knowledge and training that …those that have left have and you know the learning process is being really disturbed and the progress even of the institution is being let down* (Participant 2 FGD).

Several participants mentioned resistance and negative attitudes towards and perceptions of HIV and AIDS.

> *Usually when these workshop come. … They come with change. …And as you know when there's change…there's going to be resistance and other things. …as an office, as the quality office. …We try to… deal [with] change, resistance and other things* (Participant 12).

> *…But you also get negative attitude… You come and try to sit down with your cadre. … 'Guys…let's do it this way...' and you get negative … support you see. …At the end of the day you are the one who is frustrated. … Because you're the one who attended it you know exactly what to do. … But they are giving you a negative attitude. …At departmental level* (Participant 7).

> *…So I was asking them, 'But why are you doing this because we are using the opt out method here, this is not CIHTC, it's PIHTC?' …I think eh it's because of the situation of HIV the way people… think about it* (Participant 5).

The study shows that numerous personal, institutional and systems factors challenge post- training implementation. The findings also suggest that the combined effect of the above factors causes lack in behaviour changes, failure to provide quality care, lack of implementation, growth of negative practices, and frustration and disillusionment among nurses. Reports from the study hospital confirm inadequate, unreliable and faulty equipment as a major challenge and further confirm that many issues that require the involvement of management remain unattended, causing personnel to abandon implementation and to feel disillusioned (Quality Assurance, 2014).

Similar studies attribute poor post-training application to lack of after training follow-up resulting from financial limitations and burdens on instructors' time (The ACQUIRE Project, 2008), lack of personnel, and great workloads which might further increase turnover (Cox et al., 2013; Ng, Pacquė- Margolis, Kotellos & Brantley, 2012; Pellico et al., 2009). Other studies confirm inadequate support from management from colleagues and from members of the interdisciplinary team, resulting in disillusionment (Pellico et al., 2009). Poor post-training applications in the study also appears to be rooted in HIV allied stigma and discrimination as shown by lack providers' adherence to standard HTC procedures (Joint United Nations Programme on HIV/AIDS [UNAIDS], 2014).

5.2.3.3. Disabling organisational structural support and environment

A few participants highlighted service delivery challenges that hinder post-training implementation such as but not limited to unresolved matters and impractical challenges.

> *…in the practical area, yah as I've said … there are still unanswered questions. …We are still doing what we were doing before someone is just doing what they are comfortable to do …so you, see it's still really a challenge because we don't know where we are facing. …So at the end of the day, we're doing different things … in a department. … You see the way you understand it* (Participant 7).

The above comment underscores the general lack of support from management, superiors, workmates and providers of in-service training to influence the transfer of knowledge, skills, and attitudes in the work place (The ACQUIRE Project, 2008). This may suggest lack of relevant standards, procedures, strategies and protocol to serve as guidance for what is expected, while also taking into consideration situational elements outside the sphere and control of the study hospital that impact on post-training application (Brinkerhoff & Derrick, 2003). Unresolved matters and impractical challenges therefore require further studying to identify foundational causes and find possible solutions (IntraHealth International, n.d.).

5.2.3.4. Superficial pre-service knowledge

A few participants referred to poor preparation of new nurse graduates at pre-service level in terms of acquisition of clinical skills, thus requiring a longer time to orient or retrain at service delivery, which affects the continuity and sustainability of in-service training. Major causes here are the large number of nursing students admitted in nursing schools and universities, and limited opportunities to practice in a clinical environment.

> *…the training institutions for now in the country they are taking quiet a large number of students, of which at times some of the students come out from the training not knowing some of the procedures. …It becomes difficult to train someone who is … who has passed in class. … Who is now qualified, who is now having you know being certified … capable … in the Nursing Council* (Participant 3).

> *…the problem is we… receive these new employees to our institution and it takes a lot… a longer time to orient … them to the departments. …So you find yourself taking six months to a year … getting that person … to function well in the department* (Participant 12).

In the comments above, the participants suggest that pre-service training is deficient in adequately preparing nursing students to take up nursing jobs in the country thus requiring the service area to retrain them over time.

Pre-service education is an important component of in-service training and continuing education as it lays the foundation for service provision to completing scholars (The ACQUIRE Project, 2008). Studies confirm pre-service challenges, which include large numbers of undergraduates, few faculty members thus limiting effective instruction and occasions for graduates to rehearse and gain clinical expertise (WHO & JHPIEGO, 2005). There is lack of follow-up to acquaint students with the dissimilarity between the model academic world that is furnished with the required means and equipment, versus the actual world that has limited resources (WHO & JHPIEGO, 2005). Pellico et al. (2009) agree that nurses are insufficiently prepared at pre-service level in practical expertise for actual service delivery. Other studies concur that proficient nurse in-service trainers are not available and most health professional educators are not appropriately prepared as teachers and trainers (WHO, 2013). Furthermore, the nurses, lack efficient managerial attributes, they do not integrate best practice in medicine during clinical teaching in general, barely apply pertinent theories (Lẹgarẻ et al., 2015). Therefore, the conversion of graduate nurses from the educational set-up to the work environment is challenging (Sherman, Lynn & Dyess, 2010). It presents difficulties such as being pressured to speedily operate like expert nurses, and experiencing conflict in individual opinions about nursing and the actual experience of being a new nurse (Pellico et al., 2009).

5.2.3.5. Poor in-service infrastructure

A few participants also verbalised the challenge of a weak in-service infrastructure, which is exhibited by a shortage of staff.

> *The reason I'm saying the in-service … office staffing shortage there, because … whatever in-service is … going on. You have to participate, you have to be there. …But at the same time there is another coming you need to get prepared for them. … while you are doing this one. … it's a lot of work to be done. …So the staffing part if one person is there he cannot do it all by herself or himself*
> (Participant 10).

The ACQUIRE Project (2008) reveals that a functional in-service training system requires competent trainers, training management capacity, well-equipped training establishments, and the ability to collect, handle, study and disseminate data at facility, regional and national levels.

5.3. SYNTHESIS

This chapter highlighted the challenges that participants encountered in in-service training. The chapter shows that the provision of in-service training presents complex challenges on planning and attendance, delivery, continuity and sustainability. These elements are connected to workloads, staff shortages, high staff turnover, high morning hospital routines, parallel and conflicting trainings, poor logistics, lack of good practice, funding challenges, poor planning and resource allocation, poor facilitation and bulky teaching materials, post-training challenges, superficial pre-service knowledge, and poor in-service infrastructure. The chapter highlighted the identified challenges, which comprise personal and group elements, structural elements, and elements that fall outside the study setting which obstruct the quality, efficiency and sustainability of in-service training.

CHAPTER 6

FINDINGS AND DISCUSSIONS OF RECOMMENDATIONS FOR IMPROVING NURSES' IN-SERVICE TRAINING

6.1. INTRODUCTION

In the previous chapter discussion of findings pertaining to challenges experienced by nurses' in in-service training were presented, in response to the second research question. This chapter presents the recommendations through participant voices in response to the last research question, namely, "How can the provision of in-service programmes for nurses be improved in one hospital in Swaziland?" The participants' suggestions were based on what they thought would improve in-service training in the study based on the challenges that they identified as on the ground and hands-on people. Three themes emerged from their responses, namely proper organisation and design of in-service training, proper implementation of in-service training and improving the work environment, which encompasses motivating nurses to participate, and improving the in-service infrastructure.

6.2. FINDINGS AND DISCUSSIONS

The themes and sub-themes relating to the recommendations for improving nurses' in-service training in the study are discussed in the text and summarised in the subsequent Table 6.1.

THEMES	CATEGORIES
Theme 1: Proper organisation and design of in-service training	• *Effective planning* • *Coordination and regulation of training* • *Objective selection and delegation of in-service trainees*
Theme 2: Proper implementation of training	• *Quality in-service training* • *Improved post-training support*
Theme 3: Improve the work environment	• *Improve working conditions* • *Reinforce support for in-service training and motivate nurses to participate* • *Improvement of the in-service infrastructure*

Table 6.1: Themes and categories relating to recommendations for improving nurses' in-service training

6.2.1. Proper organisation and design of in-service training

This theme discusses the participants' recommendations to proper organisation and design of in-service training, which they felt should occur at national and local levels. This could be achieved through effective planning, coordination and regulation, proper scheduling and dissemination of information, objective selection and delegation of in-service trainees.

6.2.1.1. Effective planning

By effective planning, the participants referred to conducting training needs analysis before offering the in-service training. They also felt a training plan should be developed to ensure that the in-service training is delivered in a systematic and organised manner.

Several participants suggested a training needs analysis of in-service training:

> *… at first I'll just do a need assessment. …Just to go there and see … what are the things (sic), what are the topics ... That we need to cover, maybe in the first quarter, second quarter… third quarter. … Then from there, I draw a training plan* (Participant 12).

The FGD verified the significance of planning in-service training and underscored the need for involvement of pertinent departments and stakeholders.

> *Proper planning from the word go, January planning for the whole year. … That is involving all the stakeholders so that we can move smoothly with all our in-service that are being maybe those ones which are in-house* (Participant 6 FGD).

> *There are also doctors there's also support staff. Eh let's …focus … a certain topic is supposed to be for a certain focused group. Singabhicani (let us not be mixed up) at the end of the day if you ask a support staff what she gained, she didn't gain anything, she was just there because she was told kuthi (that) 'You have to attend.' So … focus, focused group on … a certain topic* (Participant 4 FGD).

From the above accounts, it is clear that effective and comprehensive planning of in-service training is important to participants in the provision of appropriate trainings and relevant participation of nurses with minimal service disruptions. Several studies recommend training needs assessments with input from trainees trainee managers, and hospital administrators (MOH, 2015; IntraHealth International Inc, 2012). A training needs analysis is essential to guarantee that performance shortfalls are recognised and (Eaton et al., 2011; Institute of Medicine, 2011; Jaradeh & Hamdeh,). However the literature warns that in-service planning and design is a difficult procedure (American Institute for Research and Academy for Educational Development, 2011) which is not free from challenges (Tax & Stuart, 1997).

6.2.1.2. Coordination and regulation of training

Some participants made reference to coordination and regulation of in-service training, which was further corroborated by the FGD. Appropriate scheduling, timing of the training and proper coordination was also suggested.

> *…maybe with the hours that we are using in the hospital, may be from eleven to twelve, if… it's an hour's in-service. … Because at least at ten there are those who are coming so at least there will be an added staff. … And then there is not much routine, between ten and …eleven I mean between eleven and twelve* (Participant 2).

> *So if there was a regulating body. … So that the in-service, or the training per se would not come at the same time* (Participant 3).

The above comments also came up in the FGD:

> *…maybe if they can change the time of the in-service, instead of every one we say maybe one maybe two or three something* (Participant 8 FGD).

> *I'm complaining about after lunch … by after lunch {'sleeping!' P4 says and other participants laughing in understanding as P6 speaks} … we are so tired! I've worked in the ward then you tell me to come and sit, 'No it won't work.' …Maybe the elven. …*
> (Participant 6 FGD).

The participants further recommended morning sessions to take place from 11:00 to 13:00 for scheduling internal trainings, rather than earlier or in the afternoon. This is because of workloads and the likelihood of having additional nurses around the suggested time compared to an earlier time, or weariness in the afternoon. A study by Omar (2014) confirms that timing is an important element in the success of in-service training, agreeing that after lunch, and after work might not be appropriate times as nurses might be exhausted. The American Institute for Research and Academy for Educational Development (2011) further reveals that timing a course so that the highest number of participants is secured is often a challenge and bears financial consequences. It is for these reasons that the USAID HCI Project (2013) emphasises prudent planning and scheduling in-service training.

The findings further highlight the need for proper regulation of internal and external trainings provided by government and partner organisations, to avoid conflict. Document analysis reports at the study hospital concur on the need to reinforce the coordination of in-service training both nationally and internally by cooperating with relevant institutions and departments to address the challenges of concurrent trainings (In-service Department, 2012). A facility report advocates that all units in a study facility need to develop training plans as a mechanism to regulate long-term education in a way that minimises disturbances in service delivery (Leave and claim form consultative meeting with supervisors, 2014).

6.2.1.3. Objective selection and delegation of in-service trainees

The participants were totally against the bias manner for choosing trainees for the in-service. They proposed for a transparent selection criteria. Also suggested for an adequate wards coverage and distribution of nurses during the selection so that every nurse gets the opportunity for in service training.

On the issue of impartial selection and delegation of nurses for in-service training, a participant said:

They shouldn't be choosey. Because sometimes you feel like they are choosing … Yah, they shouldn't… be choosey. … [a] person can go for [a].. workshop when he or she is working in … that department that (sic) the skill is required at that time (Participant 6).

The above comments was verified by the FGD:

… maybe if we can have a workshop whereby I will know that the whole day I will be in that in-service training; just be out of work you know… (Participant 7 FGD).

I think maybe there can be even distribution of those in part-time training. … you find that they are in the same ward, it's a challenge then. So if they can be evenly distributed throughout the hospital maybe that would help (Participant 3 FGD).

The participants emphasised a need for appropriate delegation of nurses and fair treatment, ensuring coverage in the wards for those who have been released to attend in-service training Studies confirm that nurse managers should provide exemplary leadership, behaviour and support for in-service training (Hughes, 2005; Norushe et al., 2004; Richards, 2007). Exercising impartiality by supervisors through selecting and delegating nurses who are hands-on, or based where skills are needed, is in line with the country's in-service training guidelines, which require that learners are identified according to need (MOH, 2015).

6.2.2. Proper implementation of training

The participants suggested for provision of quality in-service trainings that covers all the nurses irrespective of their work position and improved post training support.

6.2.2.1. Quality in-service training

Many participants repetitively recommended the provision of timely and excellent trainings:

...kungabi ma (it shouldn't be those) topics lokhandza kutsi (where you find) like for example, it's e bola ukhandze kokutsi mhlawumbe (where you find that maybe) after some time! now ngukhani ku presentwa nge ebola ukhandze kutsi (it is then that a presentation on ebola is given…) … the people outside already they are having the information ukhandze kutsi (you find that) we nurses uyabo (you see) we haven't been trained on that particular topic. …At that time yes. …. And in time (Participant 1).

And in the in-service I'll make sure the facilitators are well equipped with information. … That these nurses … need so much. … Yes, try to answer every question … that the staff might have. … So that they are aware of the information …to use to the patient (Participant 9).

Several participants mentioned the need to provide training for managers, all staff members, including working and recently graduated nurses.

> *I don't know …it's just that the hospital doesn't have money. I would love when someone is being promoted to a certain position. … Will be trained before he… start. … Working in that position. …Like being a supervisor you know you need the skills to be a supervisor. … I think it will be important to be trained. To have the skills for that position* (Participant 4).

> *So, I…even think that maybe everybody should be trained on it [quality improvement] because that is … where we produce quality nursing. …Maybe these people they just need training, and then everything ((can work well)) recommendation for resolving resistance among staff]* (Participant 5).

> *…we may also have an aggressive approach… on trainings for these … new staff. … I mean … we need to have an aggressive approach to in-service training especially … on orientation … of new staff. …if we can catch them during that first month of… employment. … Give them what they need so that they just hit the ground running. … I think that way we can succeed a lot* (Participant 12).

The findings propose that quality client-based trainings can be guaranteed by having expert facilitators and providing credible courses, which is also supported by the WHO (2013) and Scheckel (2009). The participants' suggestions to have training for managers, which can facilitate leadership and supervisory skills over and above discipline-based knowledge, is also suggested by the WHO (2015). The findings are in line with the Swaziland Health Sector Strategic Plan, which also advocates for health worker development as an important component of organising health institutions at national, regional and facility levels (MOH, 2012). Pellico et al. (2009) approve the provision of evidence-based and effective orientation programmes for new nurses to resolve performance challenges related to poor preparation for the work environment. The American Institute for Research and Academy for Educational Development (2011) advocate that annual in-service courses should be sufficiently pliable to repeat former courses for incoming nurses, cater new courses for every nurse and offer expert courses for veteran nurses charged with specific duties.

6.2.2.2. Improved post-training support

The participants further made suggestions to improve post-training follow up and support of trainees by providing after training support, tracking and monitoring trainees. Some participants voiced their suggestions pertaining the above recommendation as follows:

> *But I want to emphasize on the follow up …When you gave us new information, new things to implement. Let them [come] back to us to ask 'How are you going about this … are you able to do it?' … 'How far have you gone?'… 'Has everyone grasped?' … You see things like that. …'Is it really practical?' …we really need the follow up if there is … any in-service training done* (Participant 7).

> *… for example may be if I went for training. … Then when I come back … maybe even in the ward. … in the morning the Sister in charge may be will ask 'What did you learn?' so that we can share the information with each one in the department, but there's not that support (Participant 1).*

Several participants also suggested tracking and monitoring of trainees, and setting up a proper feedback reporting system to strengthen reporting

> *And the in-service training office should have close contact with these guys to make sure they do report… in the departments. …And they also write a report as in the one … who had come for the training they should write a report, bring it back to the office, that I went to this training, I got this information. I've disseminated to my staff, my colleagues at the department* (Participant 12).

Provision of post training follow up and support by supervisors and providers of in-service training is also recommended by the participants since it was reported as poor in the study. Hart et al. (2012) concur that assisting trainees in the workplace following a course is vital. This support should be constant, vigorous and offered over a period of time (Everett, 2010). The participants also suggested designing monitoring mechanism to track trainees, their performance and behaviour changes at facility and unit levels of the study hospital, which is endorsed by Intra Health International Inc. (2012); Burlew et al. (2014) and the URC- Swaziland (2014). Central to the above is reinforcing the ability of everyone in a health care organisation to take charge of their personal conduct, recognise tactics of advancing care, and observe and assess best practices and health results so that resolutions and guidelines are based on and driven by proof (WHO, 2015).

6.2.3. Improve the work environment

Improving the work environment was also one of the strongly discussed recommendations. The participants suggested hiring more nurses and improving working conditions, improving management involvement and support, engaging partners, reinforcing support for in-service training, motivating nurses to participate in in-service training, and improving in-service infrastructures.

6.2.3.1. Improve working conditions

Many participants referred to increasing staffing in the nursing department as a cross-cutting solution to in-service training challenges, including improving staff benefits and resolving burnout. A few participants recommended the provision of needed resources.

> *Eh so I think …the bottom line would be the increase of staffing so that the… programmes are attended fully by most of the staff* (Participant 11).

> *…they should… should bring closer what the people are scouting for outside* (Participant 2).

> *In the issue of burnout maybe if they can change the hours if it can be possible to change the hours. Instead of working eight hours a day say maybe four hours then we change. …Not working the long hours every day. …Try to do the rotation of staff. … To other departments. … Maybe every three months …* (Participant 8).

> *And if there're equipment which needs to be purchased. … Because now we've got a problem with our patients in the department* (Participant 7).

Some participants further suggested management support towards improving staff benefits, resolving exhaustion, and supporting staff development and facilitation:

> *…we can expect the institution to pay…But [if] it happens that maybe you can pay for yourself but the institution should also allow me to go … for the workshop if maybe it cannot pay I will pay for myself. … they should [also]pay … My training leave. … So it's another option that the institution can have* (Participant 11).

> *…we need the support from management. … Like when you're requesting the outside people … to come, they have to support us because some of the… people are being paid. … They want money for coming to the hospital for the lectures. So the management has to help with that. … Like maybe with the fuel or with providing lunch. … that will make things much more easier* (Participant 10).

The FGD verified the above and pointed out that the management of the study facility should bear the sole responsibility for resolving staff shortages and human resource challenges.

> *So this… problem involves management a lot. There's a lot that management has to do [pertaining severe staff shortage] … No management really has to give itself out and look into this issue [high staff turnover, overwork, knowledge and skills drain]* (Participant 2 FGD).

> *…for me it's just a question kutsi ingabe (that really) 'What is the management doing about the shortage of staff because most of the time we can plan from January to December but we find that during the time of the in-service maybe there is a shortage in the ward so you find at the end of the day kutsi (that) you won't be able'* (Participant 7 FGD).

A few participants mentioned the importance of financial planning and seeking support from donor partners, which was verified by the FGD.

> *It's difficult. … Because they need maybe to ask money from the partners. … To run the in-service* (Participant 8).
> *I'm just thinking … about the partners we are having if we can involve them in some of the lack of equipment. I'm just wondering if they cannot help us, if we inform them this is what we need and it's very important. …* (Participant 7 FGD).

In the above comments participants suggest that improving staffing and working conditions is critical to retaining nurses and resolving in-service challenges. They see this recommendation being realised with management's involvement. The document analysis concurs on engaging management to explore means of personnel retention to prevent the depletion of resources, which occurs when workers in an institution are educated, but resign afterwards on account of poor employment conditions (Quality Assurance, 2014). The literature confirms that managerial and administration support, dedication, and answerability at national, regional and facility levels are necessary conditions for the success of in-service training (WHO, 2015).

Several studies agree on the use monetary balanced with non-monetary inducements, and upgrading work settings to improve work conditions and staff retention although this is not directly linked to in-service training (MOH, 2012; McCaffery, Joyce, Massie, Training Resources Group & IntraHealth International, 2009; Yumkella & IntraHealth International, 2006; WHO, 2015). A Swaziland study shows that non-monetary inducements produced uncertain effects on conduct and had no effect on work contentment (Luoma, Ravishankar, Price, Bedford & Mndzebele, 2011). Yumkella (2005) therefore, argues that the numerous retention strategies and illustrations suggested in the literature have not been tested.

The above comments reinforce to the importance of drawing a financial plan for in-service training and seeking donor support. The USAID HCI Project (2013) advocates for budgetary allocations for in-service training activities at ministerial level. The literature further recommends that an adequate percentage of the health budget to should be allocated to in-service training and compensation for health workers at national, regional and facility levels (WHO, 2015).

6.2.3.2. Reinforce support for in-service training and motivate nurses to participate

Several participants indicated the need to strengthen support for in-service training amongst nurses to promote participation, for example by prioritising the training and calling for obligatory attendance.

> *Yah. Eh also I think … the institution has to really strengthen the need actually. …for attending the workshops and the one hour … programmes that are offered up there… So I think … the need of reorientation. … that part it's like it should be something that comes easy from a nurse that … 'No I should empower myself with knowledge so that I can help the client' …Instead of 'I will stick around to the patient and help the patient,' … eh while the knowledge is not current. … So if you reorient that* (Participant 11).

> *… I…will make sure … there's enough time for everyone … to do the in-service. … That would be my first point* (Participant 9).

> *…I…think departmental …the in charge … may invite people to come and share experiences [from] the other departments…. …Maybe those things should be done or we need in-service to come and do it or quality but I think sharing internally* (Participant 10).

> *… Because these trainings they come not always, they come in a period of time. … So I'll…make sure that everyone has the hours that are needed more especially for renewing our licenses. …Maybe I can make sure that those who don't attend yet we have invite[d] them they have to pay something. … And that penalty has to be high. … either money or your time* (Participant 6).

Some participants also recommended that the study facility should assist and inspire nurses to participate in in-service training.

> *…and eh maybe even the nurses they need some motivation because these CME's are there…I think we need more in-service trainings, which will cut across all the carders…and eh in the nursing department … all the… nurses from NA, staff nurse …I think even the nursing assistants should be involved* (Participant 5).

> *… May be going out to another venue. … Yes, it also can improve. …so if you… tell them that you are going out to maybe Tums, or Summerfields they'll be like 'Oh, I want to go*

there,' … you know so you tend to get more people getting more information. …and also the food. … People are used to the food that we eat … in the kitchen. Maybe if there will be food coming … from outside. (Participant 4).

… If the institution can afford money … for appreciation, like transport money for those who attended. …Sometimes you are called at home to come and attend a training. So if there can be reimbursement of that you know. … only if I can be rewarded for… doing that. … actually that's my time (Participant 12).

The above was validated by the FGD, in which additional motivation strategies were also suggested.

Even in the case of snacking even a fruit after that one session get an apple on your way out, get a banana or a fruit ne (at least) just a way of appreciation that at least you were there, you listened and participated. That even if it was one hour (Participant 4 FGD).

…And certificates (Participant 3 FGD).

Under the motivation too we add those the departments that are doing well. …after those trainings … should be… recognised (Participant 6 FGD).

The participants further suggest motivation strategies to promote participation comprise positive, monetary, non-monetary, including negative rewards as suggested by ICN et al. (2008). Monetary rewards may include improving remuneration (McCaffery et al., 2009; Yumkella & IntraHealth International, 2006); hardship allowance, accommodation, and awards (WHO, 2015). Non-monetary rewards include but are not limited to provision of housing; excellent supervision practices, amendment of professional structures to improve succession prospects; appreciation for excellent performance and granting independence on the job (Yumkella & IntraHealth International, 2006; McCaffery et al., 2009; WHO, 2015). Work setting improvements may entail providing occasions for: suitable workload; provision of needed materials or equipment, health employee safety, compassionate leadership and administration (MOH, 2012; Yumkella & IntraHealth International, 2006; WHO, 2015).

The literature agrees on the use of monetary incentives balanced with non-monetary incentives, and work setting upgrading to improve work conditions and staff retention (MOH, 2012; McCaffery et al., , 2009; WHO, 2015). ICN et al. (2008) and McCaffery et al. (2009) add that the right kind of incentive when correctly channeled even if small is capable of producing drastic change or wanted outcomes. McCaffery et al. (2009) further cautions that implementing non-

monetary incentives to promote in-service training requires educated human resource experts to liaise, agree with concerned health personnel, and offer strategic guidance. However, a Swaziland study showed that non- monetary rewards produced uncertain effect on behaviour and had no effect on work contentment (Luoma et al., 2011), and therefore need further research (Yumkella, 2005).

The findings and the literature supports promotion of in-service training as a lifelong activity among nurses and other health professionals (AACN & AAMC, 2010). However, it is clear that, this would require policy support dedicated and enlightened leadership and collaboration among several stakeholders such as academic institutions, health care systems, regulatory bodies, and hospitals.

6.2.3.3. Improvement of the in-service infrastructure

Some of the participants made recommendations for the improvement of the in-service infrastructure and the allocation of adequate resources to the in-service department. This was verified in the FGD, in terms of constructing a suitable and well-equipped training venue for internal trainings.

> *Yah in this facility, because we are a training hospital. … It can be improved by having a fully-fledged in-service committee the one that will include also one of the lectures from the training institution. …So that … we do not clash. …They must know what we are doing, how we do things and we are in a better position to know how … the students are taught at school. …we need to revamp the committee. …* (Participant 3).

> *Uh I think if we can strengthen the in-service… department so that they have enough staff, enough resources to follow up …participants in the in-service training. …we have got to have computers so that we feed in data you know …so that … we are able to follow up. …We can all rob in the M and E officer* (Participant 12).

> *At least maybe if we can have a proper conference room not the [Hospital venue], but a conference room where we are going to have our meetings. And I'm sure it can be built higher standard maybe. …There's chairs, aircon, everything* (Participant 1 FGD).

Infrastructural improvements as suggested by participants comprise establishing a representative in-service committee that will maintain continuity with pre-service education to ensure uniform training and to ensure ongoing in-service activities. The study further recommends an in-service department that comprises a structure with an office, computers, and a well- designed data management system, and appropriate and fully equipped conference facility, adequate and skilled

in-service officers who possess the capacity to effectively monitor the activities of the programme, and technical support from a monitoring and evaluation officer.

The document analysis concurs with the suggested improvements. These include the addition of in-service in strategic programmes of the study facility for growth in the department, a well-prepared division for a training hospital, reviving the in-service committee, and increasing personnel (In-service Department [first quarter], 2014). It is suggested that the local in-service structure liaise with regional and ministerial structures for consistency in national in-service training efforts, for support, and for successful coordination (USAID HCI Project, 2013). This is because the governmental level in-service training system directs the formation and execution of educational rules, criteria, evaluation procedures, standards identification for educators, trainees and training sites, procedures for conducting trainings, follow-up and regulations (The ACQUIRE Project, 2008), and certification of health personnel education (WHO, 2013). It also collaborates with training providers at provincial and other levels and regulatory bodies to control in-service training and develop effective and sustainable training systems.

Similar to this study, the URC- Swaziland (2014) found that in-service committees were an essential component of in-service training at hospital level and suggested that they be resuscitated where they are non-operational, or developed where they are non –existent, and to further scrutinise how they operate. The URC- Swaziland (2014) further approves the formation of a forum for discourse among pre-service and in-service educators to form a viable strategy that can sustain ongoing education from pre-service to training levels on the job.

6.3. SYNTHESIS

This chapter outlined the recommendations, which the participants advanced to improve in-service training. They recommended proper organisation and design, proper implementation, improving the work environment, motivating of nurses toward in-service training, and improving the in-service infrastructure. These recommendations are supported by the literature and clearly show that systemic versus isolated improvement strategies may resolve the multifaceted challenges experienced in in-service training. Improvement strategies would need to be executed over a protracted period to realise notable progress rather than fragmented over short-term interventions.

Continual devoted political, administrative, and financial support is also essential for improvements to occur (WHO, 2014). It is clear that the suggested recommendations encompass personal, micro- and macro-level elements as WHO (2015) allude.

CHAPTER SEVEN

SUMMARY, CONCLUSSIONS, IMPLICATIONS AND RECOMMENDATIONS

7.1. INTRODUCTION

The aim of this study was to explore nurses' experiences of in-service training in one hospital in Swaziland. The study aimed to answer three central questions: What are the experiences of nurses regarding in-service training in one hospital in Swaziland? What are the current challenges in offering in-service training in one hospital in Swaziland? and How can the provision of in-service programmes for nurses be improved in one hospital in Swaziland? This chapter presents a summary of the responses to the above questions based on the participants' expressions of their lived experiences of in-service training, and the subsequent themes that emerged under each research question. This is followed by conclusions, implications of the study, recommendations, and limitations of the study.

The researcher selected a qualitative approach, an interpretivist paradigm and descriptive phenomenology originated by Edmund Hursserl (1900; 1970) to arrive at the findings, conclusions, implications and recommendations of this study. The researcher therefore used in-depth interviews and FGD as data generation methods. The qualitative method permitted the researcher to learn and comprehend nurse participants' experiences of in-service training in the study from manifold and thorough perspectives. The researcher used the interpretivist paradigm to further view and appreciate the physical reality of the nurse participants' lived experiences of in-service training. Interpretivism also allowed the researcher to seek for multidimensional and extensive elements that shape individual nurses' experiences of in-service training based on the context of the study. Descriptive phenomenology allowed the researcher to learn the core of the in-service training experience as lived by each participant in the study at a comprehensive level, particularly because nurses' in-service training is insufficiently described or appreciated (Polit & Beck, 2012). Descriptive phenomenology permitted studying the experience of in-service training, challenges and likely answers in a non-biased and scientific manner (Wojnar & Swanson, 2007). The researcher used Colaizzi's (1978) method of descriptive phenomenology as a tool for data analysis to maintain a full appreciation of the data and context, and to validate findings with participants (Polit & Beck, 2012).

From the data that emerged, the theory of planned behaviour was validated as befitting. This theory was coined by Ajzen (1988), and used to relate participants' personal meanings, understandings and descriptions of their in-service training experience (Wojnar & Swanson, 2007). The theory of planned behaviour was an appropriate theoretical lens to view the findings of this study since it also allowed the researcher to understand nurses' subjective articulations of the in-service training experience from a professional and neutral standpoint (Giorgi, 2005), and to further consolidate the participants' personal meanings into a collective narrative of the experience.

7.2. CONCLUSIONS

Based on the perspective of the theory of planned behaviour, the findings of the study indicate that the participants' experiences of in-service training are governed by complex factors that entail personal elements, significant others like leadership and peers, and situational and organisational elements both internal and external to the study hospital. The study has shown that nurse participants have both positive and negative intentions towards the in-service training offered at the study hospital, have experienced in-service training positively and negatively, have challenges presented by personal, significant others, internal and external, contextual and institutional elements. To reach an improved experience of in-service training by the nurse participants in this study, the theory of planned behaviour further holds that this can be achieved by systematically improving or attending to the personal elements, significant others, internal contextual, organisational and external or health systems factors that direct the experience.

The conclusion for the study is presented according to the three themes that transpired from the study. The themes are in congruence with the study questions which are: the experiences of in-service training, the challenges of in-service training, and recommendations for improving the training.

7.2.1. Experiences of in-service training

The study has found that the nurse participants encountered different dimensions of the in-service training experience, namely organisation and design, implementation, and benefits of in-service training.

The study shows that the participants experienced in-service training as both organised and inadequately organised. In-service organisation entailed various modes of communicating like memos, telephones, cell phones, and person-to-person. What was also clear is that these communication methods need to be closely monitored to be effective since each mode contains good and bad elements. The participants' accounts further revealed that in-service notifications were challenged although to some extent dispatched in advance covering topics, dates, and time of in-service training.

The study also showed that the selection of trainees for external trainings was done through matrons, and for internal trainings through ward nurse supervisors. This practice contradicts the principles of in-service planning since it disregards a needs analysis and the study facility's strategic plan. The findings also indicate that the selection of trainees for in-service training faces challenges. The participants confirmed the existence of a documentation system for in-service training at the national and facility levels, for example a register from the MOH, a nurses' logbook from SNC, and a facility booklet.

The participants' accounts mention different types of in-service trainings, the topics covered, facilitation strategies, the teaching strategies, which they liked, the in-service training providers, the effectiveness of the training, and post-training support. The study shows that short- and long-term in-service trainings are offered. Short term in-service training comprises on-site and external trainings. The findings indicate that internal in-service trainings have helpful aspects that need to be continued and adverse aspects that need to be improved. External and residential trainings were the most liked by many participants and were found to be inspirational and favourable to learning. The study also shows that long-term trainings cover both part- and full-time courses. The topics that offered are HIV and AIDS related which dominated the course content, maternal neo-natal and child health, quality management, medical surgical, emergency/ intensive care, general patient care and other uncategorised topics. The topics covered in this study match the country's main health concerns and vision to offer quality health care services to every client in the health sector by 2022 (MOH, 2012). The training methods which that participants mentioned are lectures, active involvement, and reflective methods. The teaching approaches, which they liked, comprise active involvement methods. The providers of in-service training are mainly international donors, the MOH the Southern Africa Development Community, international faith based organisations, and

hospital level providers. The majority of the participants further revealed that the facilitation was excellent although it was also raised as a challenge, in-service training was a positive and desired programme, and the trainings were accessible although not to a satisfactory level.

The participants further felt that post-training support was inadequate and challenged. However, some training areas are supported, for example, HIV and AIDS programmes and blood transfusion. Post-training activities include mentorship, couching, feedback, and the provision of equipment and materials.

The study further found that the participants gained personal, departmental, institutional, patient level, and nursing profession benefits whilst undergoing in-service training. At the personal level, participants reported knowledge and skills development, self-assessment, increased self-confidence, personal refreshment, and enhanced socialising skills. Departmental benefits include betterment of the quality of care, contentment, and a stress-free job as a result of being given new equipment. Hospital level benefits were improvements in the facility's systems, in personnel performance, and in service delivery. At the patient level, the study reported reduction in disease incidence, morbidity, and mortality. Nursing profession benefits comprise reflection, self – development, and being able to meet regulatory requirements.

7.2.2. Challenges of in-service training

The challenges, which the participants encountered, were multifaceted and ranged from planning and attendance to delivery, continuity, and sustainability, and were linked to various interrelated causes. These causes include personnel shortages and workload, high morning hospital routines, parallel and conflicting training plans, poor logistics, lack of good practice, funding challenges, and uncompromising concurrent programmes. Internal and part-time trainings suffered from poor planning, regulation, and resource allocations. Implementation challenges consisted of poor delivery of in-service training, which was associated with poor facilitation, bulky material, lack of necessary equipment, and time constraints. Continuity and sustainability of in-service training was marred by post-training constraints and a lack of sustainability in invested learning. Here the participants recounted deficient post training support, inadequate post-training reporting, inadequate application of learned knowledge, shortage of working tools and materials, lack of team work, resistance from staff, and lack of support from the organisational structure and environment. The inability to sustain invested learning is caused by non-application of skills, lack of continuity,

negativity from staff, loss of skilled staff due to high turnover, and superficial pre-service knowledge from newly graduated nurses. Participants also identified inadequate in-service infrastructure as the cause of ineffective planning, implementation, and follow-up after training.

7.2.3. Recommendations for improving in-service training

The participants highlighted the need for proper organisation and design of in-service training programmes. They considered the following important: appropriate in-service training planning with training a needs analysis that involves all concerned; proper training plan development, scheduling, and timing of internal trainings; correct coordination of on-site and external trainings; proper dissemination of information; and unbiased selection of nurses for in-service training. Moreover, the participants underlined the need for just treatment of nurses; guaranteed ward coverage and fair distribution of nurses studying on part-time basis to improve training attendance and to prevent the disturbance of service delivery. Proper implementation of in-service training was another critical recommendation by which they meant quality trainings that are well-timed and repeated to cover more personnel. The participants also referred to the need to provide training to all personnel including managers, working nurses and recently qualified nurses, which they deemed crucial for performance advancement. Improving post-training support and implementation was also mentioned, such as tracking, monitoring, assisting trainees and creating a feedback system to reinforce post-training reporting. The participants further recommended improvements in the work setting by employing additional nurses, upgrading working conditions, engaging management, employing the help of donor partners, strengthening the support for in-service training, encouraging nurses' involvement in in-service training, and upgrading the study facility's in-service infrastructure. It is fundamental that above recommendations are applied in totality rather than individually to achieve long-term improvements. Ongoing steadfast political, managerial and funding assistance is also essential for success.

7.3. IMPLICATIONS OF THE FINDINGS

The findings of this study suggest the need to strengthen and improve in-service training planning, design, delivery, post-training support and application, general support and sustainability. The findings have implications for different stakeholders. These stakeholders include nurses, nurse managers, facility leadership and management, in-service training coordinators, providers of in-

service training, donor agencies, the MOH, relevant central ministries such as the Ministry of Finance, the Ministry of Education, Public Service, Labour, the Ministry of Finance, nurses' tertiary institutions, regulatory bodies, and professional associations. Moreover, the findings of the study imply that players in in-service training at different levels should work in partnerships to realise success and sustainability.

The researcher therefore recommends the following:

The MOH needs to take leadership in supporting in-service training by providing verified training standards, guidelines and policies which are periodically revised to guide uniform in-service training planning, design, and delivery at national, regional and facility levels.

A budgetary provision by the MOH to support in-service training activities, employee costs, and the development of an in-service infrastructure, learning tools and materials including equipment required for practice, and service delivery at facility level is also crucial.

Central ministries like the ministries of finance and public service need to work jointly with the MOH to assist in the success and sustenance of in-service training initiatives. Also, the providers of in-service training at national, regional and facility levels, regulatory and professional bodies, health care facilities, in-service coordinators, line supervisors should adopt and comply to the national in-service training standards at all times.

Through the Training Unit, the MOH ought to design, execute and evaluate an instrument for harmonising in-service training at national, regional and facility levels to strengthen the coordination of in-service training, which the study found to be weak. It is crucial that health care facilities maintain strong collaboration with the MOH and other providers of in-service training.

The MOH ought to set up a functional monitoring mechanism to capture specific in-service training data at national, regional and health facility levels that will guide decision-making, resource allocation and improvements in in-service training.

Apportioning time and finances for advocacy activities at ministerial, regional and facility levels is essential to motivate for support of in-service training undertakings among regulators, administrators and management.

The management at facility level needs to offer tangible support towards in-service training by improving working conditions, which facilitate staff retention, ensuring conducive staffing levels, apportioning a budget towards in-service training, developing the in-service infrastructure, providing the necessary resources to support in-service training implementation, and adopting and supporting an ethos of lifelong education among nurses and health workers.

The MOH in collaboration with the nurses' regulatory body need to assume the crucial role of regulating and accrediting providers of in-service training at national, regional and facility levels to ensure quality in-service training.

Nurses' regulatory and professional bodies need to offer tactical leadership to in-service training providers and health facilities, and require them to design reasonable and unbiased in-service training systems. Provision of nursing standards and nursing competencies by SNC can strengthen performance appraisals, and a training needs analysis can contribute to relevant and competency based in-service training.

Strengthening the links between nurses' pre-service institutions, health care facilities, and nurses' national professional councils is also important for continuity and sustainability of in-service training.

The provision of a robust orientation programme that is regularly evaluated for efficiency through the MOH in collaboration with SNC plus regional levels and health care facilities to assist nurse graduates to convert training into practice would be gainful. The donor community could provide relevant financial, technical, research focused and other support in in-service training through the MOH, at national, regional and facility levels.

In-service coordinators and providers of in-service training should involve nurses and management during the planning phase of in-a service training to ensure that the training addresses needed competencies, plus institutional and community needs to foster commitment, participation and support from nurses, leadership and nurse supervisors.

Providers and in-service coordinators should also incorporate anticipated costs of the entire programme including evaluation and post-training support during the planning phase to ensure success and continuity.

It is also vital that providers of in-service training and in-service coordinators at national, regional and facility levels design, test and regularly update training materials. Moreover, acquire customary curricula, training manuals, trainee handbooks and evaluation tools; ascertain adequate physical resources and logistical arrangements in advance for successful training delivery. The training programmes, plans and details pertaining to in-service training to health care facilities and trainees should also be communicated and disseminated well in advance of the training.

In-service providers should consider and maintain important principles in training delivery such as but not limited to the provision of education materials, tools and articles based on anticipated aims. The use of varied economical and tested education methods; performance based achievement, evaluation of knowledge and skills; nurses' performance outcomes and patient outcomes using evidence-based methods should be well thought out.

Strengthening post-training support is important by supplying current knowledge, materials and technology to assist trainees in work performance after training.

Facility and unit nurse managers should ensure that the delivery and uptake of in-service training by nurses is just and unbiased. The managers should also assist nurses to apply and share new knowledge, ensure adequate staff coverage and balanced distribution of nurses. Also worth consideration is to promote a conducive work environment, provide straightforward job tasks to enable active participation in training needs analysis, performance staff appraisals, model and promote lifetime learning aptitudes among nurses, and encourage peer support from trained teams and staff members. Training and support for nurse managers in transformational leadership, performance management, career planning and development is essential.

The nurses need to embrace participation in-service training and lifelong learning as personal and professional obligations for their professional growth and upkeep of expertise. They also need to make use of in-service training, be keen to participate in training needs analyses at departmental and facility levels, and participate in the appraisal of their performance and career development.

7.4. DISSEMINATION OF THE RESEARCH

Sharing research results is a crucial step in completing a research study. Therefore, the findings of this study will be disseminated as follows:

- Copies of the final report will be submitted to the University of Kwa-Zulu Natal Library, study hospital and the Swaziland Scientific and Ethics Committee.
- The findings will be presented at the national health research conference, nurses' workshops, and to other stakeholders.
- The findings will also be submitted for publication in nursing journals and hopefully gets published to contribute to the international nursing community.

7.5. SUGGESTIONS FOR FURTHER RESEARCH

This study does not claim to be exhaustive and final hence the suggestions for possible research as follows:

- A similar study to explore nurses' experiences of in-service training can be repeated in another referral hospital, in the same region or different regions of Swaziland.
- It would be valuable if additional studies confirm the benefits of in-service training that have been voiced by participants in this study.
- The recommendations suggested by participants to improve in-service training in this study can be applied and where applicable, further investigated to validate effectiveness since the literature consistently indicates that there is not much evidence to support usefulness.
- A study on the use of the theory of planned behaviour to develop and implement an in-service training programme that targets clinical behaviour changes would be beneficial. The literature shows that the majority of health worker in-service training events are not designed to support clinical behavioural change.

7.6. LIMITATIONS OF THE STUDY

The researcher makes no claim that the themes, which emerged, are exhaustive and therefore acknowledges limitations linked to sample size, biases and time constrains as listed below:

- The sample size was small and limited to thirteen participants from the study hospital due to the qualitative nature of the study. The findings can therefore not be generalised. The researcher kept an in-depth description of every stage of the study to address this limitation.
- The researcher was in charge of directing the entire study and results, which means that researcher prejudice, cannot be ignored. However, the researcher employed phenomenological and qualitative strategies to limit bias, for example bracketing, reflexivity, and intuiting. The researcher also employed triangulation and member checking**.**
- Time to undertake and complete the study within stipulated time frames was a challenge because of competing factors like job and family demands.

7.7. SYNTHESIS

The study has given an in-depth description of nurses' experiences of in-service training, the challenges they face, and recommendations for improvement. The nurses' experiences of in-service training is an area that has not been fully explored in the context of Swaziland. The findings have shown that the participants have experienced in-service training both positively and negatively. Central to the participants' experiences of in-service training is in-service training planning, design, implementation, post-training follow-up support and application. It is also clear that participants' experiences of in-service training at the various training cycles are influenced by personal factors, leadership, significant others, internal situational factors at the study facility, and elements at the macro level. Much as the participants expressed having derived benefits from the in-service training that was offered in the study, challenges were identified such as, planning, design, implementation, post-training support and application, general support, and sustainability. The study has also shown that the improvement of the participants' experience of in-service training at the different phases of the training cycle can be crafted from a multifaceted approach that addresses personal elements, components pertaining to leadership and significant others, institutional elements, and elements at health systems level. Hence, the study foregrounds the importance of participants' personal meanings, understandings and descriptions of their experiences as people on the ground. The theory of planned behaviour was an appropriate theoretical lens to view the findings of this study since it also allowed the researcher to understand nurses' subjective articulations of the in-service training experience from a professional and

neutral standpoint. This assisted to consolidate the participants' personal meanings into a collective narrative of the experience and suggestions on how they feel the in-service training can be improved in their context.

LIST OF REFERENCES

Action for the Rights of Children. (2005). *Facilitator's toolkit – Reach out refugee protection training project*. Retrieved February 13, 2016, from http://www.unhcr.org/4371d7c92.pdf

Ajzen, I. (2012). The theory of planned behavior. In P. A. M. Lange, A. W., Kruglanski & E. T. Higgins (Eds.), *Handbook of theories of social psychology* (pp. 438-459). London, UK: Sage. Retrieved December 5, 2016, from https://www.researchgate.net/publication/263998069_The_theory_of_planned_behavior

American Association of Colleges of Nursing and the Association of American Medical Colleges. (2010). *Lifelong learning in medicine and nursing. Final conference report.* Hosted by the American Medical Colleges & American Association of Colleges of Nursing. Retrieved October 29, 2014, from http://www.aacn.nche.edu/education-resources/MacyReport.pdf

American Institute for Research, & Academy for Education Development. (2011). *First principles: Designing effective education programs for in-service teacher professional development compendium.* Educational Quality Improvement Program 1. United States Agency for International Development. Retrieved September 30, 2016, from http://www.equip123.net/docs/E1-FPIn-SvcTPDCompendium.pdf

American Nurses Association & National Nursing Staff Development Organization. (2010). *Nursing professional development: Scope and standards of practice.* Silver Spring, MD: American Nurses Association.

American Nurses Credentialing Center. (2011). *2013 ANCC primary accreditation application manual for providers and approvers.* Silver Spring, MD: Author. Retrieved November 20, 2014, from http://docplayer.net/7204581-Reference-2013-ancc-primary-accreditation-application-manual-for-providers-and-approvers-ancc-2011-revision-3-0-2013.html

American Nurses Credentialing Center's Commission on Accreditation. (2012). *The value of accreditation for continuing nursing education: Quality education contributing to quality outcomes.* Silver Spring, MD: American Nurses Credentialing Center. Retrieved November 5, 2014, from http://www.nursecredentialing.org/accreditation/resourcesservices/accreditation-whitepaper2012.pdf

Aguinis, H., & Kraiger, K. (2009). Benefits of training and development for individuals and teams, organizations, and society. *Annual Review Psychology, 60,* 451-474. Retrieved February 6, 2016, from www.annualreviews.org

Ashaver, D., & Igyuve, S. M. (2013). The use of audio-visual materials in the teaching and learning processes in colleges of education in Benue State-Nigeria. *Journal of Research & Method in Education, 1(1),* 44-55. Retrieved May 9, 2016, from http://s3.amazonaws.com/academia.edu.documents/32474673/G0164455.pdf

Awasthi, D. (2014). Utilising audiovisual aids to make learning easy and effective in primary education. *International Journal of Scientific Research, 3(2), 62-63.* Retrieved May 9, 2016, fromwww.worldwidejournals.com/ijsr/file.php?val=August_2014...pdf

Baby Friendly Hospital Initiative training report. (2014). Raleigh Fitkin Memorial Hospital.

Bailey, R., Bluestone, J., O'Malley, G., McCarthy, C., Ngobua, S., Petracca, F., &Wuliji, T. (2013). *Impoving health worker in-service training to better deliver quality services.* Retrieved November 19, 2016, from https://www.frontlinehealthworkers.org/improving-health-worker-in-service-training-to-better-deliver-quality-services/

Baker, B. (2011). CIA's learning strategy: Focusing out on the organization we serve. In N. Paine (Ed.), *Learning strategies* (pp.20 - 28). The MASIE Center. Retrieved May 6, 2016, fromwww.masie.com/images/pdfs/learningstrategies%20final-8-2-11.pdf

Bandura, A. (1971). *Social learning theory.* New York City: General Learning Press. New York City: General Learning Press. Retrieved April 5, 2015, from http://www.jku.at/org/content/e54521/

BC Recreation and Parks Association. (2014). *BCRPS Facilitator training manual*. Vancouver. Retrieved February 20, 2016, from http://www.bcrpa.bc.ca/fitness_program/documents/TFLFacilitatorManual-2014.pdf

Bloom, B.S. (2005). Effects of continuing medical education on improving physician clinical care and patient health. *International Journal of Technology Assessment in Health Care, 21*(3), 380-385.

Bluestone, J., Johnson, P., Fullerton, J., Carr, C., Alderman, J., & BonTempo, J. (2013). Effective in-service training design and delivery: Evidence from integrative literature review. *Human Resource for Health, 11*(51). Retrieved October 4, 2014, from http://www.humanresource-health.com/content/11/1/51

Booyens, S.W. (Ed.). (2008). *Introduction to health services management* (3rd ed.). Cape Town: Juta & Company Ltd.

Brinkerhoff, Derick. (2003). *Accountability and Health Systems: Overview, Framework, and Strategies.* Bethesda, MD: The Partners for Health. Retrieved August 8, 2016, from http://www.who.int/management/partnerships/accountability/AccountabilityHealthSystemsOverview.pdf

Bryman, A. (2004). *Social research methods* (2nd ed). Oxford: Oxford University Press. Retrieved September 5, 2014, from http://www.sagepub.com/bjohnsonstudy/articles/Bryman.pdf

Bryman, A., & Bell, E. (2011). *Business research methods* (3rded.). New York: Oxford University Press.

Burlew, R., Puckett, A., Bailey, R., Caffrey, M. & Brantley, S. (2014). Assessing the relevance, efficiency, and sustainability of HIV/AIDS in-service training in Nigeria. *Human Resource for Health12*(20). Retrieved September 1, 2014, from http://www.human-resource-health.com/content/12/1/20

Caffarella, R. (2002). *Developing effective learning programs for adults*. Australian Principals Centre. Monograph Number 5. Retrieved March 25, 2016, from https://research.acer.edu.au/cgi/viewcontent.cgi?article=1004&context=apc

Campbell, J., Collins-McNeilc, J. & Khayile, T. (2012). Nursing shortage: A comparative analysis. *International Journal of Nursing, 1*(1), 22-27. Retrieved November 12, 2016, from http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.300.9995&rep=rep1&type=pdf

Casper, E. S. (2007). The theory of planned behavior applied to continuing education for mental health professionals. *Psychiatric Services, 58*(10), 1324-1329. Retrieved December 5, 2016, from http://ps.psychiatryonline.org/doi/abs/10.1176/ps.2007.58.10.1324

Cervero, R. M., & Gaines, J. K. (2014). *Effectiveness of continuing medical education: Updated synthesis of systematic reviews.* Chicago: Accreditation Council for Medical Education. Retrieved April 5, 2015, from http://www.accme.org/sites/default/files/2014_

Chan, C. Y., Fung, Y., & Chien, W. (2013). Bracketing in phenomenology: nly undertaken in data collection and analysis process?.*The Qualitative Report, 18*(59),1-9. Retrieved October 2, 2014, from http://www.nova.edu.ssss/QR/QR18/chan59.pdf

Chartered Management Institute. (2006). Training needs analysis.

Colaizzi, P. (1978). Psychological research as the phenomologist views it. In R. Valle & M. King (Eds.), *Existential phenomological alternatives for psychology* (pp. 48-71). New York: Oxford University Press.

Cox, C., M., Farrell, C., M., Ng, C., Burlew, R., &Pacquė- Margolis, S. (2013). *Creating an enabling environment for human resources for health program implementation in three African countries.* USAID. Capacity Plus. Retrieved August 7, 2016, from http://www.capacityplus.org/files/resources/creating-an-enabling-environment-for-hrh-program-implementation.pdf

Creswell, J. W. (2014). *Research design* (4th ed.). London: SAGE.

Damrichi, Q. V., Kazemian, M., Hafezian, M., Kani, B. K., &Gholizadeh, S. (2014). The effect of workers in-service training on their self-confidence at health organization of Mazandaran. *International SAMANM Journal of Business and Social Sciences*, *2*(1), Retrieved February 3, 2014, fromwww.samanmjournals.org/.../

De Cruz, L. (2010). *Up close and personal: The role of the bracketing interview in interpretative phenomenological analysis and its impact on the researcher*. Retrieved January 9, 2015, from http://www.keele.ac.uk/media/keeleuniversity/facnatsci/schpsych/documents/counselling/conference/4thannual/Up%20Close%20and%20Personal.pdf

Deussom,R., Jaskiewicz,W., Adams, E.,&Tulenko,K. (2012). *Ensuring a positive practice environment: Occupational safety and health for health worker productivity*. Retrieved August 8, 2016, from http://www.capacityplus.org/files/resources/ensuring-positive-practice-environment-occupational-safety-health-worker-productivity.pdf

DiCicco-Bloom, B. & Crabtree B. F. (2006). Making sense of qualitative research: The qualitative interview. *Medical Education;* 40, *314-321.* Retrieved September 4, 2014, from http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2929.2006.02418.x/pdf

Dirckx, J. H. (Ed.). (1997). *Stedman's concise medical & allied health dictionary* (3rd ed.). London: Williams & Wilkins.

Dlamini, M. (2014, 10-12). *In-service training policy of the government of the kingdom of Swazialnd. Ministry of public service and information, February 2014.* Power point presentation at the in-service improvement workshop, Matsapha, Swaziland.

Eaton, K., Brookes, J., Patel, R., Batchelor, P., Merali, F. & Narain, A. (2011). *The impact of continuing professional development in dentistry: A literature review.* Retrieved April 5, 2015, from http://www.gdc-uk.org/Aboutus/policy/Documents/

Egan, J., P. (2013). Learning community or community practice: Preliminary findings of a transfer of learning study. *Issues in informing Science and Information Technology,* 10, 137-144. Retrieved, March 17, 2016, from http://iisit.org/Vol10/IISITv10p137-144Egan0103.pdfhttp://iisit.org/Vol10/IISITv10p137-144Egan0103.pdf

Eckman, M., &Comerford, K. (Eds.). (2012). *Medical surgical nursing made incredibly easy* (3rd ed.). Philadelphia: Lippincott Williams & Wilkins. Retrieved May, 1, 2016, from www.rhc.ac.ir/.../pdnursingbooks/Medical-Surgical%20Nursing%20Ma

Elliot & Associates. (2005). *Guidelines for conducting a focus group*. Retrieved January 9, 2015, from https://assessment.aas.duke.edu/documents/How_to_Conduct_a_Focus_Group.pdf

Everett, R. (2010).Tangible return on investment: Integrating learning to reach desired results. In P. Keller (Ed.), *The best of measuring & evaluating learning/T&D* (pp. 40-43). Sponsored by DDI.

Ferraro, J. M. (2000). Reflective practice and professional development. *ERIC Digest.* Washington DC: ERIC Clearinghouse on Teaching and Teacher Education. Retrieved November 16, 2016, from http://www.csun.edu/sites/default/files/Holle-Reflective-Teaching.pdf

Finlay, L. (2009). Debating phenomenological research methods. *Phenomenology & Practice, 3*(1), 6-25. Retrieved June 2, 2015, from www.psyking.net>HTMLobj-3824>De

Fort, A., Ng, C., & Nicholson, E. (2015). *Guidelines for developing monitoring and evaluation plans for human resources for health.* IntraHealth International United States Agency for International Development. Retrieved June 6, 2016, from http://www.capacityplus.org/files/resources/guidelines-HRH-monitoring-and-evaluation-plans.pdf

Gass, M. A. (1985). Programming the transfer of learning in adventure education. *Journal of Experiential Education, 8*(3),18-24. Retrieved April 16, 2015, from www.researchgate.net/.../transfer-of-learn-

Giorgi, A. (2005). The phenomenological movement and research in the human sciences. *Nursing Science Quarterly 18*(1), 75-82. Sage Publications. Retrieved May 25, 2015, from www.brown.uk.com>teaching>giorgi

Giri, K., Frankel, N., Tulenko, K., Puckett, A., Bailey, R., & Ross, H. (2012). Keeping up to date: Continuing professional development for health workers in developing countries. *Technical Brief: Capacity plus:Serving health workers, saving lives.* Retrieved June 27, 2014, from www.capacityplus.org/files/resources/

Graf, C.M. (2006). ADN to BSN: Lessons from human capital theory. *Nursing Economic$, 24*(3), 135-141. Retrieved May 9, 2015, from http://search.proquest.com/openview/76824135cc4b1adc074081ee2d3407c8/1?pq-origsite=gscholar&cbl=30765

Grove, S. K., Burns, N., & Gray, J. R. (2013). *The practice of nursing research: Appraisal, synthesis, and generation of evidence* (7th ed.). St. Louis, Missouri: Elsevier Saunders.

Guba, E. G., & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. In N. K. Denzin & Y.S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 105-117). Thousand Oaks, CA: Sage. Retrieved May 26, 2015, from http://www.uncg.edu>hdf>Tudge>G

Gusdorf M. L. (2009). *Training and development instructor manual: Society for human resource management.* Alexandria: SHRM Academic Initiatives. Retrieved February 6, 2016, from http://www.dphu.org/uploads/attachements/books/books_5216_0.pdf

Haddock, P. (2015). *Parix paper 30: Monitoring and evaluating training challenges opportunities and recommendations*. INTRAC. Retrieved June 25, 2016, from http://intrac.org/data/files/resources/871/Monitoring-and-Evaluating-Training.-Challenges-opportunities-and-recommendations-Praxis-Paper-30..pdf

Hamza, M. (2012). Training material development guide. Swedish Civil Contingencies Agency. Retrieved February 13, 2016, from https://www.msb.se/RibData/Filer/pdf/26433.pdf

Hart, L., Harber, L., Lee, C., Canoutas, E., Young, K., & Clapp, S. (2012). Moving evidence into action: Effective training practices. FHI 360 The Science of Improving Lives. Washington DC. Retrieved August 10, 2016, from https://www.fhi360.org/sites/default/files/media/documents/FHI_360_Effective_Training_Brief_0.pdf

Health Care Foundation. (2012). *Evidence scan: Quality improvement training for health care professionals.* Retrieved February 12, 2015, from http://www.health.org.uk/public/cms/

Hughes, E. (2005).Nurses' perceptions of continuing professional development. *Nursing Standard*, *19 (43),* 41-49. Retrieved October 11, 2014, from www.republishing.com

Holland, P., Allen, B. C. & Cooper, B. K. (2012). *What nurses want: Analysis of the first national survey on nurses' attitudes to work and work conditions in Australia.* Department of Management Monash University. Retrieved November 12, 2016, from http://anmf.org.au/documents/reports/What_Nurses_Want_Report.pdf

Hamza, M. (2012). Training material development guide. Swedish Civil Contingencies Agency. Retrieved February 13, 2016, from https://www.msb.se/RibData/Filer/pdf/26433.pdf

Husserl, E. (1970). *Logical investigations*: *Vol. 1 (N. Finlay, Trans).* New York, NY: Routledge.

In-service Department. (2012). *Report for January to March 2012*. Raleigh Fitkin Memorial Hospital.

In-service Department. (2012). *Report for October-December 2012*. Raleigh Fitkin Memorial Hospital.

In-service Department. (2013). *Report for April-June 2013*. Raleigh Fitkin Memorial Hospital.

In-service Department. (2014). *Report for January–March 2014.* Raleigh Fitkin Memorial Hospital.

In-service Department. (2014). *Report for April-June 2014*.Raleigh Fitkin Memorial Hospital.

In-service Department. (2014). *Report for July–September 2014*. Raleigh Fitkin Memorial Hospital.

Institute of Medicine. (2011). *The future of nursing: Leading change, advancing health*. Washington, DC: The National Academies Press. Retrieved November 1, 2014, from http://www.nap.edu/catalog/12956.html

International Council of Nurses. (2009). *ICN framework of competencies for the nurse specialist.* Geneva, Switzerland: Author.

International Council of Nurses., International Hospital Federation., International Pharmaceutical Federation., World Confederation for Physical Therapy., World Dental Federation., & World Medical Association. (2008). *Guidelines: Incentives for health professionals.* Retrieved September 10, 2016, fromwww.who.int/workforcealliance/documents/Incentives-Guidelines%20EN.pdf

International HIV/AIDS Alliance. (2003). *100 ways to energise groups: Games to use in workshops, meetings and the community*. United Kingdom. Retrieved May 9, 2016, fromwww.icaso.org/vaccines_toolkit/subpages/.../energiser_guide_eng.pdf

IntraHealth International. (n.d.). *Transfer of learning: Transfer of learning matrix*. Retrieved August 6, 2016, from http://www.intrhealth.org/tol/supervisors1.html

Intra Health International Inc. (2012). *Training and Learning Standards A checklist and tool for developing and implementing high-quality training and learning interventions*. Retrieved August 8, 2016, from http://www.intrahealth.org/files/media/training-and-learning-standards/Training_Learning_Standards_2012_En

IntraHealth Technical Leadership Department. (2013). *Optimizing performance and quality*. Chapel Hill: NC. Retrieved August 8, 2016, from http://www.intrahealth.org/files/media/optimizing-performance-and-quality/OPQ_FINAL.pdf

Israel, M., & Hay, I. (2006). *Research ethics for social scientists*. Sage Publications Ltd.

Jaradeh, M., &Hamdeh, H. A. (2010). Nurses' experiences of continuous professional development. *Jordan Medical Journal, 44*(3), *313-322*.Retrieved October 4, 2014, from http://journals.ju.edu.jo/JMS/article/

Jehanzeb, K., & Bashir, N. A. (2013). Training and development programme and its benefits to employee and organization: A conceptual study. *European Journal of Business and Management, 5*(2), 243-252. Retrieved February 6, 2016, from http://www.iiste.org

JHPIEGO. (2003). *Training works! What you need to know about managing, designing, delivering, and evaluating group-based training*. Baltimore. Maryland. Retrieved August 10, 2016, from http://www.intrahealth.org/files/media/training-works-/trainingworks.pdf

Joint United Nations Programme on HIV/AIDS. (2014). *Reduction of HIV related stigma and discrimination.* UNAIDS Information Production Unit. Retrieved August 8, 2016, from http://www.unaids.org/sites/default/files/media_asset/2014unaidsguidancenote_stigma_en.pdf

Kamp, M. (2011). *Facilitation skills and methods of adult education. A guide to civic education at grass roots level.* Kampala: Konrad-Adenauer-Stiftung. Retrieved February, 20, from http://www.kas.de/wf/doc/kas_29778-1522-2-30.pdf?111219190922

Karagiorgi, Y., &Symeou, L. (2007). Teachers' in-service training needs in Cyprus. *European Journal of Teacher Education*, *30*(2), 175-194. Retrieved June 3, 2016, from http://www.tandfonline.com/

Kaur, D., Singh, J., Seema, Mahajan, A., & Kaur, G. (2011). Role of interactive teaching in medical education. *International Journal of Basic and Applied Medical Sciences, 1*(1),54-60. Retrieved March 7, 2016, from http://www.cibtech.org/J-MEDICAL-SCIENCES/PUBLICATIONS/2011/Vol%201%20No.%201/12%20Interactive-teaching.pdf

Kebede, F., Asres, A., Gutema, K., &Wuliji, T. (2012). *Towards a national in-service training strategy : Workshop report*. Published by the United States Agency for International Development Health Care Improvement Project Bethesda, MD: University Research Co, LLC (URC). Retrieved July 7, 2014, from www.hciproject.org

Kebede, F., Gutema, K., Asres, A., Wuliji, T.,& Lanford, E. (2014). *Rapid assessment of health worker in-service education situation in Ethiopia: Survey of training program provider practices and key informant interviews. Research and evaluation report*. Published by the USAID Health Care Improvement Project. Bethesda, MD: University Research Co. LLC (URC). Retrieved July 7, 2014, from www.usaidassit.org

Kelly, L. (2008). *Teenagers' perceptions of advertising in the online social networking environment*. Unpublished master's thesis, Queensland University of Technology. Retrieved September 5, 2014, from http://eprints.qut.edu.au/26966/2/Louise_Kelly_Thesis.pdf

Kirkpatrick, D. L. (1994). *Evaluating training programs: The four levels.* San Fransisco, Carlifornia: Berrett-Koehler Publishers Inc.

Kirkpatrick, D. L. (2010). AT & D Classic: How to start an objective evaluation of your training program. In P. Keller (Ed.), *The best of measuring & evaluating learning/T&D* (pp. 3-5). Sponsored by DDI.

Kirkpatrick, D. L., & Kirkpatrick, W. K. (2010). ROE rising star. In P. Keller (Ed.), *The best of measuring & evaluating learning/T&D* (pp. 62-66). Sponsored by DDI.

Kitzinger, J. (1994). The methodology of focus group: The importance of interaction between research participants. *Sociology of Health & Illness.* (1), 103-121.

Kleinman (2004) Leadership: a key strategy in nurses' retention. *Journal of Continuing Education in Nursing, 35*(3), 128-132. Retrieved October 28, 2014, from http://tools.hhr.rhs.ca/

Kolb, D. A. (1984). *Experiential: Experience as the source of learning and development*. Englewood Cliffs, NJ: Prentice Hall. Retrieved on August 30, 2014, from http://www.businessballs.com/kolblearningstyles.htm

Kovner, C., & Brewer, C. (2013). *The RN work project a national study to track career changes among newly licensed registered nurses.* (Progress Report Grant ID: 51120, 57992). Robert Wood Johnson Foundation. Retrieved on October 28, 2014, from http://www.michigan.gov/.../rwjf_RN_work_project_465117_7.pdf

KPMG Consulting Barents Group. (2001). *Training of Trainers presentation and facilitation participant guide.* Retrieved February 20, 2016, from http://pdf.usaid.gov/pdf_docs/Pnadj934.pdf

Légaré, F., Andriana, F., Thompson-Leduc, P., Borduas, F., Luconi, F., Boucher, A., Witteman, H. O., & Jacques, A. (2015). The majority of accredited continuing professional development activities do not target clinical behavior change. *Academic Medicine, 90*(2).Retrieved April 5, 2015, from http://www.sacme.org/Resources/Documents/

Leave and claim form consultative meeting with supervisors. (2014, April 9). Raleigh Fitkin Memorial Hospital. (2014, April 9).

Letlape, H.R., Koen, M.P., Coetzee, S.K. & Koen, V., (2014). The exploration of in-service training needs of psychiatric nurses, *Health SA Gesondheid19*(1), Art. #763, 9 pages. http://dx.doi. org/10.4102/hsag.v19i1.763. Retrieved February 3, 2015, from www.hsag.co.za/index.php/HSAG/

Lincoln, Y.S. & Guba, EG. (1985). *Naturalistic Inquiry*. Newbury Park, CA: Sage Publications.

Lopez, K. A., & Willis, D. G. (2004). Descritive versus interpretive phenomenology: Their contributions to nursing knowledge. *Quality Health Research, 14*(5),726-735. Retrieved May 25, 2015, from www.ResearchGate>publications>links

Luoma, M., Ravishankar, N., Price, A., Bedford, J. & Mndzebele, A. (2011). *Using nonfinancial incentives to improve performance and retention among health workers: results from an impact evaluation in Swaziland.* Bethesda, MD:Health Systems 20/20 project, Abt Associates Inc. Retrieved August 10, 2016, from https://www.hfgproject.org/wp-content/uploads/2015/02/Using-Nonfinancial-Incentives-to-Improve-Performance-and-Retention-among-Health-Workers-Results-from-an-Impact-Evaluation-in-Swaziland1.pdf

Management Sciences for Health. (2012). *Access to medicine and health technology*. Arlington, VA: Management Sciences for Health. Retrieved February 10, 2016, from www.apps.who.int/medicinedocs/.../s19577en.pdf

Maree, K. & Van Der Westhuizen (2007). Planning a research proposal. In K. Maree (Ed.), *First steps in research* (1st ed., pp.24-44). Pretoria: Van Schaik.

Marinopoulos, S.S., Dorman, T., Ratanawongsa, N., Wilson, L.M., Ashar, B.H., Magaziner, J.L., Miller, R.G., Thomas, P.A., Prokopowicz, G.P., Qayyum, R., & Bass, E. B. (2007). *Effectivenessof continuing medical education*. Evidence report/technology assessment no. 149. Rockville, MD: Agency for Healthcare Research and Quality. Retrieved April 5, 2015, from http://archive.ahrq.gov/downloads/pub/evidence/pdf/cme/cme.pdf

Marshall, C., & Rossman, G. B. (2006). *Designing qualitative research* (4thed.).Thousand Oaks: Sage Publications. Retrieved June 7, 2015, from www.sagepub.com>upm-data

Marshall, C., & Rossman, G. B. (2010). *Designing qualitative research* (5th ed.). Thousand Oaks, CA: Sage Publications.

McCaffery, J. A., Joyce, S., Massie, B., Training Resources Group. & IntraHealth International. (2009). *Health worker retention and performance incentives: Making better strategic choices.* Capacity Project. NC: Chapel Hill. Retrieved August 9, 2016, from http://www.intrahealth.org/files/media/health-worker-retention-and-performance-initiatives-making-better-strategic-choices/techbrief_16.pd

McClure, P. (2013). *Making practice based learning work: Reflection in practice.*Retrieved April 22, 2016, from www.cw.routledge.com/.../data/.../8_Reflection%20in%20Practice.p.

Merriam, S. B. & Leahy, B. (2005). Learning transfer: Areview of the research in adult education and training. *Journal of lifelong Learning, 14, 1-24.* Retrieved March 6, 2016, from https://www.iup.edu/.../DownloadAss

Miller, J. A., & Osinski, D. M. (2002). *Training needs assessment*. Members of SHRM Training and Development Committee. Retrieved October 10, 2014, from http://www.ispi.org/pdf/suggestedReading/Miller-Osi

Ministry of Education & Training. (2011). *The Swaziland education and training sector policy*. Kingdom of Swaziland. Mbabane, Swaziland: Author.

Ministry of Health. (2009). *National health sector strategic plan 2008-2013.* Kingdom of Swaziland. Mbabane, Swaziland: Author.

Ministry of Health. (2010). *Service availability mapping report*. Kingdom of Swaziland. Mbabane, Swaziland: Author.

Ministry of Health. (2012). *Human resource for health strategic plan 2012-2017.* Kingdom of Swaziland. Mbabane, Swaziland: Author.

Ministry of Health. (2012). *Quality assurance strategic plan 2012-2016.* Kingdom of Swaziland. Mbabane, Swaziland: Author.

Ministry of Health. (2015). *In-service training guidelines*. Kingdom of Swaziland. Mbabane, Swaziland: The Human Resources Unit.

Ministry of Health &Social welfare. (2007). *National Health Policy.* Kingdom of Swaziland. Mbabane, Swaziland: Author

Ministry of Health and Social Welfare. (2009). *Strategy for national in-service education.* Republic of Liberia: Author. Retrieved February 3, 2015, from http://www.basics.org/.../National-In-Service-Education-Program Liberia.pdf

Mizell, H. (2010). *Why professional development matters.* Oxford: Learning forward. Retrieved February 12, 2015, from http://learningforward.org/docs/pdf/

Moorhead, S. A., Hazlett, D. E., Harrison, L., Carroll, J. K., Irwin, A., &Hoving, C. (2013). A new dimension of health care: systematic review of the uses, benefits, and limitations of social media for health communication. *Journal of Medical Internet Research*, *15*(4), e85. Retrieved June 8, 2016, from http://www.jmir.org/2013/4/e85/?utm

Motalingoane-Khau, M. S. (2010). *Women teachers talk sex: A gendered analysis of woman teachers' experiences of teaching sexuality education in rural schools in the age of HIV and AIDS.* Unpublished Doctoral thesis, Durban: University of KwaZulu-Natal.

Moustakas, C. (1994). *Phenomenological research methods.* Thousand Oaks, Carlifonia: Sage Publications. Retrieved January 13, 2015, fromhttp://www.inside-installations.org/OCMT/

Munhall, P. L. (2007). A phenomenological method. In P. L. Munhall (Ed.), *Nursing research: A qualitative perspective* (pp. 145-210). Sudbury, MA: Jones and Bartlett

National Archives. (2013). Effective Communications: Raising the profile of your archive service. United Kingdom: National Archives. Retrieved May 5, 2016, from www.nationalarchives.gov.uk/.../effective-commu...

National Council for the Professional Development of Nursing and Midwifery. (2004). R*eport on the continuing professional development of staff nurses and staff midwives.* Retrieved October29, 2014, from www.pna.ie/~pnaie/images/ncmc/ SNM%20%Report.pdf

Nazarene Health News. (2012). First Quarter.

Nazarene Health News. (2012). Third Quarter.

Nazarene Health News. (2013) First & Second Edition.

Ng, C., Pacquė- Margolis, S., Kotellos, K., & Brantley, S. (2012). Integrating family planning and HIV/AIDS services: Health workforce considerations. *Capacity Plus*. Retrieved August 7, 2016, from http://www.intrahealth.org/files/media/integrating-family-planning-and-hivaids-services-health-workforce-considerations/integra

Nieuwenhuis, J. (2007). Introducing qualitative research. In K. Maree (Ed.), *First steps in research* (1st ed., pp.47-66). Pretoria: Van Schaik.

Nieuwenhuis, J. (2007). Qualitative research designs and data gathering techniques. In K. Maree (Ed.), *First steps in research* (1st ed., pp.69-92). Pretoria: Van Schaik.

Norushe, M., Van Rooyen, D., & Strumpher, D. (2004). *In-service education and training as experienced by registered nurses.* Retrieved October 9, 2013, from www.Curationis.org.za/index.php/curationis/article/viewFile/1009/946

Ode, E. O. (2014). Impact of audio-visual (AVs) resources on teaching and learning in some selected private secondary schools in Makurdi. *International Journal of Research in Humanities, Arts and Literature, 2*(5),195-202. Retrieved May9, 2016, from www.impactjournals.us/download.php?...Impact%20of%20Audio-Visual..

Omar, C.M.Z.C. (2014). The need for in-service education for teachers and its effectiveness in school. *International Journal for Innovation education and research, 2(11),* Retrieved February 12, 2015, from http://www.ijier.net/assets/

Pearson, N., Lessor, E., & Sapp, J. (2010). *A new way of working. Insight from global leaders.* IBM Corporation: New York. Retrieved May 7, 2016, from ftp://public.dhe.ibm.com/software/.../pdfs/GBEO3295

Peeler, A., Fulbrook, P. S., & Kildea, S. (2013). The experiences of parents and nurses of hospitalized infants requiring oxygen therapy for severe bronchiolitis: A phenomenological study. *Journal of Child Health, 1(13*. Retrieved June 5, 2015, from www.resarchgate.net

Pellico, L., H., Brewer, C., S., & Kovner, C.T. (2009). What newly licensed registered nurses have to say about their first experiences. *Nursing Outlook*, 57 (4), 194-203. Retrieved August 10, 2016, from http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Vol152010/No1Jan2010/Articles-Previous-Topic/Changing-Work-Needs-of-New-RNs.html

Phillips, J. J. (2010). Measuring ROI: Fact, fad, or fantasy. In P. Keller (Ed.). *The best of measuring & evaluating learning/* T& D (pp. 30-35). Sponsored by DDI.

Pickard, A. J. (2007). Major research paradigms. In *Research methods in information* (pp. 12-18). London: Facet Publishing. Retrieved May 26, 2015, from http://www.facetpublishing.co.uk/downloads/file/pickard-ch1.pdf

Polit, D. F., & Beck, C. T. (2012). *Nursing research: generating and assessing evidence for nursing practice (9th ed.).* Philadelphia:Wolters Kluwer/Lippincot Williams & Wilkins.

Polit, D. F., & Beck, C. T. (2014).*Essentials for nursing research: appraising evidence for nursing practice* (8thed.). Philadelphia: Wolters Kluwer/Lippincott Williams & Wilkins.

Pool, I., Poell, R., & ten Cate, O. (2012). Nurses' managers' perceptions of continuing professional development for older and younger nurses: A focus study. *International Journal of Nursing Studies, 50(2013), 34-43.* Retrieved August 31, 2014, from http://www.researchgate.net

Potter, P. A., & Perry, A. G., (2009). *Fundamentals of nursing*. (7thed.). Louis Missouri: Mosby Elsevier.

Prince, M. (2004). Does active learning work? A review of the research. *Journal of Engineering Education, 93(3),* 223-231. Retrieved May 10, 2016, from http://www4.ncsu.edu/unity/.../Prince_AL.pdf

Quality Assurance Department. (2012). Report on QI training. Manzini: Swaziland Nazarene Health Institutions.

Quality Assurance Department. (2014). *End of year report.*Manzini: Swaziland Nazarene Health Institutions.

Rahimaghaee, F., DehghanNayer, N., &Mohammadi, E. (2010, November). Iranian nurses´ perceptions of their professional growth and development. *The Online Journal of Issues in Nursing*, *16*(1), Retrieved September 26, 2014, from http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Vol-16-2011/No1-Jan-2011/Articles-Previous-Topics/Iranian-Nurses-and-Professional-Development.html

Richards, L. E. (2007). *Perceptions of nurses with regard to continuing formal education.* Unpublished master's thesis, University of South Africa, Pretoria, South Africa. Retrieved August 29, 2014, from http://uir.unisa.ac.za/bitstream/handle/10500/572/

Rise, J., Sheeran, P., & Hukkelberg, S. (2010). Theory of self-identity in the theory of planned behavior: A meta-analysis. *Journal of Applied Social Psychology*, 40(1), 1085-1105. Retrieved, March 21, 2017, from http://files.2epub.net/sites/default/files/inputfiles/2013_3/900/the_role_of_self_identity_in_the_theory_of_planned_behavior_0.pdf

Rycus, J. S., & Hughes, R. C. (2000). *What is competency-based in-service training?.* Institute for Human Services. Retrieved February 12, 2015, from http://www.narccw.Org/TRAINet/Resource%20Paper%201.pdf

Saldana. (2013). Power and conformity in today's schools. *International Journal of Humanities and Social Science 3*(1), 228-232. Retrieved November 18, 2016, from http://www.ijhssnet.com/journals/Vol_3_No_1_January_2013/27.pdf

Sampson Jr, P. J. (2012). A guide to quantitative and qualitative dissertation research. *Educational Psychology and learning systems. Faculty Publications.* Paper 1.

Sava, S. (2012). Needs analysis and programme planning in adult education. Barbara Budrich Publishers. Toronto. Retrieved February 7, 2016, from http://s3.amazonaws.com/academia.edu.documents/

Scheckel, M. (2009). Nursing education: Past, present, future. In G. Roux & J. Halstead (Eds.), *Issues and trends in nursing* (pp. 27-55). Sudbury, Massachusetts: Jones and Bartlett. Retrieved February 17, 2015, from http://www.jblearning.com/samples/0763752258/52258_CH02_Roux.pdf

Seidenberg, P., Nicholson, S., Schaefer, M., Semrau, K., Bweupe, M., Masese, N., & Thea, D. M. (2012). Early infant diagnosis of HIV infection in Zambia through mobile phone texting of blood test results. *Bulletin of the World Health Organization*, *90* (5), 348-356. Retrieved June 6, 2016, from http://www.scielosp.org/

Seifert, K. (1983). *Educational psychology.* Boston: Houghton Miffin Company.

Sherman, R., O., Lynn, C., E., & Dyess, S. (2010). New Graduate Transition into Practice During Turbulent Economic Times. *Journal of Nursing Education,* 49(7), 367-368. Retrieved August 9, 2016, from http://www.healio.com/nursing/journals/jne/2010-7-49-7/%7B213d1c38-9961-4acd-bdab-9d56b784716d%7D/new-graduate-transition-into-practice-during-turbulent-economic-tim

Shosha, G. A. (2012). Employment of Colaizzi's strategy in descriptive phenomenology: A reflection of a researcher. *European Scientific Journal, 8(27),* 31-43. Retrieved August 27, 2014, from http://eujournal.org/index.php/esj/article/viewFile/588/657

Southey, G. (2011). The theories of reasoned action and planned behaviour applied to business decisions: A selective annotated bibliography. *Journal of New Business Ideas & Trends*, 9 (1), 43-50. Retrieved March 21, 2017, from http://www.jnbit.org/upload/JNBIT_Southey_2011_1.pdf

Surgenor, P. (2011). Tutor, demonstrator & coordinator development at UCD: Reflective practice. UCD Teaching and Learning/ Resources. Retrieved November 16, 2016, from http://www.ucd.ie/t4cms/Reflective%20Practice.pdf

Swaziland Nazarene Health Institutions (n.d.). *Presentation of SNHI.* Unpublished power point presentation, Raleigh Fitkin Memorial Hospital, Manzini, Swaziland. Bitchong, R: Author.

Swaziland Nazarene Health Institutions. (2012). *Annual performance report*. Swaziland Nazarene Health Institutions 2012/213.

Swaziland Nazarene Health Institutions. (2013). *Annual performance report.* Swaziland Nazarene Health Institutions 2013/2014.

Swaziland Nazarene Health Institutions. (2014). *Annual performance report*. Swaziland Nazarene Institutions 2014/2015.

Swaziland Nursing Council. (2010). *Nursing education & practice standards* (1st ed.). Mbabane, Swaziland: Author.

Swaziland Nursing Council. (2010). *The scope of nursing practice* (1st ed.). Mbabane, Swaziland: Author.

Swaziland Nursing Council. (2011). *A continuing professional development framework for Swaziland (1st ed.).*Mbabane, Swaziland: Author.

Swaziland Nursing Council. (2011). *Perceptions of learning needs and preferred teaching and learning methods among nurse midwives.* Unpublished study.

Tan, H., Wilson, A., &Olver, I. (2009).Ricoeur's Theory of Interpretation: An Instrument for Data Interpretation in Hermeneutic Phenomenology. *International Journal of Qualitative Methods.8 (4),* 1-15. Retrieved May 26, 2015, from http://ejournals.library.ualberta.ca>article

Tawfik, L. &Kinoti, N. (2006). *The impact of HIV/AIDS on the health workforce in developing countries.* Quality Assurance Project, University Research Co., LLC. World Health Organization. Retrieved November 12, 2016, from http://www.who.int/hrh/documents/Impact_of_HIV.pdf

Tax, S., S. & Stuart, I. (1997). Designing and implementing new services: The challenges of integrating service systems. *Journal of Retailing* 73 (1). Retrieved September 29, 2016 from http://www.producao.ufrgs.br/arquivos/disciplinas/508_tax_stuart_1997[1].pdf

Taylor, C.R., Lillis, C., LeMone, P., Lynn, P. A., & LeBON, M. (2011). *Fundamentals of nursing: The art and science of nursing care* (7th ed.).Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins.

The ACQUIRE Project. 2008. *Programming for training: A resource package for trainers, program managers, and supervisors.* New York: EngenderHealth/The ACQUIRE Project. Retrieved August 10, 2016, from https://www.engenderhealth.org/files/pubs/acquire-digital-archive/10.0_training_curricula_and_materials/10.2

The Human Resource for Health Knowledge Hub. (2009). *Mapping Human Resources for Health Profiles from 15 Pacific Island Countries.* Australian Agency for International Development. Retrieved November 19, 2016, from https://sphcm.med.unsw.edu.au/sites/default/files/sphcm/Centres_and_Units/SI_Mapping_15_PacificCountries-report.pdf

Tufford, L., & Newman, P. (2010). Bracketing in qualitative research. *Qualitative Social Work,* 11*(1),* 80-96. Retrieved June 2, 2015, from http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.915.1408&rep=rep1&type=pdf

Tuli. F. (2010). The basis of distinction between qualitative and quantitative research in social science: Reflection on ontological, epistemological and methodological perspectives. *Ethiopia Journal of Education & Science 6(1),* 97-108. Retrieved January 9, 2015, from www.ajol.info/index.php/ejesc/article/download/65384/53078

United Nations Children's International Education Fund. (1998). *Games and exercises. A manual for facilitators and trainers involved in participatory group events.* Nairobi: UNICEF-ESARO. Retrieved May 9, 2016, from http://www.click4it.org/images/5/55/Visualisation_in_Participatory_Programmes_-_Games_and_Exercises.pdf

United Nations Development Programme. (2009). *Handbook on planning, monitoring and evaluating for development results.* New York: UNDP

United Nations Educational Scientific and Cultural Organization. (2004). *Training guide and training techniques.* Thailand: UNESCO Asia & Pacific Regional Bureau for Education. Retrieved February 10, 2016, from http://unesdoc.unesco.org/images/0013/001356/135603e.pdf

United States Agency for International Development Applying Science to Strengthen and Improve Systems Project. (2014). *United States Agency for International Development Applying Science to Strengthen and Improve Systems Project experience improving HIV services*. Bethesda, MD, University Research Co., LLC (URC): Author. Retrieved July 7, 2014, from http://www.usaidassist.org

United States Agency for International Development Health Care Improvement Project. (2013). *A global improvement framework for health worker in-service training*. Retrieved August 28, 2014, from www.usaidassist.org

United States President's Emergency Plan for AIDS Relief (PEPFAR). (n.d.). *Training Evaluation Framework and Tools*. Retrieved September 1, 2014. http://www.go2itech.org/resources/TEFT/images-graphics-and-photos/Teft%20Framework%20Graphic.pdf

University Research Co., LLC. (2015). *Improving efficiency, effectiveness, and sustainability of in-service training in Swaziland.* Retrieved August 23, 2016, from https://www.usaidassist.org/sites/assist/files/swaziland_in_service_training_jun15_a4_ada.pdf

University Research Co., LLC Swaziland. (2014). *A report on the assessment of health worker in-service training in Swaziland.* University Research Co., LLC Swaziland: Author.

Valva, L. (2009). Benefits of using newspapers, magazines and books in classroom. *LCPJ Publishing, 2(2)* 12-17. Retrieved May 9, 2016, from www.lcpj.pro/skedaret/1354544987-Article%2011.pdf

Van Rensburg, G. H., Alpaslan, A.H., Du Plooy, G.M., Gelderblom, D., Van Eeden, R., &Wigston, D. J. (2010). *Research in the social sciences.* Pretoria: University of South Africa.

Vellios, G. (2010). On the level. In P. Keller (Ed.), *The best of measuring & evaluating learning/T&D* (pp. 36-39). Sponsored by DDI.

Wojnar, D. M., & Swanson, K. M. (2007). Phenomenology: An exploration. *Journal of Holistic Nursing, 25(3),* 172-180. Retrieved September 20, 2014, fromhttp://jhn.sagepub.com/cg/content/abstract/25/3/172

World Health Organization. (1987). *Report of a WHO expert committee on the role of hospitals at the first referral level* (Technical report series 744). Geneva: Switzerland: Author. Retrieved June 6, 2015, from www.whglibdoc.who.int

World Health Organization. (2004). *A glossary of terms for community health care and services for older persons* (Vol. 5). World Health Organization Centre for Health Development. Geneva, Switzerland: Author. Retrieved June 6, 2015, from www.WorldHealthOrganization>ageing>ah...

World Health Organization (2006). *World health report 2006. Working together for health.* Geneva, World Health Organization. Retrieved July 6, 2016, from http://www.who.int/whr/2006/en/

World Health Organization (2013). *Transforming and scaling health professionals' education and training. WorldHealth Organization Guidelines 2013.* Switzerland: WHO Library Cataloguing-in- Publication Data. Retrieved May 16, 2014, from http://www.who.int/hinari/en/

World Health Organization. (2014). *Human resources for health: Foundation for universal health coverage and the post-2015 development agenda. Report of the Third Global Forum on Human Resources for Health.* WHO Press. Geneva: Switzerland. Retrieved August 8, 2016, from http://www.who.int/workforcealliance/knowledge/resources/report3rd_GF_HRH.pdf

World Health Organization. (2015). *Health workforce 2030 towards a global strategy on human resources for health.* WHO Press. Geneva. Retrieved September 10, 2016 from http://www.who.int/hrh/documents/15-295Strategy_Report-04_24_2015.pdf

World Health Organization & JHPIEGO. (2005). Effective teaching: A guide for educating health care providers. Geneva: WHO Press. Retrieved August 10, 2016, from http://apps.who.int/iris/bitstream/10665/43372/2/9241593806_facilitator.pdf

Wuliji, T. (2014). *What we have learned so far: The in-service training session in a nutshell.*Blog post January 5, 2014.Retrieved on July 7, 2014, from http://www.usaidassist.org/blog/harversting-good-practices-lessons-learnt

Yfantis, A., Tiniakou, I. &Yfanti. E. (2010). Nurses' attitudes regarding continuing professional development in a district hospital of Greece. *Health Science Journal*, 4(3). Retrieved August 31, 2014, from www.hsj.gr/volume4/issue3/440.pdf

Yumkella, F. (2005). *Retention: Health workforce issues and response actions in low-resource settings.* The Capacity Project: IntraHealth International, Inc. Retrieved August 8, 2016, from http://courses.washington.edu/thesis/Manual%202/1_Literature/Retention_Resource_Paper_05.pdf

Yumkella, F. & IntraHealth International. (2006). *Retention of health care workers in low-resource settings: Challenges and responses.* Chapel Hill, NC: Capacity Project. Retrieved August 31, 2016, from http://www.capacityproject.org/action_workshop/source_file/resources/retention.pdf

APPENDIX A: CONSENT LETTER FROM THE HOSPITAL

22 December 2014

Khawulile Magagula
University of Kwazulu-Natal

Dear Madam

RE: AUTHORIZATION TO DO A RESEARCH IN THE HOSPITAL

Your application on the fore mentioned endeavors has been duly considered and Authorization granted on the following conditions please;

a). That confidentiality is strictly observed
b). That the hospital receives a copy of the report on the proposed research.

Again thank you for considering the Institution for such a task and wishing you all the best.

Sincerely yours

APPENDIX B: CONSENT LETTER FROM SWAZILAND SCIENTIFIC AND ETHICS COMMITTEE

Telegrams:
Telex:
Telephone: (+268 404 2431)
Fax: (+268 404 2092

MINISTRY OF HEALTH
P.O. BOX 5
MBABANE
SWAZILAND

THE KINGDOM OF SWAZILAND

April 13th, 2015

Miss Khawulile Magagula
Principal Investigator
MBABANE

REF: MH/599C/ FWA 000 15267/ IRB 000 9688

Dear Miss Magagula,

RE: Experiences of nurses regarding in-service training in a hospital in Swaziland

The committee thanks you for your submission to the Swaziland Scientific and Ethics Committee, an expedited review was conducted.

In view of the importance of the study and the fact that the study is in accordance with ethical and scientific standards, the committee grants you authority to conduct the study. You are requested to adhere to the specific topic and inform the committee through the chairperson of any changes that might occur in the duration of the study which are not in this present arrangement.

The committee requests that you ensure that you submit the findings of this study (**Electronic and hard copy**) **and the data set** to the Secretariat of the SEC committee.
The committee further requests that you add the SEC Secretariat as a point of contact if there are any questions about the study on 24047712/24045469.

MINISTRY OF HEALTH
Swaziland Scientific and Ethics Committee (SEC)
15 APR 2015
P.O. Box 5 Mbabane H100
SWAZILAND

Yours Sincerely,

RUDOLPH T.D. MAZIYA
THE CHAIRMAN, SEC

cc: SEC members

APPENDIX C: CONSENT LETTER

18 December, 2014

INFORMED CONSENT LETTER

I am a student at the University of KwaZulu-Natal, College of Humanities, in the School of Education, Edgewood Campus, studying towards a Master of Education degree. My name is Khawulile Magagula. I am under the supervision of Doctor Thoko Mnisi. I am undertaking a research study on the experiences of nurses regarding in-service education in Swaziland, which will be conducted at your hospital. The title of my study is 'exploring nurses' experiences of in-service training at a hospital in Swaziland.' You are requested to take part in the study. Your participation will require that you go through a one hour interview and on a later date a two hour focus group discussion so that I can collect information on the study. You will be asked some questions during the interview. The study may help to uncover good aspects of nurses' in-service training, including challenges and recommendations for improvement.

Please be assured that:

- The study has been permitted by the University's Ethics Committee, your hospital's administration and the Swaziland Ethics Committee.
- You are free to choose to participate or not to participate in the study, not to give information and to withdraw at any point from the study. You will not be punished if you chose not to participate, withhold information or withdraw from the study.
- There are no anticipated risks or harms from participating in the study. Researcher will try to address any arising concerns or discomfort.

- Your personal identity and that of your institution will not be disclosed when reporting or publishing research findings, to safeguard your confidentiality. An identification code will be used instead of your name on interview information you give, including records and files. Your particulars may also be concealed or a general description used in an effort to maintain confidentiality.

- Any information given by you cannot be used against you, and the collected data will be used for purposes of this research only.

- Researcher will be solely responsible for transcribing interview and focus group discussions audio records. The researcher's supervisor and other academic team members may review research study data to ascertain the integrity of study findings.

- Study records will be kept unnamed in a protected storage at the University of KwaZulu-Natal in line with contemporary standards. Records will be destroyed after 5 years.

- Your involvement is purely for academic purposes only, and there are no financial benefits involved.

- Outcomes of the data you will provide will be shared with you as needed to confirm the truthfulness of findings, up to the final report.

- You are free to contact me or my supervisor at any phase of the study, should you have any question.

If you are willing to be interviewed, please indicate in the space provided below by ticking whether you can be audiotaped or not by the researcher.

Willing	**Not Willing**
Audio equipment	

I can be contacted at:

Email: khawulilem@gmail.com

Cell: + 268 7607 5408

As already mentioned above, my supervisor is Doctor Thoko Mnisi. Her contact details are as follows:

Tel: +27 (0) 31-2607476, Cell: +27 (0) 84 400 1137, E-mail : mnisi@ukzn.ac.za

The University of KwaZulu-Natal's Humanities and Social Sciences Research Ethics Committee (HSSREC) can be contacted as thus:

Mr. Prem Mohun

University of KwaZulu-Natal

HSSREC Research Office

Goven Mbeki Centre

Durban

4000

Tel: +27 (0) 31- 260 4557, E-mail: mohunp@ukzn.ac.za

The Swaziland Scientific and Ethics Committee (SEC) can be contacted at:

SEC Secretariat

Ministry of Health

Strategic Information Department

Omnicentre, Mbabane

Swaziland

Tel: +268 2404 7712 / +268 2404 5469, E-mail: babazileshongwe@gmail.com

Thank you for your input in this research.

Sincerely

Khawulile Magagula

APPENDIX D: DATA GENERATION

Data collection schedule for study on Exploring nurses' experiences of in-service training at a hospital in Swaziland

Serial No.	Activity	Date	Departments involved	Duration	Venue
1	Bracketing interview	24.04.2015	Researcher/Interviewer	1 hour	Hospital Medical Library
2	Piloting a. Interviews	27-29 .04. 2015	3 nurses from in & out patient departments: Nursing Sister, Staff Nurse, Nursing Assistant	1 hour each	At the nurse's department/ Medical Library
	b. Focus group discussion	30.04.2015	The above 3 nurses	2 hours	Medical Library
3	**Interviews**	**4-15.05.15**	**10 people(8 nurses from in & out patient departments, a matron & a quality improvement coordinator**	**1hour each**	**Nurse's department/Medical Library**

APPENDIX E: INTERVIEW GUIDE

Interviewer: _____ Interviewee code: _____

Date:_____

Venue:_____ Time:_____

What are your experiences regarding in-service training for nurses in this facility?

_____

_____

_____

- What topics were covered?, when,

_____

_____

- What was your role in these?,

_____

- How were the programs offered?

_____

_____

- Who offered them? What form of support was offered after training?

_____

How did you benefit from the in-service education sessions attended in this facility?

_____

_____

_____

_____

What enhances or makes these experiences better or successful

What enhances or makes these experiences better or successful?

_____

_____

_____

What retards or makes these experiences worse or unsuccessful?

_____

_____

_____

(i.e. Think back over in the past 3 years / past year/ months you have participated in an in-service training. Tell me your fondest memories / what particularly went well/ what were the challenges?)

_____

_____

- Any other challenges you have experience in in-service training in this hospital?

_____

How can the provision of in-service education for nurses be improved in this facility?

- Suppose you were in charge and could make one change that would make nurses in-service training better at this hospital. What would you do? (This will be a follow up question)

_____

_____

_____

_____

Is there anything else you would like to tell me or any question you would like to ask?

_____

_____

_____

Is it alright with you for me to come back to talk to you again, in case more questions arise or I wish to ascertain the truthfulness of my understanding of your responses.

Demographic data

Age :

Gender :

Designation :

Department :

Year employed :

Qualifications :

SNC registration :

Current license :

Thank you for your participation and contribution.

APPENDIX F: FOCUS GROUP DISCUSSION GUIDE

Welcome

- Introduction of moderator and recorder.
- Circulate sign in sheet for participants to indicate demographic data, designation , carder

Purpose

- Explain to group that researcher is undertaking a study on the experiences of nurses regarding in-service education in Swaziland.
- Topic of the study is 'Exploring nurses' experiences of in-service training at a hospital in Swaziland'
- The study may help to uncover good aspects of nurses' in-service training, including challenges and recommendations for improvement.
- Each participant in the group was requested to participate in the focus group because they have participated in in-service trainings offered by the hospital. Their experience of in-service education in this hospital is valuable to the study, as it seeks to discover those experiences.
- The focus group discussion will help in learning those experiences, gaining more understanding of the experiences and confirming the experiences.

Logistics

- Focus group will last for about two hours.
- Discussions will be audio recorded by cell phone.
- Refreshments are available at the end of the session.

Guidelines

- Everyone should feel free to speak and participate as your views are important
  .
- No right or wrong contribution.
- Feel free to state any differing opinion, but respect and listen to others as they share their views.
- Both negative and positive comments important, in some instances negative comments are most helpful.
- Speak to the group, aloud to be heard due to recording.
- Keep information shared confidential.
- Request to switch off cell –phones etc. to minimise disturbances.
- Assure participants of confidentiality and that no names will be used in transcripts and final report.
- Moderator will help to guide the discussions.
- Ask participants if there are any questions before the discussion and recording begins.

Moderator: _____ Recorder _____ Date_____

Venue:_____ Time_____

QUESTIONS

What are your experiences regarding in-service training for nurses in this facility? (How have you been involved in nurses in-service training at this hospital?)

How did you benefit from the in-service education sessions attended in this facility?

Think back over the past 3 years you have participated in an in-service training at the hospital, and tell us your fondest memories?

Think back over the past year of the in-service trainings that you attended at this hospital. What went particularly well?

What were the challenges?

What needs improvement?

How can the provision of in-service education for nurses be improved in this facility? (Suppose you were in charge and could make one change that would make nurses in-service training better in the hospital. What would you do?)

What can each one of us do to make nurses in-service training better at this hospital?

Conclusion

Of all the things we discussed, what to you is the most important?

Moderator will give summary of key points then ask: Is this an adequate summary?

Moderator will review purpose of study, then ask: Have we missed anything?

Is it alright with you for me to come back to talk to you again, in case more questions arise or I wish to ascertain the truthfulness of my understanding of your responses.

Thank participants for their participation and contributions. Invite them to refreshments.

APPENDIX G: SAMPLE SIGNIFICANT STATEMENTS TRANSCRIPT 1

Significant statement	Transcript No.	Page No.	Lines no.
Okay, okay the good part about the in-service training, eh, is that we are up to date with the information, especially if may be there are new things that have arised maybe.	1	4	1-3
Um, but I have the bad part about, some of them I've written here (opening a script of paper and looking through it).	1	4	7
most of the time there is no time to attend because of i (the) shortage … of staff.	1	4	11-13
And another thing that I've observed is that there is no dissemination of information. if I go for training when I come back…. There won't be that dissemination of information…. everybody will keep the information to him or herself.	1	4	15-16, 18, 20
		5	2
Another thing, maybe there is no schedule or plan ahead.	1	5	4
so you find that there are same people who will be attending because there is no schedule.	1	5	10-11
It improves our skills, of training.	1	6	7
Okay PMTCT … PMTCT is more or less the same with HTC.	1	6	17-20
October twenty thirteen.	1	7	11
currently we've learned about empathy.	1	7	2
The HTC its twenty fourteen I think beginning of twenty fourteen	1	7	15

It was learning and discussion with PMTCT and practicals. We were doing practicals, there were some role plays.	1	8	7-8
We were participating, sometimes we were a patient, or a nurse role playing.	1	8	10 - 11
Yes a participant.	1	8	14
Eh teaching, videos some audios sometimes.	1	8	16
Yes, flipcharts.	1	9	6

APPENDIX H: SAMPLE FORMULATED MEANINGS TRANSCRIPT 1

Significant statement	Formulated meanings
" the good part about the in-service training, eh, is that we are up to date with the information, especially if may be there are new things that have arised maybe" (Transcript 1, page 4, lines 1-3).	A positive aspect about the hospital in-service is that nurses are updated with information especially new developments.
" but I have the bad part about, some of them I've written here (opening a script of paper and looking through it)" (Transcript 1, page 4, line 7).	Participant indicates that the hospital in-service training also has bad aspects.
"Most of the time there is no time to attend because of (the) shortage … of staff" (Transcript 1, page 4, lines 11-13).	Participant elaborates that there is no time to attend in most instances due to staff shortage.
"And another thing that I've observed is that there is no dissemination of information. … if I go for training when I come back…. There won't be that dissemination of information…. everybody will keep the information to him or herself"(Transcript 1, page 4, lines 15-16, 18,20, and page 5, line 2).	There is also no dissemination of information after attending a training, information remains with that person.
"Another thing, maybe there is no schedule or plan ahead" (Transcript 1, page 5, line 4). challenge	An in-service schedule or plan is also not provided in advance.
".so you find that there are same people who will be attending because there is no schedule" (Transcript 1, page 5, lines 10-11).	Same people attend in-service trainings due to the lack of schedule.
"It improves our skills, of training" (Transcript 1, page6, line 7).	In-service training improves nurses' skills.
"Okay PMTCT … PMTCT is more or less the same with HTC. October 2013" (Transcript 1, page 6, lines 17-20, and page 7, line 11).	PMTCT is a topic that was covered in 2013 and it is similar to HTC.
"..currently we've learned about empathy" (Transcript 1, page 7 , line 2).	Participant attended a training on empathy in 2015.

“The HTC its twenty fourteen I think beginning of twenty fourteen” (Transcript 1, page 7, line 15).	Participant attended HTC training in 2014.
“It was learning and discussion with PMTCT and practicals. We were doing practicals, there were some role plays” (Transcript 1, page 8 , lines 7-8).	In the PMTCT training participants were taught through learning, discussion, practicals and role plays.
“We were participating, sometimes we were a patient, or a nurse role playing” (Transcript 1, page 8 , lines 10-11).	Trainees were actively involved in training through role playing.

APPENDIX I: SAMPLE CONSTRUCTION OF THEME CLUSTER

CONSTRUCTION OF CLUSTERS/ THEMES FOR THEME 1, UNDER EXPERIENCES OF IN-SERVICE TRAINING FROM

FORMULATED MEANINGS AND THEME CLUSTERS

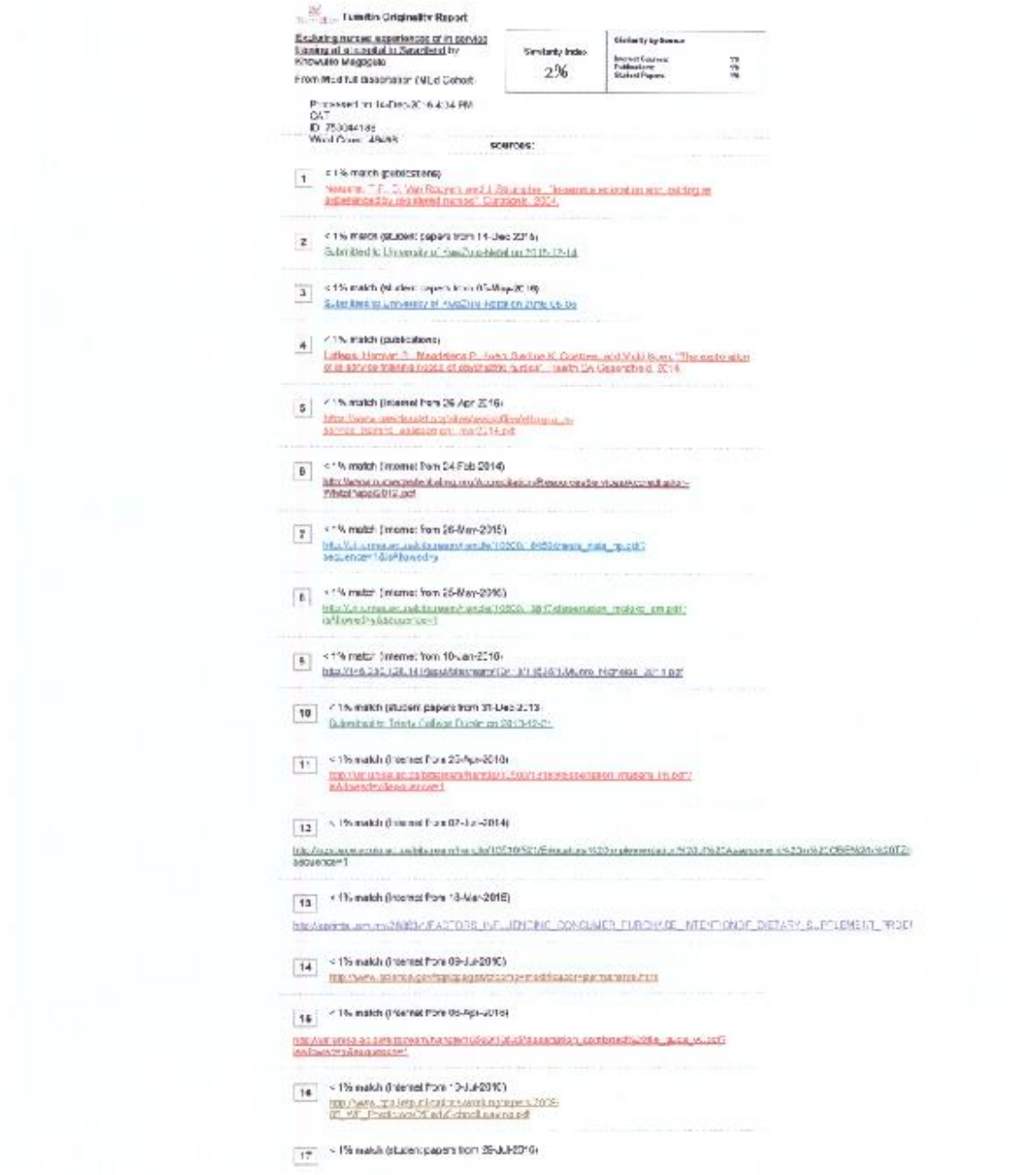
Formulated meanings	**Theme clusters**	**Emergent theme**
In the hospital in-service training is often planned. Units are informed about the topics in order to organize who will go for the trainings. P4 Some trainings are planned whilst others come haphazardly. P4	Planning of in-service training	Organisation of in-service training
The training was organized, department was informed earlier, they managed to arrange who would attend, and participant was ready. P1		
In-service is planned there are usually set dates for some trainings. P11		
Participants were not informed prior about expectations of the course, like for NARTIS training. P6		
Participant was surprised to attend the course when not trained on the basic one and that she had to supervise those who had the basic course. P5		

The in-service office informed them about the trainings. P5	Notification about in-service training	
Wards are informed about in-service through memo, time is also stated. P7		
Message is passed on from one person to another, it might be distorted when it is received, mostly the telephonic ones. P10		
Witten invitations are better everything is more clear. P10		
Nurses are notified about the specific topics being offered and training dates. P10		

Formulated meanings	**Theme clusters**	**Emergent theme**
Nurses are informed on time about in-service training in the hospital. P10	Notification about in-service training	Organisation of in-service training
Reflects on a training that was held at Lugogo, Ezulwini. You may not know training. Was informed through whatsapp P4		
Matron receives message for external training and ensure that a nurse is delegated. P10	Selection/ delegation of nurses	

The in-charge assigns nurses for hospital based trainings.P10		
As a supervisor she would inform the nurses when it is their turn and they would attend. P5		
Facility compiles a comprehensive list of nurses who need to go for in-service. P3		
Recalls register from Ministry of Health where biographic and other data is recorded. P5	Documentation of in-service training	
Indicates that there is a register from Nursing Council that requires nurses to obtain hours for license renewal. P6		
The nursing department has a booklet for nurses to record in-service hours and for annual license renewal. P11		
Facility has also developed a booklet that is currently sufficient to be issued to doctors. P11		

TURNIT IN CERTIFICATE



Turnitin Originality Report

Similarity Index
2%

sources:

1 < 1% match (publications)

2 < 1% match (student papers from 14-Dec-2016)

3 < 1% match (student papers from 07-May-2016)

4 < 1% match (publications)

5 < 1% match (Internet from 26-Apr-2016)

6 < 1% match (Internet from 24-Feb-2014)

7 < 1% match (Internet from 26-May-2015)

8 < 1% match (Internet from 25-May-2016)

9 < 1% match (Internet from 10-Jan-2016)

10 < 1% match (student papers from 31-Dec-2013)

11 < 1% match (Internet from 23-Apr-2016)

12 < 1% match (Internet from 07-Jun-2014)

13 < 1% match (Internet from 13-Mar-2015)

14 < 1% match (Internet from 09-Jul-2016)

15 < 1% match (Internet from 05-Apr-2016)

16 < 1% match (Internet from 2-Jul-2016)

17 < 1% match (student papers from 25-Jul-2016)