NURSES' EXPERIENCE OF CONTESTING DISCOURSES IN HIV/AIDS ACTIVITIES IN THE PRIMARY HEALTH CARE SETTING

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ABSTRACT

This paper explores the experience of nurses who work both as Primary Health Care Providers and counsellors trained in the narrative model of counselling in primary health care settings. Five focus groups were conducted in both Xhosa and English. Discourse analysis was used as a method of analysing the data. Training nurses in the narrative counselling model introduced an alternative discourse, which was experienced as contradicting their usual way of working. Two dominant discourses were the "not knowing" approach, assumed by the narrative model of counselling, and the "knowing" stance, assumed by health education. The institutionalised construction of counselling by doctors and matrons, and their power versus the power of the nurse counsellors was also cited as sources of conflict. Despite the tensions, narrative model of counselling seems to be offering new positions, which may benefit people living with HIV and improve HIV/AIDS activities in the Primary Health Care (PHC) context.

1. INTRODUCTION

The aim of the study was to explore the experience of nurses trained within a medical model and working in Primary Health Care (PHC) clinics. These nurses were trained in a narrative approach to HIV/AIDS counselling. In this paper the author reveals contradictions experienced by the nurses in their practice after training.

In the context of PHC, nurses are required to integrate preventative and promotive health care with a wide variety of curative services. This has meant adding new responsibilities to a service that has never been without problems. Walker (1995) argues that nurses working in the PHC context perceive this approach negatively because of the additional workload. They also perceive their position and their function in this context to be characterised by ambiguity and confusion. Lack of support and power struggles with nursing managers and doctors lie at the root of their problems.

A similar case is made by Petersen (1998) who describes introducing or integrating mental health care activities into PHC from a psychiatric perspective. This perspective entrenches the existing power dynamics within the medical discourse which works against the vision of PHC. The author further states that there is a need for a paradigm shift in the biomedical discourse that characterises the relationship between the health care consumer and primary health care providers.

In this paper some aspects of the training and practice of nurses working within the PHC context have been deconstructed to explore how discursive positioning mediates HIV/AIDS counselling activities.

In this paper I argue that training nurses in narrative counselling has introduced an alternative discourse in the PHC setting. The narrative approach to counselling is experienced as contesting with the dominant medical discourse in this context. Engaging in this discourse, which seems to offer new positions may benefit people living with the HIV virus and those suffering from AIDS.

Introducing nurses to the narrative model of working increased their awareness of power and may allow them to be more self-reflective and encourage a critical stance in their practise.

Of significance to this study is Foucault's understanding of the power of the medical discourse. In a Foucauldian sense the power of the medical discourse is a disciplinary power that provides guidelines about how patients should understand, regulate and experience their bodies (Vaughan, 1991). Medical observations and physical examination which includes asking questions, taking measurements such as blood pressure, using the Diagnostic Statistical Manual of Mental Disorders (DSM) booklet, and comparisons against set criteria, are all ways of making a diagnosis. All these activities are central to this power. Understood this way power is not oppressive or dominant but relational and invested in all social groups. In analysing this power Vaughan (1991) further states that the idea that individuals or groups might be posited in different relationships with power is not a possibility since this would involve conceptualising power as external to the individual.

This paper argues that a Foucauldian analysis of power has some limitations in understanding the experience of nurses working in PHC in HIV/AIDS activities and counselling.

2. THEORETICAL CONTEXT

2.1 Introduction

In this discussion a discourse is understood as a "set of ideas embodied as structuring statements that underlie and give meaning to social practices, personal experience, and organisations or institutions. Discourses often include the taken-for-granted assumptions that allow us to know how to go on in social situations of all kinds. They are linguistic in nature (provided that language is taken to include non-verbal as well as verbal practices)." (Monk, Winslade, Crocket, Epston, 1995, p.302). Through language people position themselves in discourses, and it is through these discourses that positions are made meaningful (Harris, Lea, Foster, 1995). Similarly Burr (1995) states that language in the form of discourses provides subjective experience of the world and further argues that these discourses show up in the actual things that people say and write. These are dependent upon the discursive context in which they appear.

In this sense language is the focus of interest and people use their language to construct versions of the social world. In a Foucauldian sense language is an instrument of power and power is directly linked to the ability to participate in the discourses that shape society (Burr, 1995). In her work on AIDS prevention Strebel (1997) illuminates this point further by highlighting the dual nature of discourses and how power relations are produced and reproduced through ideological systems. She states "discourses are the means through which the world emerges and actions become possible, but they constrain which meanings or knowledges become dominant. At different times for different reasons some versions of social reality are deemed legitimate, given voice and reside in the hands of experts while other are silenced". (p.111).

According to Monk et al (1995) this notion about discourses helps us to draw attention to the idea that what counts as coherent or meaningful depends on power relations. Discourses organise and regulate human interactions as power relations. Through discourses people are positioned in relation to each other and these positions have consequences for the way relationships are experienced. The authors further draw our attention to the notion of multiple positioning in discourses by stating that it is possible to hold more than one position within the same discourse, while it is

possible to hold positions in several discourses at the same time. In these discourses each position brings a variety of expectations.

2.2 Locating discourses within a socio-political context of primary health care

The significance of discourses will be more fully appreciated against the history of health care provision in the Eastern Cape. Primary health care is defined by the World Health Organisation (WHO) as essential health care based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation, at a cost that the community and country can afford to maintain at every stage of their development (WHO, 1988 p.10).

In South Africa, PHC is the underlying philosophy for the restructuring of the health system. The primary objective of this political strategy is to reduce inequalities in access to health services, especially in rural areas and deprived communities, as is the case in the Eastern Cape.

Primary health care as a discourse seeks to change the medical culture where the consumer of health care becomes a passive, powerless recipient, and health providers are dispensers of health care. In the PHC discourse the health care consumer is positioned as a partner and the professional assumes the role of facilitator, consultant, catalyst, and a resource who acts in collaboration rather than in opposition to the people.

The repositioning of both health care consumer and health care provider encourages collective action. Ideally, there should be redistribution of power, which means that health care delivery is a collaborative, enabling empowering process (Barnes, et al, 1995).

Implicit in this approach is the notion that health care providers should learn to trust people to take responsibility for their own care and learn to facilitate independence rather than create dependence. This represents a major mind set shift for many health care providers.

Primary health care delivery is comprehensive and includes primary prevention, which is prevention before illness. It focuses on prevention strategies like health education and promotion of healthy lifestyle. Secondary prevention includes curative services, and identification of those at risk. Tertiary prevention focuses on continuity of care after illness and includes rehabilitation.

It is important not to confuse these concepts with levels of health care which describe level of specialization in a service. This has nothing to do with prevention. PHC does not only refer to primary prevention. All levels of care should be present within this discourse (Uys & Middleton, 1997). PHC should also not be confused with primary care, which refers to the first contact the person has with health delivery and has a primary focus on treatment and restoration. Similarly it should not be confused with primary nursing, which refers to one nurse who is responsible for co-coordinating, planning and evaluating nursing care of a patient (Cooney, 1994).

Although there has been growth and movement towards this approach, mental health still remains the preserve of highly specialized and generally centralized hospital and private institutions, and remains a neglected component within PHC (WHO, 1990).

Despite its broad philosophical nature, and comprehensiveness of skills, nurses provide the bulk of services within primary health care. In many ways they are filling the gaps in a service which lacks health care personnel, such as social workers, psychologists, and pharmacists, who are needed to address the many health needs which nurses confront daily in the PHC context. The power occupied by the medical discourse within the South African health system contributes to a construction of PHC as cheap, simple or second class health care. The human rights discourse of PHC becomes less dominant within this context.

Given this situation nurses within this context are responsible for a wide range of curative and preventive services. These services include diagnosing and treating, informing and counselling HIV positive patients, and ordering and dispensing drugs. Nurses thus bear the brunt of a health system which is functioning without an adequate complement of human resources.

The training of many health professionals, including that of nurses, lacks skills and knowledge needed to function effectively within The primary health philosophy which is based on post-modern values of equality and justice. According to Uys et al (1997) there is a need for reorientation and training. Although PHC is constructed as a discourse about change, it is still entrenched within the medical model.

Although nursing education has experienced a remarkable growth during the 1990's, leading to new paradigms of nursing training and education, such as community – based education – problem based learning (CBE – PBL), the biomedical discourse has continued to dominate the nursing curriculum. The biomedical discourse, which dominates nursing education, has its origins within positivism. Positivism is a philosophy, which is rooted in modernity and therefore makes claims to objectivity, truth and certainty in defence of a scientific approach (Leistyna, Woodrum, Stephen & Sherblom, 1996).

Based on positivism, the biomedical discourse assumes that there is an objective reality that exists independent of human discovery and not a creation of human beings. In this approach knowledge is seen as neutral and universal rather than a social construction reflecting certain interests and ideologies.

While acknowledging the usefulness of such knowledge in informing a competent, skilled professional, such an instrumentalist and reductionistic view ignores personal beliefs and feelings of the person engaged in the process. It is, therefore, unable to capture human experience holistically and meaningfully. The true nature of the relationship is ignored.

The biomedical discourse has informed the popular scientific nursing process which guides nursing practice. Developed by Yura and Walsh, the nursing process is described by Clark (1996) as a method that is efficient in organizing thought processes for clinical decision-making and problem solving. The use of this scientific approach involves a planned execution of a series of steps, namely assessment, planning, implementation, diagnosis and evaluation. Clark further describes these steps as circular, cyclic and sequential, in that each step depends on adequate performance or prior steps. Through the use of mainly objective data, observed and described by the nurse, and subjective data, reported by others about the patient, the

nurse follows the steps of the nursing process in her practice as the objective observer or change agent.

This knowledge construction of separating the stages of the nursing process encourages the nurse to abstract her/himself from the social context when dealing with the patient. It also encourages the nurse to position her/himself as a change agent who is outside of the process, carrying out a procedure at a certain stage of the process. The patient becomes the object of this procedure, and makes no contribution to her/his health care. The person's knowledge is disregarded as the nurse responds to symptoms rather than the whole person. This is done by focusing on dynamics and causes in the quest for a diagnosis by the nurse.

Such knowledge construction leads to the nurse theorizing about the patient and not about her/himself. The nurse's subjectivity in the process is denied. There is an overemphasis on content rather than processes. I want to argue from my own personal experience, as a student of nursing and a nurse educator, that while such discourses are useful in informing the nurse to be a technically competent professional, self-reflection is not encouraged and, therefore, personal development is ignored.

Such knowledge construction can lead to insensitivity to the social and political context of caring and to ethnocentric assumptions, and biases in terms of culture, race, history and social status. As a result of the scientific approach, emphasis on content, replicability, generalization and applicability of rules, the compilation of the nursing diagnosis has led to nursing care plans that can be used for patients with certain diagnoses. These are compiled by asking direct questions from an expert position. These are used as if they hold truth for all patients in all contexts.

Using standardized nursing care plans amounts to approaching people as objects. The professional herself/himself functions as an objective instrument that will fix the ills and pain of the patient without being involved. A nurse patient relationship informed by such knowledge is inconsistent with the empowerment discourses that are desired by the PHC philosophy.

Consistent with this knowledge construction is the medicalised discourse on sexuality and sexually transmitted diseases. People are viewed as being at risk, needing expert care and knowledge to control their destiny. In addition he pre-modern attitudes of Christian morality and an understanding of syphilis and gonorrhoea caused by excessive sexuality still prevail.

Within the primary health care sites HIV/AIDS activities take place mostly at maternal and child health clinics, family planning and sexually transmitted diseases clinics. Health education is the dominant strategy.

It is within the context of Primary Health Care and the predominant medical discourses that nurses practise in South Africa in the Eastern Cape. This informs how they view the world and their positions as nurses. Nurses working in this context have been trained in programmes, which include topics like, Tuberculosis, AIDS counselling, sexual education, sexually transmitted diseases etc. These programmes have been devised to equip people to work within the PHC as counsellors. 52 nurses from such a context were trained in the narrative model of counselling by the Department of Psychology at Rhodes University, East London. The Project is run in association with the Eastern Cape Department of Health.

2.3 HIV / AIDS and counselling in the primary health care

HIV/Aids in South Africa has reached pandemic proportions despite the effort by the government and the private sector, NGOs and communities to curb its spread. The national HIV prevalence rate for South Africa was 22,8%, with signs that it was increasing, in 1998, according to the Department of Health (Latest HIV/AIDS Statistics, 1999). According to the South African Institute of Race Relations (1999), a quarter of a million South Africans would die from HIV/AIDS related deaths in 2000, six million would be HIV positive at the end of 2000, while eight million would be HIV positive by 2005.

The high prevalence of HIV and AIDS in the Eastern Cape poses a challenge to all professionals to act and prevent the spread of HIV AIDS in the region. Stigma and silence poses a threat to those living with HIV/ AIDS in the community.

The counselling component of the national AIDS plan highlights five priorities as follows:

- All people should receive pre and post-test counselling.
- The development of a network of competent counsellors in the health care sector and in communities.
- Counselling should be integrated into other services.
- Counselling should be culturally sensitive.
- Confidentially should be a cornerstone of counselling.
- Counselling should not be a professionally driven and owned intervention but rather one delivered by a broad range of people within the community.

Against this background nurses working in the PHC clinics have been trained as counsellors to counter-act the threat of HIV/AIDS in the Eastern Cape.

Epidemiological models which focus on theories of causation, risk and modes of transmission dominate these activities. In the Eastern Cape, the use of village health care workers acting out drama and music was popular. Most of the messages of health education have been aimed at rectifying the lack of knowledge which positions the audience in a powerless position of ignorance. HIV posters, depicting sad scenes of graves which are anxiety-provoking, hang in almost every clinic. Arguing from a social constructionist approach Strebel (1996) describes such constructions of HIV/AIDS as fear invoking and serving to entrench the power of the medical discourse.

Within this context the term counsellor is used to describe an individual (usually a professional nurse) providing information, health education and counselling on sexually transmitted diseases, which includes HIV/AIDS. There is no clear distinction between health education and counselling.

The World Health Organisation states that one of the basic principles for giving information to people suffering from sexually transmitted diseases is for the health professional not to make assumptions about how much the patient knows, or about their lifestyle. This may result in relevant information not being given or patients finding it difficult to ask questions about particular sexual practices. The client is recruited into a position of ignorance, as the nurse is encouraged to take up the knowing position. The health education and counselling which is constructed by this discourse implies that sexual practices are universal and that solutions to these problems lie with the nurse, regardless of patient's gender, race, and context.

In this engagement the asymmetry of the relationship is exaggerated, because the patient's voice is marginalised, thus crushing his/her agency in the prevention of HIV/AIDS. As people engage with nurses in a context in which health beliefs, values, knowledge of health and illness, and use of languages all bias the dominant culture within this setting, they are stripped of their power to articulate and realize their own ways of dealing with STD's and HIV/AIDS. The perspectives of what it means to have STD'sand HIV is defined by the nurse.

People suffering from STD's and HIV/AIDS are encouraged to accept professional knowledge while their own knowledge and sexual practices are not explored. I feel that the medical construction of HIV/AIDS as a sexually transmitted disease in comparison with other sexually transmitted diseases like syphilis and gonorrhea, has led to stigma and silencing of those with this disease, and this in turn further emphasizes their helplessness regarding the problem.

2.4 **Sexual Health Counselling Project**

It was against this background that the Department of Psychology at Rhodes University – East London Campus, embarked in 1998 on a sexual health project, which trained nurses and AIDS activists in counselling using a narrative approach. The counselling course was aimed at equipping counsellors with interpersonal, group and community skills to address the sexual issues and social practices relating to HIV and AIDS.

The aim of this project was to create an understanding of mental health issues with an emphasis on relational practices with HIV/AIDS. This alternative model in a Primary Health Care setting advocates the view that the HIV virus will not be addressed by only encouraging safer sexual practices. According to the philosophy of this project safe sex behaviours are the end point of a wide process which involves the elaboration and deconstruction of social practices that mitigate against these safer sex practices (Sexual Health Counselling Project 1999). The Sexual Health Counselling Project is situated within the meta-theoretical approach of social construction which according to Burr (1995) is rooted in the cultural and intellectual tradition of post-modernism.

Two courses were linked. One course was run for managers to provide a supportive and appropriate supervisory environment for counsellors and a second course was run for counsellors to enable them to provide and intervene on an individual, family and community level to promote the prevention of the spread of HIV/AIDS. This paper focuses on the counsellors' experience of counselling on an individual level.

2.5 Narrative model of counselling

The Narrative model of counselling is one of the models that has evolved from social constructionism. As a post-modernist approach it places knowledge within the process of social interchange and rejects absolute truths. Inherent in this approach is the idea that people's lives are socially constructed and that their senses of self and identity are socially, historically, and culturally embedded. This position views human action as taking place in a reality of understanding through social construction and dialogue (McNamee, & Gergen, 1991).

Within the Narrative model of counselling, White and Epston (1989) use Foucault's ideas to provide them with tools with which to critique their own practice that is informed in the domain of power and knowledge.

> We would work to identify and critique those aspects of our work that might relate to the techniques of social control (White & Epston, 1989 p. 33).

White and Epston understand these ideas as being directly used in the service of clients. These ideas encourage a critical stance. They further state the following:

> If we accept Foucault's proposal that the technique of power that incites a person to constitute their lives through truths are developed and perfected at the local level and are taken up at the broader levels then in joining with persons to challenge these practices, we would also accept that we are inevitably engaged in a political activity. This is not a political activity that involves the proposal of an alternative ideology, but one that challenges the techniques that subjugate persons to a dominant ideology (White & Epston, 1989 p. 33).

The relationship between counsellor and client in narrative therapy represents a positive use of power that positions the client as a person with a voice that is being heard. As stated by Monk et al (1995) for a relationship to become truly collaborative the counsellor needs to be sensitive to how power manifests itself in social and professional practice, and therefore should develop a facility for reflexive thinking about her/his own practice.

The narrative model of counselling also draws largely from Derrida's deconstructionism and Whorf's linguistic hypothesis, which suggests that language shapes our perceptions of reality. Deconstructive listening, which is an important aspect of narrative therapy, refers to the analytic process of taking part in critical enquiry to dissect a phenomenon in order to understand its construction (Leistyna et al 1996). This type of listening involves understanding peoples stories without rectifying or intensifying their powerlessness, painfulness and pathological nature of their stories (Freedman & Combs, 1996). According to Monk et al (1995) through careful listening and attentive reflection, summarising and paraphrasing, the counsellor invites the client to listen to her/his story in a new way and to be an audience to her/his own production of self in ways that facilitate growth in courage, resourcefulness and hope. In this way the narrative approach directs one to pay attention to alternative stories of protest and resourcefulness.

In narrative counselling, deconstructive listening is guided by the belief that people's stories have many possible meanings. Meaning is made through looking for gaps and ambiguities, and asking questions to fill the gaps. Through this process new constructions may emerge (Freedman & Combs, 1996).

To achieve these objectives the counsellor adopts an externalising attitude toward the problem. This is an attitude of challenging the subjugation of power. Externalisation is a practice which is supported by the belief that a problem is something operating or

impacting on or pervading a person's life. Implicit in this notion is that the person is not the problem. Rather the problem is something separate and different from the person (Freedman & Combs 1996).

The second aspect of narrative therapy is the "not knowing approach". This position is not a denial of knowledge but an attitude of needing to know more, rather than conveying preconceived opinions and expectations about the client and problems. Interpretation and understanding relies on the continuing analysis of experience, and is contextually sensitive. In this approach the emphasis in counselling is not to produce change, but through opening a space for conversation, new stories and alternatives may be generated, one's thinking is challenged and change may occur (McNamee & Gergen,1996).

As a result of these techniques and attitudes narrative therapy is located in the discourses of psychological emancipation which makes therapy a liberating experience that assists a person to challenge and stand up against power (White, 1995b).

In this participatory approach one of the basic assumptions is that ideas arise from social interchange, which are mediated through language. Language, and discourses that people live by, forms an important aspect of counselling. In the "not knowing" approach counsellors are always moving towards the yet unknown. This implies that they should not be asking questions from a position of pre-understanding (Freedman & Combs, 1996).

The "not knowing" approach, as a way of asking questions, if used properly, may result in locally constructed meaning using local vocabulary. In this approach counselling is collaborative and empowering.

The "not knowing" approach is in contrast to the nurse's professional "knowing stance" where questions are asked in order to predict, classify and deploy ideas that are tested and tried. In this knowing approach questions often imply direction and seldom open a space for ideological exchange. The knowing approach in counselling confines the counsellor to her/his own experience and theoretical perspective which might not be historically and culturally sensitive. This may encourage counsellors to

use judgements that are not necessarily relevant to the person which could have a discriminating or undermining effect for the client.

Training nurses in narrative counselling, which challenges the medical discourse, potentially creates an interesting dynamic. Nurses may thus be torn in different directions by competing discourses. The aim of the study was to explore their experience of these contesting discourses and to reveal the contradictions.

3. STUDY

3.1 Context of the study

The Eastern Cape, is one of the most disadvantaged of the nine provinces in South Africa. It has an estimated population of 5,8 million people. The restructuring and transformation of health care services has been a difficult and slow task in this region. The Eastern Cape includes the two underdeveloped, neglected homelands of former Transkei and Ciskei. The former under resourced services had to be integrated with the better resourced services in the urban areas and the extensive commercial farming areas in the Cape Province so that the PHC philosophy could work better.

This study was conducted in three of the districts namely Butterworth, Elliot and Umzimkhulu. Nurses from the Butterworth district were working in Ngqamakhwe, Butterworth hospital, and Tafalofefe primary health care sites. The Elliot district included nurses from Cala, Maclear, Barkly East and Elliot. Nurses from Umzimkulu district, which falls on the borders of the former Transkei and KwaZulu Natal included the following areas: Mount Ayliff, Umzimkulu and Saint Margaret's.
Research on HIV/AIDS in this province shows that it is the highest cause of death in people between 15 – 54 years (Meidany and Puchart, 1999).

3.2 Aim

The first aim of the study was to explore the experience of nurses initially trained in a medical model and working within PHC, who have subsequently been trained in a narrative approach to HIV/AIDS counselling.

The second aim was to reveal contradictions in nursing practice as experienced by the participants. The framework for understanding this experience is discourse analysis.

3.3 **The Research Design**

3.3.1 The Participants

The participants involved in the study were working both as nurses and counsellors for people with HIV/AIDS at primary health care settings in three districts in the Eastern Cape namely Butterworth, Elliot and Umzimkulu districts. Information was collected for discourse analysis from 52 nurses trained as counsellors in the narrative approach. Five focus groups ranging from 6 to 23 people each were held. The length of the focus groups varied from 1 hour 15 minutes to 1 hour 30 minutes. The group discussion focused on the experience of working both as nurse and counsellor trained in narrative therapy in the prevention of HIV/AIDS in primary health care settings. Both Xhosa and English were used in the discussion.

3.3.2 Data Collection

Data was collected during the follow-up and mentorship visits to the counsellors during 1999.

Focus groups, as a qualitative method of collecting data, were found to be a useful way of exploring the question. In a focus group the interaction results in the group members sparking one another off in a way that adds new dimensions and nuances to the original discussion. This results in a totally new understanding of a subject emerging from the group discussion. As a method it is useful for exploring people's knowledge and experiences and can be used to examine what people think and why they think that way. Three focus groups were audio taped and recorded, and two focus groups were videotaped and recorded. The information was transcribed verbatim and translated from Xhosa to English where necessary.

The question to which the focus group was asked to respond was:

> 'What has been your experience of working both as a nurse and a counsellor in the primary health care setting when dealing with people suffering from HIV/AIDS'.

Responses to these questions were tackled and used innovatively in the different topics to pose other questions to explore their experience.

For example these questions were asked:

- Could you explore your experience of being a jack-of-all-trades and a Master of none?
- What has been your experience of wearing multiple hats in primary health care?

3.3.3 Data Analysis

Consistent with the theoretical context and the nature of the data, discourse analysis was used to analyse the data drawing from the work of Potter and Wetherell, (1987), Burr (1985) and Strebel (1997). As a methodology discourse analysis goes beyond just the description and includes an analysis of the role discourses play in the life of institutions, power and the transmission of ideology. In discourse analysis, taken for granted meanings are disrupted and the ways in which discourses support or challenge institutions and the distribution of power may be exposed. Categories of persons who gain or lose from the use of the discourse are identified (Potter & Wetherell, 1987).

Discourse analysis aims to account for how particular conceptions of the world become fixed and pass as truth. As a reflective process it aims to provide an account of how objects in the world are constructed against a background of socially shared understandings which become institutional and gain a factual status. It provides an account for human action and social practice by showing the conditions of possibility with which they are embedded (Durrheim, 1997). The author further contends that to conduct discourse analysis is to exercise the cutting tool of knowledge toward the aims of human emancipation.

Another important aspect in discourse analysis is that language is constructive. Potter et al (1987) states that we deal with the world in terms of constructions. The authors further states that in discourse analysis the researcher is involved in simultaneously analysing the interpretive context.

The data were prepared by listening to the audio-tapes and watching videos. The verbal text was transcribed verbatim and translated from Xhosa to English and

translated from English to Xhosa were necessary. This produced about 160 pages of hand written transcribed text. After a re-reading of the text, the process of analysis was done in three stages.

First, due to the qualitative nature of the information, the data were coded drawing from the work of Miles & Huberman (1994). The researcher used descriptive codes to pull out phrases that related directly to the research question. Accounts which highlighted contradictions in the participants' experience and those which had important implications for the practice were extracted.

The second stage of the analysis involved pattern coding, Miles and Huberman (1994) states that pattern codes are explanatory and function to identify ermergent themes pulling together a lot of information into more meaningful units of analysis. After coding the researcher had to decide which evolving story to tell, therefore not all emerging themes were developed. It is acknowledged that some of these themes could have had alternative constructions which could have influenced the research findings. Accounts which highlighted contradictions in the participants' experience and those which had important implications for practice were explored. Some emerging themes, which made the researcher curious, were also explored for their significance.

The third stage of analysis drew on the discourse analytic approach. This involved the following :

- How were accounts constructed?
- What was gained by these accounts?
- Which linguistic resources were available to the speakers?
- The analysis involved identifying positions offered by the different discourses and the political implications of these.

The dominant discourses revealed by the analysis were:

u The contradiction between the 'not knowing approach' assumed by the narrative model of counselling and the knowing stance assumed in health education.

- The contradiction between the nurse/patient relationship and the relationship between the narrative counsellor and the client as experienced during counselling and health education.

- Power issues, in two forms, seemed to interact with each other. These are:

  * The nurse versus the patient.
  * The nurse versus the matrons and doctors.

- The constructive nature of language, regarding the linguistic characteristics of English versus Xhosa.

4 **Revealing the contradictions**

4.1 The "Not Knowing" versus "Knowing" stance

There was a contradiction between the 'not knowing' stance assumed by the narrative model of counselling and the 'knowing' stance of the expert/professional approach. The nurses' accounts were largely drawn from the medical discourse. These accounts revealed a clash of discourses and an understanding of the "not knowing" stance. The two discourses were seen as conflicting with consequences that are constraining to the prevention and counselling of people with HIV/AIDS within the primary health care context. The practice of nurses within the PHC context is firmly positioned within the medical discourse.

The following accounts highlight nurses' experience of the contesting discourses.

> 'The not knowing approach becomes difficult because anybody with STD's has to be informed about AIDS. This is how we prevent potential problems.'
> 'Adopting the "not knowing" approach becomes difficult because as nurses patients expect us to know.'
> 'As a nurse your role is curative, we take history, do physical examination. We are skilled in asking questions.'
> 'STD Patients do not disclose their HIV status even if they know, there is no time for rapport, sometimes we see up to hundred patients.'

The language used in these accounts is drawn both from the nursing process and medicine, which largely informs their practice in this context.

The recognition of contradictions in these discourses is an awareness of the other available discourse and the positions the different discourses offered. In these accounts the conflicting discourses are depicted as having a constraining effect on counselling in the prevention of HIV/AIDS within primary health care. The respondents were still positioning themselves within the medical discourse. This discursive positioning maintains the status quo within this context. The dominant diagnostic practice of asking direct questions to get to the symptoms and a diagnosis is in contrast to the "not knowing" stance which is assumed in the narrative model of counselling. These direct questions, which focus on symptoms and rely on the nurse's knowledge of potential problems, has been described as objectifying on the individual (White 1995b). The author is critical of the medical discourse for having individualizing and pathologizing practices. These practices can be described as labelling and stigmatising, resulting in the health care consumer simply being seen as an illness rather than as a whole person. This situation undermines the trust between the health care provider and health consumer.

4.2 Counselling versus health education

The participants also experienced a conflict between health education and counselling. The following accounts highlight their experience.

> 'The patients do not come because they are HIV positive but while taking history, you discover that the person is HIV positive, and you do counselling and health education together.'
> 'It is difficult to do health education and counselling together.'
> 'Switching from one role to the other is not easy.'

In these accounts there is a struggle to position in discourses, which are experienced, as diverse and conflicting. In this context people suffering from sexually transmitted diseases are understood to need information for AIDS risk reduction because they are at risk and vulnerable. Therefore a person who is HIV positive presents a special challenge to the process of counselling. The different position demands different activities and practices of engaging, which are seen as contradictory. The construct of

risk provides an opportunity for prevention. The individual is constituted as at risk of HIV/AIDS, and needing health education as stated in the previous accounts.

> ……. 'anybody with STD's has to be informed about AIDS, this is how we prevent potential problems'.

As stated, health education is about giving medical knowledge to individuals.

The individual is recruited into a position of ignorance, as the nurse is encouraged to take up the knowing position. People who are HIV positive provide common ground for both counseling and medical discourses, because of their need for information concerning risk reduction and their own need for support and care. Each of these discourses is distinguished by typical goals and strategies as well as points of positions to the other. The struggle to position one between the "not knowing" assumed by the narrative model of counseling and the "knowing" stance assumed by an expert is still evident in these accounts.

Throughout the discussion patients with sexually transmitted diseases were referred to as "STD's" by the nurses as demonstrated in the following account:

> "STD patients do not disclose their HIV status even if they know, there is no time for rapport, sometimes we see up to a hundred patients".

Referring to the health care consumers as STD's gives the nurse power to give them advice on how to prevent HIV/AIDS. The person is then given information about the disease and individual behaviour change, regardless of whether she/he already has the disease. The consequence is that people seldom disclose their HIV status, as revealed in the discussion. In this discussion, nothing was said about a person who is already HIV positive or suffering from AIDS, emphasis was on preventing the disease.
Failure of the STD patients to disclose their HIV status was used to justify a discursive positioning that maintains the status quo. The nurse gives information and advice but no counselling. This position maintains the power and expertise of the nurse and is not conducive to the empowering and empathic dialogue required to support a person living with the HIV virus.

4.3 Nurse's power versus power of doctors and matrons

Another emerging contradiction was that of the power nurses have versus the power of doctors and matrons.

> 'We do not have a problem with space and time. Our problem is doctors and matrons. Doctors think that counselling is just another task that can be finished in one day.'
> 'Doctors think we are machines.'
> 'They use matrons to fire at us.'
> 'You will be called to do something else while in the middle of counselling'.

In these accounts the respondents are willing to engage in the narrative discourse of counselling. However, this is experienced as conflicting to the counselling that is constructed by the medical discourse. The matrons are experienced as participating in a medical discursive practice in which nurses in this context are constructed as passive instruments for carrying out doctors' orders in order to improve the patient's health status. In this context there is an institutionalised construction of counselling as synonymous to health education and advice giving so that patients/clients can make informed choices. Viewed in a Foucauldian sense, as Perterson et al (1997) points out, health education is a constructive exercise of power that improves the medical gaze. The power from the doctors and matrons is a circulation of this gaze. In this sense power is not oppressive but productive.

Contrary to this understanding the respondents in this context articulate the experience of being objectified and being used as instruments to objectify patients. This is in conflict with their new understanding of counselling in the narrative discourse. As they engage in the narrative discourse they experience the power from matrons and doctors as hindering counselling in this context.
The following accounts further illuminate their experience:

> 'Doctors think that counselling is about convincing patients to make what they think is the right decision. They think we have been given skills to overpower.'
> 'When they want you to counsel they want you to do it immediately as if you are operating a machine.'

> 'You are regarded as a failure if you counsel a patient to make a choice that the doctor thinks is not good. Supervisors do not understand the counselling process. We are expected to see up to hundred patients a day.'

In this mechanistic view of counselling the success of the counsellor is measured by the degree to which the client complies and makes choices based on the professional knowledge. This view of empowerment is grounded on victim blaming and people taking responsibility for their own health using professional knowledge. What is often missed is that, once empowered, people might make choices which are contrary to those of the health professional. This construction of empowerment, coupled with the workload in the PHC setting, leaves the respondents powerless, and is not beneficial to the counselling of people living with HIV/AIDS in the PHC context.

> 'We feel blamed, inadequate and powerless. The nurse's abilities are over-estimated.'
> 'We have been castrated' (sifana nenkunzi zenkomo enqunyulwe impondo), literally meaning 'We are like bulls that have been dehorned.'
> 'I wish everybody could be 'narrative'.'
> 'Narrative is empowering, and it goes well with PHC.'
> 'We are now a resource to communities.'

As respondents engage in the narrative discourse, not only do they have a new construction of counselling but there is also a realisation of their own power. There was a feeling that in this context they have been rendered less powerful than they really are. In these accounts there are shifts and new understandings which could be of benefit to clients/patients as there is a readiness to relate differently.

4.4 The constructive nature of language

These new understandings are taken further in the following accounts:

> 'We do not have a name for 'counsellor' in Xhosa. When patients come to us, they come to us as nurses and expect advice. Curious questions become a waste of time because they know that we know.'

In these accounts there is an awareness of patterns of relationships that are offered by the different positions of being nurse and counsellor. Language is seen as central in

the negotiation of these different positions. Having no Xhosa word for 'counsellor' was used as an excuse to justify discursive practice that maintains the status quo. Although there is a Xhosa word for "nurse" (Umongikazi) the commonly used word is 'nesi', which is a dejargonisation of the word 'nurse', which has no effect in patterns of relationships and social practice. This familiar practise, which has been unquestioned in this context, is now made obvious by the challenge and contradictions introduced by the narrative discourse. These accounts demonstrate the constructive nature of language. The linguistic issues in this context are further made complex by the use of these English- Xhosa jargons.

This awareness led to a further deconstruction of the term counsellor by the group research participants. This is captured in the following list of Xhosa synonyms for counsellors generated by one of the focus groups:

> Mncedisi – helping the person with a problem, giving a hand (ukufaka isandla) helping the person to help himself.
> Mcebisi – giving an advice
> Mkataleli – care-giver
> Mhlanguli – rescuer
> Ngcambazisa - helping a helpless person
> Msombululi - problem solver
> Mhlangabezi - sharing, helping a person that is already trying, meeting the person half way
> Mthungululi - Removing mud from ones "eyes". (This word has its origin from cleaning the eyes of a newly born puppy. The contradiction here is that the puppy does this itself).
> Ntozonke - expert, Jack-of-all-Trades and Master of None.
> Vula-kuvaliwe - an expert
> Nokwaka - a builder
> Nolwazi - an expert, one with knowledge.

The interpretative repertoires were not direct translations of words and phrases from English to Xhosa. These constructions were drawn from both languauges. In this list many of the words are generally used for males in Xhosa, even though by far the majority of focus group members were women. Relations of dominance and submission, therefore, were still heavily embedded in these accounts. There were constructions of counsellor which depicted unequal power relations, with power vested in the hands of the counsellor. These constructions are consistent with the

medical model. The counsellor was also seen as sharing power or "giving a hand", which is consistent with the narrative discourse. These interpretative repertoires reflected the nurse's experience and identity within the PHC context. In the following accounts the respondents are becoming aware of their multiple positions and the different patterns of relations demanded by each of these positions.

In these discourses each position brings a variety of expectations. These understandings bring hope for HIV/AIDS in the light of the respondent's experience of working both as nurses and counsellors.

In the following accounts the respondents no longer saw English/Xhosa words for counsellors as an excuse for a status quo in patterns of engaging but are willing to engage in practices that will result in new experiences for people with HIV/AIDS, when necessary.

> 'Kawunsela (a dejargonisation of the term 'counsellor') is associated with the stigma of psychiatry and cannot be used for people with AIDS, otherwise we will be more stigmatised.'
> 'We do not need a Xhosa name, people will give a name to their understanding and experience like they did with AIDS (Ugawulayo).'

There is an awareness of patterns of relationships that are offered by the different discourses.

5. CONCLUSION

HIV/AIDS presents special challenges to nurses working in this context. The nurses find themselves confronted with a condition that calls for infection control and precautions through health education. The need for counselling however challenges the traditional nurse-patient relationship.

The use of nurses as counsellors, while still expecting them to carry on with their nursing roles, could easily lead to the exclusion and silencing of people with HIV/AIDS from psychological support if the medicalised construction of counselling is not challenged. Contrary to the Foucauldian's understanding of people willingly subjecting themselves to the medical gaze, people suffering from STD's and

HIV/AIDS in this context are usually financially excluded from elite psychological services or have little or no knowledge about psychological support and counselling. Nurses in PHC centres become the only human resources available to them.

Ideally, the discourse the health provider chooses should depend on what patients/clients bring to them. However, the medical discourse dominates nurses' training and practice in the PHC context regardless of what clients bring to them. Training nurses in narrative counselling has introduced another discourse which seems to have created a tension. Despite this tension a shift has been articulated in the respondents' accounts and these may lead to better HIV/AIDS activities if the process is nurtured. An awareness of this discourse will not necessarily transform HIV/AIDS activities without guided action.

The introduction of the narrative discourse challenged some of the taken for granted assumptions and social practices which have been ongoing in the PHC context. The respondents became aware of the importance of language, and became aware of power in patterns of relationships. They were aware of being positioned in what they experienced as contesting discourses in 'their' HIV/AIDS activities. They articulated willingness to engage in the multiple discourses.

There is an urgent need to train counsellors and psychologists to take up the task of counselling within PHC so that nurses can refer people needing counselling. If nurses are to take up the task of counselling themselves there is a need for training and reorientation of nurses training. Nurses working in this context need to be empowered as self-reflecting practitioners who are able to take up their positions in the multiple discourses.

As self-reflecting practitioners, the nurse/counsellors will be able to recognise that each patient interaction holds the opportunity to address the sexual health needs of their patients, which includes HIV/AIDS counselling. While it might be difficult to collapse the positions of being nurse and counsellor into one, it is seems possible to shift from one to the other with proper support networks and supervision.

6. A PERSONAL NOTE

This research was a personal journey for me as well as for the research participants. The choice of theory, how the research question was constructed, the method of data analysis chosen, and understandings, reflect my own experience and positioning. My position of being a black, female, South African, who has trained and worked as a nurse, and is working as an intern psychologist, in the analysis of these discourses was not neutral. As a Xhosa speaker I became more aware of the importance of language in discourse analyses. My feeling is that the richness and meaning of discourses was retained because of my understanding of both English and Xhosa. The language used in some of these accounts was Xhosa. English was used as a second language. In writing the research report in English I feel confident that the thick descriptions have been retained. As a trained nurse and an intern psychologist I experienced a lot of contradictions in my practice as well.

As an intern psychologist my role was that of a mentor, to support and facilitate the learning process within the primary health care setting where these counsellors were living and working. Being in the PHC setting in the Eastern Cape meant that, as an intern psychologist, I was engaging in activities with disadvantaged, under serviced communities, which included people who worked as nurses and counsellors and those who were served by these health care workers. For many I was the only psychological support they have ever come across.

My sense of working and living in these communities was that of a challenging task especially on the issue of HIV/AIDS counselling. The nurses' experience within the communities and within the PHC health centres with doctors and nursing managers reminded me of my own feelings of dispossession and powerlessness in this context. I struggled to remain neutral and not knowing, and I kept shifting between my positions of being nurse and intern psychologist. I was angry at seeing nurses being used within the PHC philosophy as a transformative force to drive a political activity which demands a mindshift without themselves being empowered. I saw them being pulled in all directions by other professionals. Although my understanding of PHC is that of a discourse of change with a human rights emphasis, it has been taken up enthusiastically by doctors and clinical psychologists trained within the medical discourse, as a cheap, secondary health service. This construction as cheap secondary

health care service will continue if unchallenged. In my struggle with these issues as a psychologist trained within a different paradigm I see my role as that of consciousness raising and emancipation of people in this context.

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