Chapter Three

METHODOLOGY

This chapter describes the aims and objectives of the study; the research design employed to achieve these objectives; the participants who were targeted; the methods of data collection that were used; and the type of strategies adopted to analyse the data.

3.1 PRIMARY AIM

The overall aim of the research project was to investigate the beliefs and practices of a sample of mothers living with HIV/AIDS who were attending an HIV clinic at a Provincial Hospital in the Gauteng area, regarding infant feeding.

3.2 SECONDARY OBJECTIVES

In order to address the above aim, the following secondary objectives were formulated:

1. To identify the feeding practices among a group of HIV positive mothers attending an HIV clinic at a Provincial Hospital in the Gauteng area.
2. To determine the mothers’ attitudes towards and perceptions of breastfeeding.
3. To elicit information regarding the mothers’ views in relation to formula and bottle-feeding.
4. To ascertain participants' knowledge of the manner in which the HIV infection may be transmitted, and if mothers were aware that HIV could be transmitted through breast milk.

5. To probe whether antenatal counselling/information regarding HIV transmission was perceived as adequate.

6. To obtain information on the mothers' feelings regarding their HIV positive status.

7. To explore the mothers' perceptions of the communities' attitudes towards bottle-feeding and whether their communities perceived bottle-feeding as being an indicator of HIV status.

8. To ascertain what happened to the free formula milk that the mothers received.

3.3 RESEARCH DESIGN

In order to investigate the primary aim and secondary objectives of the study, an exploratory-descriptive, cross-sectional survey research design was employed, which incorporated both qualitative and quantitative dimensions. The study was regarded as exploratory research as it allowed the researcher the opportunity to explore a relatively unchartered area and gather a large amount of in-depth information on a few cases. It assisted in highlighting the importance of the social context and culture for understanding the social world (Peat, 2002).

The design was considered to be descriptive as it endeavoured to describe a situation with the view to developing a theory (Rosnow, 1996). A form of survey, which incorporated an interview schedule,
was used for data collection (Kerlinger, 2000). The survey was cross-sectional as data were collected from a sample of participants at one point in time. Quantitative data were obtained via closed-ended demographic questions, while qualitative data were elicited via open-ended items. The advantage of a combined design is that one can obtain a broader understanding of the concept being explored (Kumar, 2005). The disadvantage of combining qualitative and quantitative approaches is that in a single study it can be expensive, time consuming and lengthy. Furthermore, some qualitative and quantitative purists would not agree with a combined approach, stating that by their very nature they should not be used in tandem (Peat, 2002).

3.4 PARTICIPANTS

The current study investigated the cultural beliefs and feeding practices of mothers living with HIV. The mothers were attending Coronation Hospital, which is a Provincial Hospital situated in Coronationville, Johannesburg, South Africa. Participants were recruited at the time of their coming to the Hospital for the monthly collection of their baby's milk formula.

The reason for targeting the participants at this Hospital was that it was the only Paediatric Hospital in Gauteng that had a free formula milk scheme in place for HIV positive mothers, at the time of the study. Also these mothers were accessible to the researcher as she was employed at the Hospital as a speech-language pathologist and audiologist at the time of the study. The participants were recruited from the HIV clinic, which was held on Tuesdays, at Coronation Hospital. This Clinic was intended for mothers with infants under the age of two years. Formula milk was only distributed on
Tuesdays, while a separate clinic operated on Thursdays, which catered for infants older than two years. Two separate HIV clinics were in operation at Coronation Hospital as there were vast numbers of HIV positive children, requiring these services.

3.4.1 Sampling Procedure

Initially it was felt by the researcher that 30 participants would be an appropriate sample size as this number is deemed to be a statistically significant number (Kumar, 2005). However 42 participants were recruited for the study, as this was the number of persons that volunteered over the weeks of testing. Although random sampling is the preferred method of participant selection, it was not realistic or feasible to use this approach in the present study, where the sample was fairly specific (Bowling, 1995). A purposive, non-probability sample of 42 HIV positive mothers with infants between the ages of one month and six months was recruited. Shipman (1997) describes this method of sampling as selecting individuals who are representative of a target population. Despite the fact that non-probability sampling limited the generalisability of the results of this study (Peat, 2002), it was anticipated that many of the beliefs and practices found, would apply to the population of mothers living with HIV/AIDS who were attending Coronation Hospital. This non-probability sampling was also regarded as convenient and economical (Berg, 1995).

However, it is acknowledged that the participants were also all volunteers, which can be problematic in that volunteers may introduce biases into the study. For example volunteers have been found to be more approval motivated and more self-
disclosing than non-volunteer samples (Rosnow & Rosenthal, 1996).

3.4.2 Participant Inclusion Criteria

The participants selected for this study were required to meet with the following criteria in order to be eligible for participation in the study:

- Participants needed to have been diagnosed with HIV based on serology studies in order to provide confirmation of their HIV positive status. More specifically, an initial Enzyme-linked Immunosorbent Assay (ELISA) test result was required. This test is regarded as being reliable in establishing HIV status and was adopted as standard practice in all provincial Hospitals at the time of the study.

- Participants were also required to have given birth to an infant during the previous six months. The reason for choosing this time frame is that free formula is only provided by Provincial Hospitals and clinics for the six month period following delivery of an infant. From six months of age the World Health Organisation (WHO) also recommends that semi-solid foods be introduced and thus formula feeding or breastfeeding is no longer the only means of nutritional intake for the infant after this age.

- The participants’ infants needed to be between one month and 6 months of age, so that they would have already established a feeding pattern.

- The participants were also required to have been attending Coronation Hospital on a monthly basis to obtain free formula milk.
- Participants were required to be fluent in English or Zulu in order to participate in interviews conducted by the researcher in English or by the interpreter in Zulu, thereby minimising threats to the internal validity of responses arising from language factors (Lee, 1993).

### 3.4.3 Participant Exclusion Criteria

- Mothers were excluded from the study if they were not living with HIV/AIDS.
- Mothers who had given birth to an infant more than six months prior to the commencement of the study were excluded.
- Mothers who were not attending the milk formula scheme at Coronation Hospital, were also excluded from participation in the study.

### 3.4.4 Demographic Data

The demographic information of the mothers and their infants is set out in Table 3.1. All the participants interviewed were female and HIV positive.
Table 3.1: Socio-demographic Characteristics of Participants (N = 42)

<table>
<thead>
<tr>
<th>Demographic Factors</th>
<th>Sub-Category</th>
<th>No</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Language</td>
<td>Zulu</td>
<td>38</td>
<td>90</td>
</tr>
<tr>
<td></td>
<td>Xhosa</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>Educational Level Mothers</td>
<td>Matric / higher</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Standard 8/9</td>
<td>23</td>
<td>54</td>
</tr>
<tr>
<td></td>
<td>Standard 7/less</td>
<td>13</td>
<td>30</td>
</tr>
<tr>
<td>Educational Level Fathers</td>
<td>Matric / higher</td>
<td>10</td>
<td>24</td>
</tr>
<tr>
<td></td>
<td>Standard 8/9</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Standard 7/less</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Education unknown</td>
<td>27</td>
<td>64</td>
</tr>
<tr>
<td>Marital relationship</td>
<td>Single</td>
<td>19</td>
<td>45</td>
</tr>
<tr>
<td></td>
<td>Cohabiting</td>
<td>17</td>
<td>40</td>
</tr>
<tr>
<td></td>
<td>Together</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Married</td>
<td>6</td>
<td>14</td>
</tr>
<tr>
<td>Mother’s employment status</td>
<td>Salaried</td>
<td>28</td>
<td>67</td>
</tr>
<tr>
<td></td>
<td>Casual</td>
<td>6</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>Self-employed</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Student</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Unemployed</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Housing</td>
<td>House</td>
<td>19</td>
<td>45</td>
</tr>
<tr>
<td></td>
<td>Backroom</td>
<td>7</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>Informal Settlement</td>
<td>6</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>Lodger</td>
<td>5</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>(Flats, Sharing)</td>
<td>5</td>
<td>12</td>
</tr>
<tr>
<td>Water Supply</td>
<td>Tap within Dwelling</td>
<td>35</td>
<td>83</td>
</tr>
<tr>
<td></td>
<td>Tap within yard</td>
<td>5</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Electricity</td>
<td>Within Dwelling</td>
<td>30</td>
<td>71</td>
</tr>
<tr>
<td></td>
<td>None</td>
<td>12</td>
<td>29</td>
</tr>
<tr>
<td>Cooking Methods</td>
<td>Electric Stove</td>
<td>28</td>
<td>67</td>
</tr>
<tr>
<td></td>
<td>Paraffin Stove</td>
<td>12</td>
<td>29</td>
</tr>
<tr>
<td></td>
<td>Open Fire</td>
<td>2</td>
<td>5</td>
</tr>
</tbody>
</table>
Figure 3.1: – Age Distribution of Infants (N=42)

Figure 3.2: – Age Distribution of Mothers (N=42)
The average age of infants in the study was three months of age, whilst the modal age of the mothers in the study was 20 to 29 years of age. Current research in the field of HIV/AIDS in South Africa reveals that the fastest growing population with the disease is females aged 18 to 30 years of age (McIntyre, 2005).

3.5 RESEARCH INSTRUMENTATION

3.5.1 Motivation for the use of an interview schedule for data collection

An interview schedule was used to probe the different areas explored in the study. This method has the advantage of being able to gather a large amount of data from one person at a time.

A further advantage of this format was that it allowed the facilitator the flexibility to explore unanticipated issues as they arose in the interview. In addition, the results have high face validity – because the method is readily understood and the findings appear believable (Babbie & Mouton, 2001).

There are however a number of disadvantages to using this technique. As with all methods of investigation, interview schedules have various limitations, namely that there is not always enough time to establish rapport with the participants before beginning the questioning and that the researcher has to assume that the participants are being honest in their replies (Drummond, 1996; Kumar, 2005).
The study incorporated a semi-structured interview schedule, which according to Dohrn (2005), provides the interview with a richness and spontaneity of information. However Rosnow and Rosenthal (1996) note that the disadvantages of interviews are that they can become too long, be tedious to analyse and not provide the researcher with the desired information.

3.5.2 Construction of the Interview Schedule

The interview schedule took between 30 and 45 minutes to complete, with an average time of 39 minutes. A copy of the schedule is set out in Appendix C. Some of the items were adapted from a study by Urban (2001), while others were formulated by the researcher. When designing the interview schedule, Converse and Presser's (1994) recommendations were taken into account namely, that instructions be clear and simple. The recommendations of Kerlinger (2000), that similar questions be grouped together in order to structure the questionnaire, was also acted upon.

Focus Group

The interview schedule questions were developed through focus group discussions with post-natal women attending the milk formula clinic at Coronation Hospital. Focus groups are defined as “small groups selected from a broader population and interviewed through facilitator-led discussions for opinions and emotional responses about a particular subject” (pg 147, Kumar, 2005). Mostly open-ended questions were used as these types of items are considered to offer more qualitative information than closed-ended questions (Lee, 1993; Peat, 2002). The focus group discussions were facilitated by the researcher with the help of an interpreter. It
should be noted that the interpreter was there in case any of the participants did not understand the questions in English and the questions could then be given in Zulu. There were five mothers in the focus group who all fulfilled the participant inclusion criteria. These five volunteers were selected from the mothers that attended the HIV Milk Programme at Coronation Hospital at the time of the study. This focus group served the function of fine-tuning the interview schedule and of indicating which areas needed further probing. The focus group was held in the dietician’s office at Coronation Hospital, as this was adjacent to the venue where the formula milk was distributed. A number of issues were discussed in the focus group including the following: the mothers’ attitudes towards breastfeeding, knowledge of how HIV is transmitted, what they felt was culturally expected of them with regard to feeding their baby and if they felt they had sufficient knowledge and access to sanitation to adequately bottle-feed.

The focus group results suggested that the survey focus more on cultural issues towards both breastfeeding and bottle-feeding as these seemed to be the major factors influencing choice of infant feeding amongst the women. The focus group aided the researcher in streamlining the survey questions. It should be noted that some writers recommend that focus groups should not be relied on to a large extent as they are said to be too small a sample to be representative of the population to be tested (Babbie & Mouton 2001). In retrospect the researcher should have utilised a larger focus group to enable more of the test population’s views to be expressed.
3.5.3 Content of the Interview Schedule

3.5.3.1 Information Sheet

Each potential participant was provided with an Information Sheet, a copy of which is set out in Appendix A. This document served as a written invitation to take part in the study and provided potential participants with details of the study and what was required of them. The information sheet emphasized that participation was voluntary and that the participants’ identities and the information that they provided would remain confidential. The participants were also assured that participation in the study or refusal to participate would in no way affect the treatment that they received at the hospital, nor interfere with the supply of subsidised milk formula, which they received. Furthermore, in accordance with Kumar’s (2005) recommendations, a contact number was provided to participants, in case they might have had any queries regarding the study or if they were interested in obtaining a summary of the results. The information sheet also explained to the participants that there were no right or wrong answers and that they were not obliged to answer any questions that they did not wish to answer. They were also assured that they would be able to withdraw from the study at any time, without any negative consequences.

3.5.3.2 Consent Forms

Consent forms attached to the information sheet were handed out to the participants. These served to obtain informed consent from participants to be interviewed. A copy of the consent form is set out in Appendix B.
3.5.3.3 Content areas covered in the interview schedule

In the interview schedule both close-ended and open-ended questions were used. Closed-ended questions require the participant to choose from a selection of responses already provided. These questions require less time and effort to be completed (Robson, 1993; Shipman, 1997; Miller & Salkind, 2002). Open-ended questions allow participants to express their opinions and enable more detailed information to be gathered. The questionnaire was formulated in English but the interpreter was on hand to translate any questions if and when the need arose.

The interview schedule set out in Appendix C, was divided into the following sections: Demographic information; Pre and post-natal counselling; Decisions regarding feeding; Feeding history; What happened to the formula; Knowledge and attitudes regarding HIV; and The mothers’ perceptions of cultural attitudes to feeding practices. Each of these sections is described separately as follows:

Demographic Information

Babbie and Mouton (2001) recommend that one begin with relatively non-threatening questions which are relatively easy to answer, so as not to discourage participation. For this reason, information probed included: age of the baby and mother, marital status, home language, education, occupation, place and type of residence, details regarding the diagnosis of HIV, and previous children. The rationale for including these questions in this section was to obtain background information on the mother and her living conditions, which could assist with the explanation of the responses to the remaining questions.
Pre and Post-natal counselling

In this section questions were posed regarding the number of times the mother had been counselled about her HIV status. These items also probed whether the mothers felt that they had received adequate counselling. The motivation for including these questions was based on the assumption that their counselling status would be likely to influence their knowledge regarding the transmission of HIV and ultimately their decision to formula feed their babies.

Decisions with regard to feeding

In this section questions were designed to explore whether the mothers felt that they were able to act autonomously in their decision to formula feed or whether they felt that the decision was made for them by a doctor, nurse, counsellor or other person.

Infant feeding practices

Questions investigating the feeding practices of HIV positive mothers were included in order to establish if they were feeding their infants a combination of breast milk and formula despite knowing the risks of HIV transmission through breast milk. Efforts were made to pose these items in a neutral manner so as to avoid creating the impression that the researcher was passing judgement on their decisions regarding feeding.

What happens to the formula

As many mothers who are living with HIV/AIDS are unemployed and come from poor economic backgrounds, questions were formulated that probed if more than one child was receiving the formula that was provided or if the formula was being sold for financial gain. It was anticipated that the replies to these questions might aid
Provincial Hospitals in administering milk formula programmes. However, the possibility of participants furnishing socially desirable responses was also acknowledged.

Knowledge and attitudes regarding HIV/AIDS

In order to establish their understanding of the virus, the mothers were asked if they thought HIV caused AIDS. Questions also probed the participants’ perceptions of the community’s attitudes towards HIV positive mothers.

Mothers’ perceptions of cultural attitudes towards infant feeding practices

In this section questions were included that investigated the mothers’ awareness of their communities’ cultural beliefs regarding infant feeding practices.

3.6 RESEARCH PROTOCOL

3.6.1 Application to the University of the Witwatersrand Human Ethics Research Committee (Medical)

The research proposal, interview schedule and consent forms were submitted to the Human Ethics Research Committee (Medical), in order to ensure that the study met the requirements for protecting participants’ physical, social and psychological welfare as well as respecting their dignity and privacy. It was emphasised that participation in the study was voluntary and that refusal to participate would not be held against the participants in any way. Confidentiality was assured, as no names of individuals participating in the study were disclosed. Participants were also
given the right to withdraw from the study at any time, with no negative consequences. Furthermore, they were given the option of refusing to answer any questions if they felt uncomfortable about doing so. The Ethics Committee required the researcher to make certain amendments. The researcher was instructed to alter the participant information sheet, by informing the participants that the questionnaire might take up to 45 minutes to complete. Research Clearance Certificate no. M02-09-40 was then issued granting the researcher permission to administer the questionnaire to individuals who were willing to participate in the study. A copy of the certificate is included in Appendix D.

3.6.2 Pre-testing the Interview Schedule

The interview schedule was pre-tested on 3 mothers who met the participant inclusion criteria, but were not included in the final study. The purpose of the pre-test was to ascertain if the interview schedule was appropriate for the study. Kerlinger (2000) recommends that every interview schedule be pre-tested, as this procedure allows the researcher to modify questions which are poorly worded, change items which expose a researcher’s bias, and replace words which are emotionally laden. The purpose of the pre-test was to ascertain the time needed for completion of the schedule and whether the questions were clear or ambiguous.

3.6.3 Setting

The interviews were conducted at Coronation Hospital, in the Dietetics Department, as it was the Dieticians’ responsibility at the hospital to distribute the milk formula to mothers living with HIV/AIDS. This setting was considered a convenient venue in which to conduct the interviews in privacy.
The interviews were held in a private room in the HIV clinic on Tuesday mornings, in order to ensure that privacy and confidentiality were maintained. The interviews were also conducted individually as participants generally feel able to share more personal information under these conditions (Peat, 2002).

3.6.4 Data Collection

After making the changes to the interview schedule required for ethics clearance, the information sheets and consent letters were sent out to the prospective participants and they were invited to participate in the study. Those who agreed to participate were asked to set aside up to 45 minutes of their time for this purpose. The mothers were interviewed when they attended their monthly visits to Coronation Hospital to receive their free milk formula. The interviews were conducted postnatally, once the mothers had already established their feeding patterns and had interacted with members of their communities whilst feeding their infants. All the interviews were carried out with the researcher present, so that the administration of the interview schedule could be monitored. An interpreter aided in administering the interview schedule as she was fluent in a number of South African languages and was able to translate the schedule where necessary. The interpreter was professionally trained to convey the meaning of the questions without adding or detracting from them.

When using an interpreter, one ensures that the interview schedule is fully understood. An interpreter also provides the added benefit of being able to set the participant in the study at ease, as they are usually of the same race and culture and speak the same language
(Peat, 2002). However, interpreters can have the effect of introducing bias to a study, in that they may unconsciously alter a participant’s responses to agree with their personal views (Shipman, 1997; Kumar, 2005). The interviewer has less control over the interview, if the interview is conducted by an interpreter as confounding variables may be introduced (Thompson, 2004). The advantage of using an interpreter in the present study was that the participants could have questions clarified in their own language. However although the interpreter was on hand for all the interviews, all 42 participants spoke fluent English and the participants themselves elected not to utilize the services of the interpreter.

It should be noted that the interpreter was usually just on hand in the interview room, as the participants understood all the items on the interview schedule and indicated that they did not require interpreting services. However, it is acknowledged that the presence of an interpreter might have had an inhibiting effect on some participants.

Responses during the interview were recorded by means of field notes, so that they could be studied and analysed at a later date. Tape-recordings were not utilised as it was felt that the women being interviewed would feel a greater sense of confidentiality by not having their voices recorded. It was also felt that tape-recordings would increase the costs of the study. The researcher was of the opinion that field notes and the surveys themselves would provide sufficient information for the study. However, in hindsight tape-recordings might have enriched the study by providing additional verbatim responses from participants and enhanced the internal validity of the study.
In accordance with the recommendations of Marshall and Rossman (1995), in the process of conducting interviews, the interviewer and interpreter endeavoured to create a permissive environment asking focussed questions in order to encourage discussion. The current study examined the beliefs and practices of a group of mothers living with HIV towards infant feeding. The participants were interviewed over a period of 4 months from September to December 2002, at Coronation Hospital.

3.7 DATA ANALYSIS

Closed-ended items, were analysed using descriptive statistics while open-ended items were subjected to content analysis. McCall (1990, p.410) defines descriptive statistics as a “procedure for organising, summarising and describing information or data. Results were described and depicted graphically in an organized assembly of information, such as tables, pie charts, bar graphs and histograms, which permits easier understanding of the data (Babbie & Mouton, 2001). This form of data coding makes information accessible to both the layman as well as other professionals (Ntshoe, 1999).

The data from the open-ended items were analysed using a form of thematic content analysis, which incorporated both qualitative and quantitative paradigms. Content analysis can be used for exploratory and explanatory research, but for this study, was used for descriptive purposes (Robson, 1993). Content analysis is a research method for assembling and analysing the content of a text. The content refers to words, meanings, pictures, symbols, ideas, themes, or any message that can be conveyed. The text is anything written, visual, or spoken that serves as a medium for
communication (Neuman, 1994). By only stating what the participants had said thereby using semantic content analysis, rather than inferring or going beyond what they said (latent content analysis), the researcher attempted to achieve neutrality (Rosnow & Rosenthal, 1996).

Data were analysed using an adapted version of Tesch’s eight steps of data analysis (in Cresswell, 1994). First, the researcher read through her field notes, transcribed the tape-recorded interviews and highlighted significant themes, words, phrases and statements. This allowed the researcher to get a sense of the ‘whole’. Second, the researcher read the transcript alongside the audiotape from which it was transcribed. This procedure allowed the researcher to get the underlying meaning of the transcript. Third, the researcher wrote down thoughts in the margin of the transcribed interviews. Fourth, during the transcription of the interviews, and perusal of the field notes, the researcher listed all emerging topics. Similar topics were clustered together to form major topics and unique topics were left over to form important points. Fifth, the researcher then reread the transcripts and field notes and underlined the main emerging themes. Sixth, coding, whereby verbal data is translated into categories was also done. Categories that were related were grouped together and the most descriptive term was found for each category (Rosnow & Rosenthal, 1996). Seventh, the numbers of persons articulating the same theme or sub-theme were then counted. Finally, the researcher’s supervisor checked the categorization of the data.
3.8 VALIDITY AND RELIABILITY ISSUES

In terms of reliability, efforts were made to enhance the reliability and consistency of data collection by having the same person conduct all the interviews with the mothers. The researcher used the same method repeatedly to analyse all results obtained in the study in order to ensure consistency. In addition, correspondence checking recommended by Converse and Presser (1994) was undertaken. This procedure involved the use of the researcher’s supervisor to analyse the categorization of data and compare the analysis with that done by the primary researcher to check for correspondence. However, it is acknowledged that using the researcher’s supervisor rather than an independent rater, constituted a limitation of the study.

In terms of validity, in constructing the interview schedules, the researcher endeavoured to enhance content validity by incorporating a wide range of questions designed to cover the topic under investigation. Similar questions had been used in previous studies on related topics and had been scrutinized by an expert in the university who was familiar with this area. The impression gained was that the interview schedule had face validity in that it appeared ‘on the face of it”, to measure what it purported to measure. The process of pre-testing the interview schedule, served to further enhance the validity of the research instrument.

3.9 ETHICAL CONSIDERATIONS

The right to privacy: The interviews were conducted in private settings, free from interruptions. In order to maintain confidentiality, no names or any identifying information were included in the final report. Participants were assured that all
personal information, such as their names and contact details, would remain confidential, and that their names would not be revealed under any circumstances. In addition, in terms of participant recruitment procedures, participants were required to give consent, to being approached before being contacted directly, by the researcher.

*Autonomy:* The participants were informed that they had the right to refuse to participate in the research at any time without any negative consequences. They also had the right to refuse to answer any particular questions.

*Full disclosure of research:* Details of the purpose and procedures of the study were included in the Information Sheet. Participants were informed of any risks and benefits and of their right to withdraw at any point without penalties.

**3.10 SUMMARY OF THE CHAPTER**

The main intention of this chapter was to describe the research design and methodology. Thus, the aims, research participants, instrumentation, research protocol and methods of data analysis were discussed. The validity and reliability of the study as well as ethical considerations were also highlighted. The following chapter presents the data that were collected through the use of interview schedules.