

**AN INTERVENTION MODEL TO SUPPORT NURSES CARING FOR PEOPLE LIVING
WITH HIV/AIDS (PLWHA) IN VHEMBE DISTRICT OF LIMPOPO PROVINCE**



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A dissertation submitted in fulfillment of the requirements for the degree

DOCTOR IN PHILOSOPHY IN NURSING

FACULTY OF AGRICULTURE, SCIENCE AND TECHNOLOGY

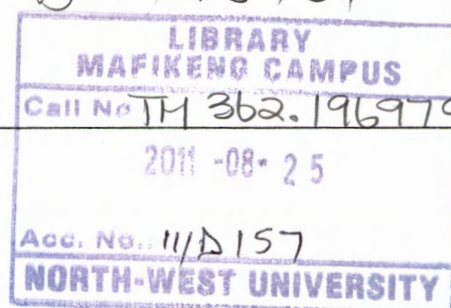
DEPARTMENT OF NURSING SCIENCE

NORTH-WEST UNIVERSITY

(MAFIKENG CAMPUS)

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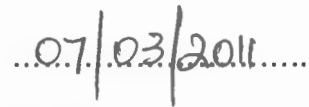
DECLARATION

I, Dorah Ursula Ramathuba, declare that,

AN INTERVENTION MODEL TO SUPPORT NURSES CARING FOR TO PEOPLE LIVING WITH HIV/AIDS (PLWHA) IN VHEMBE DISTRICT OF LIMPOPO PROVINCE is my own work, that all sources used or quoted have been indicated and acknowledged by means of complete references, and that this work has not been submitted for any other degree at this or any other institution.



D.U.RAMATHUBA



DATE

DEDICATION

This thesis is dedicated to:

- My late father Lloyd, and my mother, Maud Malindi who were always an inspiration and my mentors, who instilled the culture of learning and teaching, and gave me unconditional support.
- Special gratitude goes to my husband Benny, who supported me, and shared my dreams and aspirations, my son Muravha, and my two daughters Hulisani and Mukovhe. Thank you very much for your encouragement.

ACKNOWLEDGEMENTS

I thank God for giving me the strength, health, wisdom, determination and passion to complete this study.

I wish to acknowledge the people whose support and encouragement enabled me to complete this study.

- Prof. M. Davhana-Maselesele my supervisor, for believing in me and for supporting, guiding and sharing her knowledge and expertise with me during the course of this study.
- Limpopo Provincial Department of Health and Social Development, for granting me permission to conduct the study.
- The nursing manager of the regional hospital in Vhembe region for granting me final permission to pursue this study.
- All the committees that were involved in the process of reviewing this work, the Higher Degrees Committee of North-West University, the professional nurses in charge of the units where data was collected and the nursing personnel who participated in the study, special thanks for sharing their confidential information. Without them the study would not have been possible.
- My special thanks to Mr. Sizwe Mabena, the subject librarian who passionately assisted me with library search.
- The NWU staff in the department of nursing for their warm support, the environment was indeed conducive for learning, thanks.
- Mrs. Tshivhase SE, Mrs. Mulaudzi V.M who willingly assisted with the process of data collection.
- Mrs. Mashau N.S. and Mrs. L.H Nemathaga for translating data into English
- Special thanks go to my fellow colleagues and mentors Dr. R.T. Lebese, Dr. R.P. Risenga, Mrs. L.H. Nemathaga and Mrs. N.J. Ramutumbu the journey to Mafikeng was worth travelling through your consistent support.
- My brother, Advocate. Z.E.A Malindi and wife, Moetsi who supported me, and shared my dreams and aspirations.
- The Ramathuba family, my in-laws for their continuous support and spiritual upliftment. Thank you so much.

ABSTRACT

The challenge that is brought about by the scourge of HIV and AIDS has increased the burden of caring to the health care delivery system that is already weak. Nurses are mostly affected as they are at the forefront of health care delivery. Taking cognizance the impact that HIV has made on the health care delivery in this country, it is important to investigate on the experiences of nurses regarding the care and support they provide to people living with HIV and AIDS (PLWHA). Knowledge of these experiences provided guidelines for the development of an intervention model that will assist caregivers to provide health care to PLWHA.

A qualitative, explorative, descriptive, phenomenological and contextual study was conducted. The study was conducted in two phases. The first phase was exploration and description of nurses' experiences of care and support by means of individual face-to-face interviews. The researcher used one research question as a point of departure and more questions emanated from the discussions. Participants narrated their experiences and were reflected in words as well as quotations emphasize the described narratives. Findings revealed that nurses experienced caring as challenging physically and emotionally. Lack of knowledge on managing HIV/AIDS was also indicated as one of the challenges in rendering quality care to PLWHA and poor support system for nurses. Literature control was done to support the findings.

The second phase involved conceptualization of the concept "support", according to evolutionary method of Rodger and Knafl (1993) and the result of concept analysis formed the basis for model development. Dickoff, James and Wiedenbach (1968:423) theoretical framework was used to develop the model and model evaluation was done according to Chinn and Kramer (1999:107)

The study recommended managing the human and material resources by assessing reasons for staff attrition and absenteeism to determine the problem, and device

strategies for staff retention. Stigmatization and discrimination need to be addressed and be included in work-based support programmes and policies. Nurses should receive regular debriefing to ease the emotional pain such as anger, grief, death and depression so as to cope with such challenges in the workplace. Making HIV/AIDS information available to all personnel such as promoting awareness, disclosure and acceptance of HIV/AIDS through attendance of workshops, seminars and educational sessions by all nursing personnel.

ABBREVIATIONS

AIDS: Auto immune disease syndrome
ARV: Antiretroviral treatment
DoH: Department of Health
EAP: Employer Assistance Programme
ECSACON: East Central Southern Africa College of Nursing
GPG: Gauteng Provincial Government
HIV: Human immuno virus
HSRC: Health System Research Council
HPCSA: Health Profession Council of South Africa
ILO: International Labour Organization
NLWHA: Nurses living with HIV/AIDS
PEP: Post exposure prophylaxis
PLWHA: People living with HIV/AIDS
PMTCT: Prevention of Mother to Child Transmission
POS: Perceived Organisational Support
SANC: South African Nursing Council
TAG: Technical Assistance Guidelines
TOP: Termination of Pregnancy
TURP: Trade Union Research Project
WHO: World Health Organization
VCT: Voluntary Testing and Counselling

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CHAPTER 1

BACKGROUND AND OVERVIEW OF THE STUDY

1.1 INTRODUCTION

The current rate of Human Immune Virus (HIV) infections warrants development of an intervention model to support nurses to cope in caring for People Living with HIV/AIDS (PLWHA). In order to develop the model for support to nurses caring for PLWHA, experiences of nurses regarding care and support for PLWHA were explored. This study followed an inductive approach. In this chapter attention was given to the background, problem statement, research question, purpose and objectives of the study, ethical measures, measures to ensure trustworthiness, data collection and analysis, conceptualization, model development and model evaluation.

1.2 BACKGROUND AND RATIONALE OF THE STUDY

The HIV epidemic along with the growing complexity of medical care, have created major challenges for the health professionals who provide curative and palliative care. As treatment options have expanded, so has the stress experienced by care givers. The prolongation of the disease course, uncertainty about overall prognosis, repeated exacerbations and remission in later stages of HIV disease have intensified the emotional and physical demands of care giving (O'Neill and McKinney, 2003:20). According to Bellani, Furlani, Gneccchi , Pesota, Trotti, and Belloti (1996:207-21) and Kalichman, Gueritault-Chalvin & Demi (2000:31-37), it is reported that care givers may also be burdened by workplace related stressors, such as work overload, unrealistic expectations of what can be accomplished, lack of decision making autonomy, communication problems, role conflicts, inadequate medical resources and referral arrangements.

Dieleman, Biemba, Mphuka, Sichinga-Sichali, Sissolak, Van der Kwaak & van der Wilt, (2007:3) reported that HIV/AIDS prevalence rate in Zambia was 16.5% and it had negative impact on the workload and has considerably changed or added tasks to

already overburdened health workers. It was found that 62% of health workers reported emotional exhaustion, organisational support for health workers to deal with HIV/AIDS was either haphazardly in place or not in place at all. East Central Southern Africa College of Nursing (ECSACON), 1999:99 cited in Mavhandu-Mudzusi, (2006:3) highlighted that HIV/AIDS care givers and health workers felt exhausted due to burdens related to treating HIV such as lack of support and resources, providing less than ideal treatment, talking about illness and death, incurable patients, dealing with economic activities of the client, talking about sex and sexual behaviour, fear of being infected, heavy workload and burnout, failing to motivate the community to change their behaviours.

With the advent of democracy in 1994, the South African government of national unity committed itself to the integration and sustainability of its programmes through restructuring and development programme (RDP) by making health care to be accessible and later extended to the rest of the population with no cost. Whilst health care services are made accessible to the community at no cost, statistics of nurses show a decline in the number of nurses in the country. Statistics from the South African Nursing Council's (SANC) geographical distribution of the population versus nursing manpower in Limpopo province reflected that one registered nurse to patient population is 1:606 for professional nurses, enrolled nurses 1:1141 and auxiliary nurses being 1:649 (SANC, 2009). Throughout the world, however, healthcare systems are facing nursing shortages due to factors such as migration, the pressure of work on the remaining inexperienced personnel and the influx of patients to hospitals due to HIV related illnesses and the opportunistic infections creates further stress for the nurses who have to be seen as caring and understanding in all the circumstances of nursing care.

South Africa is also losing a number of nurses to other countries, although the exact figures are not known, nurses are leaving the country to practice their profession

outside the country. In Limpopo province the vacancy rate for health workers stood at 36% in 2005 and to alleviate the burden faced by health professionals, lay counselors were employed to complement health care staff to assist in Voluntary Counseling and Testing (Limpopo Department of Health and Social Development, 2006). According to the Health System Trust Health Review 2003/2004 it revealed that between 2001 and 2003 the workload of the public sector has increased, but the medical aid population has shrunk from 17% to 15,2% in 2002, meaning that the public health sector has grown by 6,5 million, resulting in more patient workload. Posts in the public sector including doctors, pharmacies, radiographers have decreased during the past two years, and 31,1% which translated to 52 574 vacant post were available in the country in 2003 (Mzolo, 2004/5:45). Nurses are functioning outside their scopes of practice on a daily basis, as there are not enough nurses and doctors to perform all the duties in the work situation. Stressful working conditions in South African public system were reported in an investigation by Trade Union Research Project (TURP) (2001:1) into reasons for emigration by our nurses to other countries abroad and also to other provinces to seek for greener pastures. Hall (2004:31) and Tawfik and Kinoti (2006:4) reported that physical and psychosocial work environment factors were the common factors affecting people's decisions to leave their job due to the demands made by HIV/AIDS, problems related to job overload, salaries, transfers and deaths of cadres were also linked to attrition. HIV/AIDS has impacted on the human resource by increasing the service burden associated with caring for HIV/AIDS itself and AIDS related infections with inadequate and limited human resource capacity.

The World Health Organization (WHO) launched its 3 by 5 strategy, stating that in 2005, 3 million people should be enrolled on antiretrovirals. So far the roll-out in South Africa has been slow; as it took the government long to admit the existence of HIV/AIDS, its first roll-out started by the end of 2005. The Limpopo province, where the study is undertaken was the last to roll-out, with only 63 patients receiving antiretrovirals at selected clinics and hospitals (Department of Health, 2004). <http://www.doh.gov.za/docs/pr/2007:1>, The Minister of Justice and Constitutional

development, honorable Jeff Radebe indicated that 3 382 out of 3 663 primary health care facilities are offering prevention of mother to child transmission (PMTCT) of HIV. This represents 83% of the public health clinics. In addition, 580 880 pregnant women accessed PMTCT in 2006 and of these, 74 052 received Nevirapine prophylaxis. To date in the Limpopo province the roll-out has spread to all the five districts, with most hospitals offering voluntary testing and counselling, prevention of mother to child transmission and many patients are accessing these services and this has impacted negatively on the human resource in the public sector especially in the rural areas where they are short staffed and experiencing heavy workloads.

The public health sector is burdened with large numbers of patients who come for treatments as there is no total cure for the disease and moreover the burden is due to deaths of employees, their families, loved ones and friends. These have a negative impact on the workforce, productivity and services which are provided for the benefit of the public.

According to the WHO, approximately 30 to 50 percent of workers report hazardous physical, chemical or biological exposure or an overload of unreasonable heavy physical work or ergonomic factors that may be hazardous to their health and working capacity. Health workers are exposed to blood and other body fluids because of the nature of their work. Consequently they are at risk of infection with blood borne viruses including HIV, hepatitis B (HBV) and hepatitis C (HCV). The risk of infection for health workers depends on the prevalence of the disease in the patient population and the nature and frequency of the exposure, although relatively small, this risk is compounded by staff reductions and shortages in the wake of the country's health service restructuring (Geyer, 2004/5:36).

A study done in the Nigerian University Teaching Hospitals revealed that fear can blur judgment and compromise the quality of nursing care due to isolation of patients in social and clinical setting as nurses experienced nightmares, increased anxiety levels

while nursing HIV/AIDS patients, with others requesting to be transferred or even leaving the profession (Armstrong- Esther & Hewitt, 1990:638-651).

A study done in the Gauteng Provincial Government (GPG) estimated that the total number of GPG employees who will get ill from AIDS each year will reach the levels of more than 4000 and 20% of the workforce will die of AIDS related illness by 2010 (Khaya, 2004/5:29). Furthermore HSRC, commissioned by the Department of Health (DoH) in 2002 indicated that 15.7% of health care workers were living with HIV, the prevalence was much higher among workers aged 18-35 years and 13, 7% among professional health care workers and HIV- positive health workers were twice as likely to be infected with other diseases while HIV-negative faced a high risk of contracting HIV from their patients (<http://www.thebody.com/content/art9929.html>).

Geyer (2004/2005: 38) reported that occupational exposure of Interns to blood in the area of high seroprevalence conducted at the Chris Hani Baragwanath and Johannesburg Hospitals, indicated exposure to HIV-infected blood and concluded that exposure was common but markedly underreported and nurses were not exceptional, as they also feared to become infected. Given the high prevalence of HIV among health professionals it creates a serious implication for the country's health care infrastructure because increased absenteeism amongst HIV-positive would lead to HIV-negative workers becoming overloaded with work and experiencing lower morale and burnout (<http://www.thebody.com/content/art9929.html>).

Hall (2004:7) reported that caregivers feared infecting their children and partners because of HIV/AIDS exposure at work because of their risk of nosocomial (hospital – acquired) transmission due to inadequate implementation of universal precautions, made caregivers to experience a feeling of hopelessness and pessimism. This demonstrates that there is an obligation on all to ensure that professionals and other

health care workers are empowered with skills and knowledge to assist them in dealing with the impact of HIV/AIDS. Nurses should have the right protection during the course of their professional duties, together with the right to a minimized work-related infection and facilities, equipments and supplies must be made available. There is also a need to have the legal right to complain about potentially unsafe working conditions (Kazanowski, 1992:42-43).

Dageid, Sedumedi & Duckert (n.d), explored the perceptions and emotional burdens of HIV/AIDS health workers in Limpopo between 2003-2005, they reported that the situation was marred by lack of resource, increasing health provision demands, lack of training and support, limited government involvement, and a constant emotional overload, with limited possibilities of professional accomplishment and recognition, and they felt their interaction with patients were demanding and sometimes cruel and in this light health workers might not be able to successfully cope or find meaning and benefit in their work situation.

Mavhandu-Mudzusi, Netshandama & Davhana -Maselesele (2007:259) reported that most nurses in Limpopo were trained as VCT counselors but were no longer actively participating in VCT counseling, and their training was fragmented as there was no data base and control with regard to their placement. As a result very few nurses have been trained and most of those who have been trained as VCT counselors left the profession as they could not cope as they had to deal with patients who were dying after they have developed a long term relationship with them.

Davhana-Maselesele & Igumbor (2008:70) reported that 89% of nurses in Limpopo had difficulty in coping with the number of deaths in their units and this made them feel powerless. Nurses without professional training reported to be suffering from stigma and discrimination from other staff at the hospital due to the unit in which they worked. Furthermore, the measuring of the levels of depression and burnout, shows that 34% of nurses suffered extreme depression while 55% suffered moderate to extreme

depression while, nurses without professional training reported higher levels of depression unlike those with professional training, with regard to personal accomplishment the majority reported low frequencies of emotional exhaustion.

Caring for PLWHA was found to be the source of stress and burnout amongst nurses especially because of institutional problems such as poor resources, lack of mentoring and lack of psychological support to care givers. Based on the findings of the study by Davhana-Maselesele and Igumbor (2008:70), the impact of caring for PLWHA on the mental health of nurses in Limpopo, it is therefore important to develop and evaluate an intervention model to support nurses to effectively cope in rendering care to PLWHA.

1.3 PROBLEM STATEMENT

The rapid spread of HIV/AIDS has negatively impacted on the health care system with deteriorating infrastructure, inadequate medical equipments, medications, inefficient ARV programmes and failure to prevent contagion and implement HIV policies in public hospitals. HIV and AIDS have generated fear, anxiety and prejudice amongst health workers. Government gave more attention to patients, caregivers, who in this context are nurses, were left out, leaving a gap to render compassionate care which further leads to stress and burnout. HIV/AIDS care giving have created the emotional strain of dealing with an unpredictable and currently incurable disease, some caregivers are burdened by fears of contracting the HIV even when they know there is little basis for concern, however they experience lack of support from their professional colleagues due to concerns about stigma by association, those that are already infected are worried that no one will be around to care for them when they become ill. The most dreadful source of stress is stigma surrounding HIV, rather than facing stigmatization, some caregivers try to conceal their status by withdrawing and this leads to high levels of chronic stress characterized by emotional exhaustion, depersonalisation and reduced personal accomplishment (O'Neill & McKinney, 2003:4).

Nurses working in South Africa are experiencing tremendous amount of stress as they struggle with increasing patient workloads, over more complex technology, sicker

patients and fewer resources. Hayter (1998:28) reported that nurses in public hospitals have reported increased rates of burnout, stress and fear of being exposed to HIV. To remain healthy, nurses need support. World Organisations addressing the AIDS crisis have concluded that nurses need counseling and support (UNAIDS, 2005:29).

Dealing with HIV and the deteriorating conditions of patients leads caregivers to experience feeling of hopelessness, pessimism and a feeling of non-achievement. Davhana-Maselesele and Igumbor (2008:70) reported that nurses are aware of VCT services as entry point to prevention of HIV infections but fear of infection exposes nurses to stress and burnout as they become hyper vigilant and fearful to be tested due to lack of support services that allow nurses to deal with their stressful environment. In most instances those that are living with the virus may prefer to be treated at a different health facility due to the stigma associated with HIV and AIDS. Nurses are not coping due to lack of employer support such as counselling for work-related stress, 42,2% of health workers in Uganda reported the existence of an official HIV/AIDS policy to guide health workers, a third were not aware of its existence, similarly nurses in Limpopo lacked in-depth knowledge about HIV/AIDS due to the fast changes taking place, with only few nurses trained to can deal with the problem (Hall, 2004:7; Davhana-Maselesele & Igumbor, 2008:72).

Taking into cognisance the impact that HIV has made on the health care delivery in this country, it is important to develop an intervention model that will assist caregivers to provide health care to PLWHA. In this context it is important to focus on nurses as they are the ones who spent most of their time with PLWHA. It is envisaged that support to nurses will eventually be able to address the needs of all other health care providers such as psychosocial deterrents to testing, fear of isolation, denial and rationalization and the inability of many health workers to internalize the risk. It is hoped that nurses who are HIV positive will voluntarily access the necessary care and support without stigma and discrimination, including provision of ARV's, treatment of opportunistic infections as well as psychosocial support, for those that are caring for PLWA will also

receive the necessary support to ease the pain for caring for the critically ill and dying patients.

1.4 RESEARCH QUESTION

The following research question will guide the study

What are your experiences regarding care and support to PLWHA in Vhembe district of Limpopo province?

The research question led to the formulation of research sub- questions that will further guide the study as follows.

1. What kind of support do you receive in caring for PLWHA?
2. How do nurses cope with caring for HIV and AIDS infections?
3. What should be done to enhance nurses' support?

1.5 PURPOSE OF THE STUDY

The study aims to develop and evaluate an intervention model that will provide support to nurses to cope in caring for PLWHA in Vhembe district, Limpopo province.

1.6 OBJECTIVES OF THE STUDY

The following objectives will assist in achieving the purpose:

1. To explore and describe the experiences of nurses in caring for HIV and AIDS patients.
2. To analyse emerging concepts from the data.
3. To develop an intervention model to support nurses caring for PLWHA.
4. To evaluate an intervention model of support.

1.7 PARADIGMATIC PERSPECTIVES

A paradigmatic perspective is a collection of logically connected concepts and propositions that provide a theoretical orientation that frequently guides research approaches towards the topic (Morse & Field, 1996:199). In this study the researcher endeavours to develop and evaluate an intervention model by addressing the challenges faced by nurses in dealing with HIV and AIDS.

1.7.1 Meta-Theoretical Perspective

The researcher concurs with the notion that a healthy person or caregiver exercises their duties fully and effectively when their needs and frustrations are informed by sharing their experiences. The researcher believes that an environment that deals with death and dying causes stress to the caregiver and that caregivers' needs, aspirations, frustrations in an organisation (public sector) needs to be taken care of for effective and efficient service delivery. Care givers are always going an extra mile in caring for patients, and they feel good and fulfilled when they are recognised, supported and commended for their work.

1.7.2 Theoretical Perspective

Lazarus & Folkman's (1984:141) transactional model of stress and coping was adapted to describe the theoretical framework of the intervention strategy. Lazarus 1967 cited in Rice 2000:590) contended that stress does not exist in the event, but rather it is a result of a transaction between a person and his or her environment. As such stress encompasses a set of cognitive, affective and coping variables. The model proposes that stress can be reduced by helping stressed caregivers change their perceptions of stressors, providing them with strategies to help them cope and improving their confidence in their ability to do so (en.wikipedia.org/wiki/stress-management).

Lazarus & Folkman (1984:141) defined psychological stress as a case in which individuals appraise their environment as taxing or exceeding their resources and/ or endangering their well-being. The author further defines coping as constantly changing cognitive and behavioural efforts to manage specific external and /or internal demands that are appraised as taxing or exceeding the resources of a person (Lazarus & Folkman, 1984:221). Coping involves managing the stressful situation, which may include efforts to minimise, avoid, tolerate, change or accept a stressful situation as a person attempts to master or handle his or her environment.

Lazarus and Folkman (1984:221) view coping as a process through which individuals manages the demands of the person-environment relationship, by categorising the encounter in three phases, primary appraisal serves as a judgment of the encounter as either irrelevant, benign, positive or stressful, secondary appraisal is judgment concerning what might be done, serving as an evaluation of benefits and consequences of a particular coping strategy, finally reappraisal which is a successive valuation that is based on new information obtained from the environment and or person during the circumstance.

The model identified two forms of coping, which are problem-focused coping and emotion- focused coping. Problem-focused coping encompass efforts to define the problem, generate alternative solutions, weigh the cost and benefits of various actions, take action to change what is changeable, and if necessary learn new skills. Problem-focused coping efforts can be directed outward to alter some aspects of the environment or inward to alter some aspects of self, like changing the meaning of the situation or event, reducing the ego involvement or recognizing the existence of personal resources and strengths. Emotion-focused coping strategies are directed towards decreasing emotional distress, with tactics like selective attention, venting emotions, seeking social support and meditating.

Coping, according to Lazarus and Folkman (1984:221) is influenced by cognitive appraisal, that is, the individual's assessment of the situation and availability of resources to deal with the situation. Demands of the situation and the preferences and desires of the stressed individual as well as the relation between support provider and recipient help determine one's satisfaction with support received from a member of the support network (Pierce, Sarason & Irwin, 1996:502). Through the use of cognitive appraisal the researcher can discover meanings attached to how support can be promoted within the working environment in health care institutions among nurses when caring for PLWHA.

1.8 DEFINITIONS OF CONCEPTS USED IN THE STUDY

An operational definition is description of how variables or concepts will be measured or manipulated in the study (Burns & Grove 1993:775). Operational definitions increase the understanding of the theoretical concepts.

1.8.1 Caring

The affective component of one's commitment to the welfare of another (Thesaurus and Reader's digest oxford complete wordfinder, 1993:540). In this study caring is feeling of concern and interest about the individual nurse.

1.8.2 Nurse/Carer

In this study the carer is a nurse who cares for PLWHA.

1.8.3 Support

It is to provide, give practical or emotional help (Merriam Webster's third new international dictionary, 1986:2297). In this study support is the assistance given to nurses who are caring for PLWHA to enhance their well-being.

1.8.4 Coping

It is cognitive and behavioural efforts made to master, tolerate or reduce external and internal demands and conflicts among them (Lazarus & Folkman, 1984:140). In this study, coping means being able to adjust and adapt to the working environment where one deals with PLWHA.

1.9. RESEARCH APPROACH

The study was conducted in two phases, phase one included sampling, data collection and analysis, phase two was conceptualisation, model development and model evaluation. The design was qualitative, descriptive, explorative, phenomenological model development. The design assisted in gathering information related to experiences of nurses in caring for PLWHA in Limpopo province.

The population for this study was nursing cadres (professionals, enrolled and auxiliary nurses) from a regional hospital in one of the five districts of Limpopo province. Purposive and theoretical sampling was used (Polit & Hungler, 1999:247) to sample the hospital and convenience sampling was used to sample participants since the researcher is knowledgeable about the setting and the staff complements to meet the information needs of the study.

A qualitative interview was chosen as a data collecting tool to gather a broad range of information from nurses on their understanding, perceptions and views with regard to support in caring for HIV and AIDS infections (Schneider, Elliot, LoBiondo-Wood & Haber, 2003:445). Qualitative data was analysed using open coding method according

to Tesch's eight steps in Creswell (1996:155). During this phase interrelational statements were generated based on the defined concepts. The concept was analysed following the simplified steps of concept analysis by Walker and Avant (1995:39) as well as Rodgers and Knafl (1993:78).

1.10 MEASURES TO ENSURE TRUSTWORTHINESS

Measures were taken to ensure the trustworthiness of the research findings. To ensure that the findings of the study reflected the true experiences of nurses regarding support in caring for PLWHA, the researcher used four criteria for establishing trustworthiness, namely: truth value, applicability, consistency, and neutrality (Neuman, 2000:171).

The researcher used the strategy of credibility by engaging in prolonged interaction with nurses during data collection in order to ensure truth value. The researcher used the strategy of transferability in order to ensure applicability of the study findings. Consistency examines whether two independent researchers are able to get similar results under similar circumstances, so dependability was used to ensure consistency, and conformability to ensure neutrality.



1.11 VALIDITY AND RELIABILITY

Chinn and Kramer (1999:99) criteria for model evaluation was used to evaluate the model and to ensure validity. Peer review was done to review the model to ensure validity and reliability. Theoretical validity was done by searching the definitions and usage of support from existing models, theories and related literature.

1.12 ETHICAL MEASURES

Code of ethics in qualitative research involves moral decisions that should be taken and considered by the researcher throughout the process of the research study (Neuman,

2000:376). In this study the researcher at all times undertook to do what was right without violating the rights of participants and contravening the code of ethics.

The following ethical measures were considered: permission to conduct research, obtaining informed consent, respect for human rights, freedom from exploitation, maintenance of confidentiality and anonymity. Voluntary participation and anonymity was maintained throughout the study research process.

1.13 CONCEPTUALISATION

In this phase, conceptualisation was done by defining the concept, identifying the attributes; interrelation statements generated based on defined concepts, literature review, references, antecedents as well as by integrating the findings from phase1 (Chinn & Kramer, 1999:187; Walker & Avant, 1995:37). Furthermore concept analysis integrated within a theoretical framework of Dickoff, James and Wiedenbach (1968:345) which provides the elements of a practice theory, which include the process, dynamic, context, stakeholders and purpose or outcomes to look at the activities within a theory. These phases formed the foundation for the development of a model and the criteria for evaluation.

Rodgers & Knafl (1993:78) evolutionary method of concept analysis was used. Using this approach allowed the meaning of the concept to be explored in order to improve relations and promote understanding of the support mechanisms of nurses in caring for PLWHA in Limpopo province.

1.14 MODEL DEVELOPMENT AND MODEL EVALUATION

Model development

Walker and Avant (1995:28) identify three basic approaches to theory building being analysis, synthesis and derivation. In analysis the concept was clarified, refined, and dissected into components parts so that it can be better understood; furthermore its

relationship was examined to other parts and to the whole, during synthesis information based on observation was used to construct new concepts, statements and this aids in sifting process while in derivation the terminology was shifted or structured to fit the context. Dickoff, James and Wiedenbach (1968:422) element of a practice theory was adapted to develop a model from the findings of phase 1 and from concluding statements derived from conceptualisation phase. The model development will be described fully in chapter five.

Model evaluation

Evaluation ensures that the intervention model is understood and effective. During this phase findings from phase 1 and conceptualisation were utilised to formulate standards against which support was evaluated. Evaluation of the model was done according to Chinn & Kramer (1999:99). The model evaluation will be described fully in chapter six.

1.15 ARRANGEMENT OF CHAPTERS

Chapter 1: Overview of the study

Chapter 2: Research design and methods

Chapter 3: Discussion of empirical findings

Chapter 4: Conceptualisation (phase 2)

Chapter 5: Model development

Chapter 6: Model evaluation

Chapter 7: Recommendations and conclusion

1.16 SUMMARY

This chapter focused on the impact HIV/AIDS is having on the health services and care givers. It also gave the rationale for and background of the study. Contributions of previous researchers were highlighted and aims of the study were outlined. The researcher also gave clarity pertaining to operational concepts and abbreviations used within the study. The chapter concludes by detailing information on paradigmatic perspectives, ethical consideration, measures to ensure trustworthiness, research methods and design, data analysis, concept analysis, model development and model evaluation that will be described in details in the following chapters .

CHAPTER 2

RESEARCH DESIGN AND METHODS

2.1 INTRODUCTION

This chapter covers an overview of research methodology used in the study. The discussion in the chapter is structured around the research design, population sampling, data collection and data analysis. Ethical considerations and measures to ensure trustworthiness are also discussed.

2.2 RESEARCH METHODOLOGY

According to Polit & Beck (2004:233) and Burns & Grove (2003:292), methodology refers to ways of obtaining, organising and analysing data. Qualitative methodology is dialectic and interpretive. During the interaction between the researcher and the research participants, the participants' world is discovered and interpreted by means of qualitative method (De Vos, 2002:360).

2.2.1 RESEARCH DESIGN

The present study is descriptive, explorative and contextual study. The researcher employed a phenomenological research method to achieve the objectives of this study.

2.2.1.1 Qualitative

Polit & Beck (2004:729) defines qualitative study as the investigation of phenomena, typically in an in-depth and holistic fashion, through the collection of rich narrative materials using a flexible research design. Qualitative research is person centered and takes an "emic" perspective, thus this approach explore and describe the depth, richness and complexity in the meaning of support when caring for patients with

HIV/AIDS infections. A qualitative research design was chosen to understand, interpret, describe and develop a model. The design assisted in gathering information related to experiences of the nurses regarding care and support when caring for PLWHA in Limpopo province.

2.2.1.2 Phenomenological

Phenomenological research focuses on the lived experiences of humans; it believes that there is an essence that can be understood in individuals (Polit & Beck 2004: 727; Polit & Hungler, 1999:197). Phenomenological inquiry focuses on learning and experiencing the phenomena in the same way as participants through observation and introspective reflection. The researcher will be more open to the meaning attributed to support by nurses caring for the clients in this context. The method assisted in gathering information related to experiences of the nurses with regard to care and support when caring for PLWHA in Limpopo province.

2.2.1.3 Explorative

Exploratory research is aimed at exploring the dimensions of the phenomenon, the manner in which it is manifested and other factors with which it is related (Polit & Beck, 2004:718). The exploratory study will help to uncover a relatively unknown research area to gain new insight into the phenomena under study. In-depth information was gathered by means of interviews in order to explore, their views, perceptions with regard to care and support in caring for PLWHA.

2.2.1.4 Descriptive study

Descriptive research aims at exploring, describing phenomenon in real life situations, discovering new meaning and determining frequencies with which something occurs

(Brink, 2003:109; Burns & Grove 2001:30). Through descriptive research the concepts are described and relationships identified that provide the basis for further research. In the study the caregiver's understandings, views and perceptions regarding care and support in caring for clients affected by HIV and AIDS were described.

2.2.1.5 Contextual

A contextual design focuses on studying the phenomenon because of its contextual significance, with the primary aim being to produce an extensive description of the phenomenon, event or group within the context of a unique setting of the domain of the phenomenon (Mouton & Marais 1996:133). Burns & Grove (2003:32) point out that contextual studies focus on specific events in "naturalistic settings." The study is contextual because it was undertaken at the regional hospital in Limpopo province to develop an intervention model to support nurses to cope in caring for HIV and AIDS infections. Interviews were conducted at the hospital where care givers who are nurses were working.

2.3 RESEARCH METHOD: PHASE ONE

The study was conducted in two phases, phase one included sampling, data collection and analysis, phase two was conceptualisation, model development and model evaluation. The design assisted in gathering information related to the nurses experiences of care and support in caring for PLWHA in Limpopo province. A conceptual framework was developed out of the findings of the first two phases that formed a basis for development of a model.

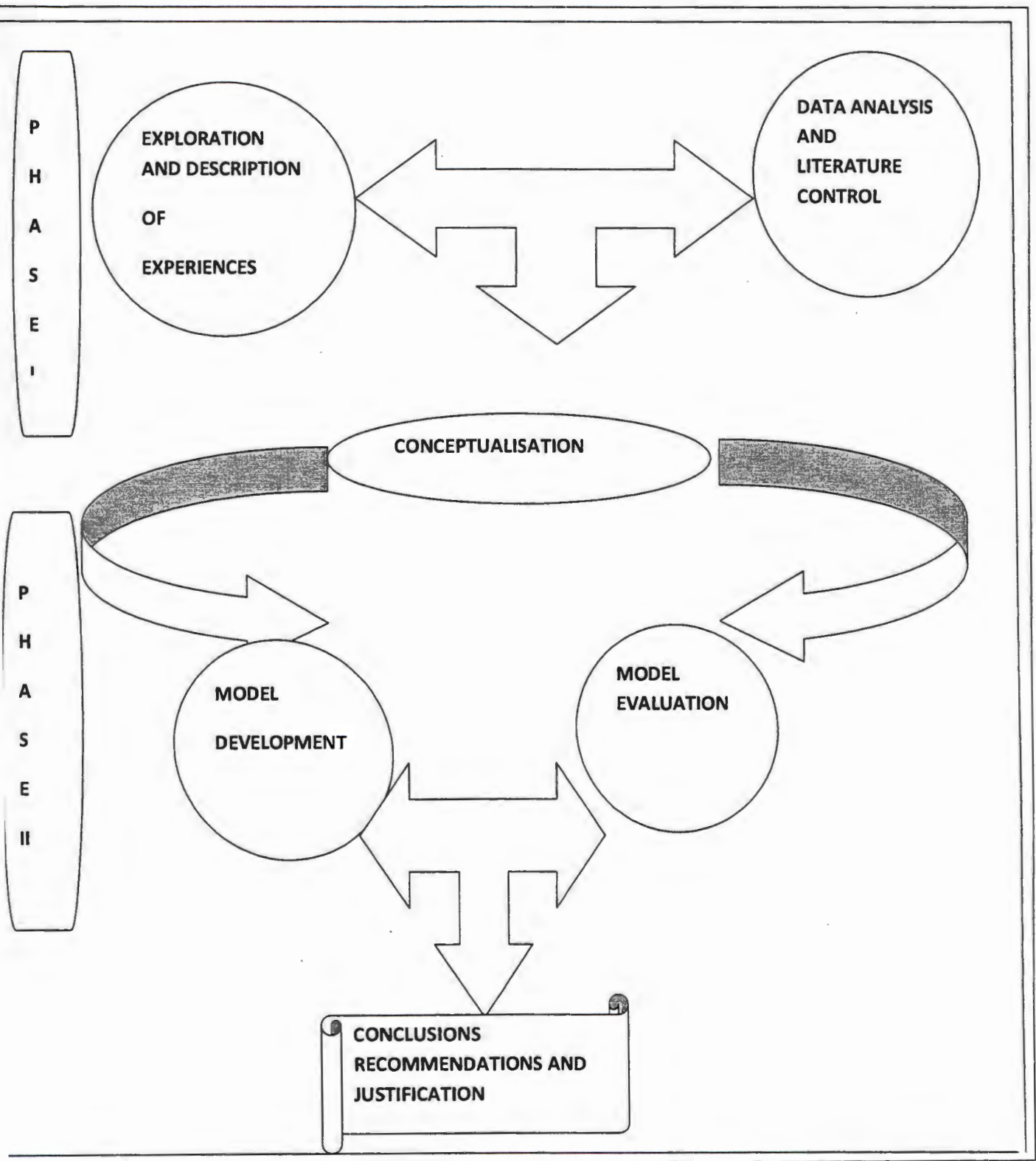


Figure 2.1. Phases of the research process

PHASE ONE: EXPLORATION AND DESCRIPTION OF THE NURSES EXPERIENCES OF CARE AND SUPPORT WHEN CARING FOR PLWHA

This phase focused on exploring and describing the experiences of nurses regarding care and support when caring for PLWHA in Vhembe district. In-depth individual interviews were conducted; observation and field notes were kept during interviews. Data collected was analysed according to Tesch's method (in Creswell, 1990:142) eight steps of analysis. Analysed data was further described against relevant literature.

2.3.1 POPULATION, SAMPLING, DATA COLLECTION AND ANALYSIS

2.3.1.1 Study population

Polit & Beck (2004:289) refers to the population as the entire aggregation of cases in which the researcher is interested. The target population was all nursing cadres (professionals, enrolled and auxiliary nurses) from one referral hospital in one of the five districts of Limpopo province. The reason for choosing this target group is that they are the primary caregivers.

2.3.1.2 Sampling method

The process of selecting a portion of the population to participate in a research study is known as sampling (Polit & Beck, 2004:291; Burns & Grove 2003:496). A sample refers to a group of people that a researcher selects from a defined population and these are the people or individuals from whom information was collected. In this study non-probability sampling was used to select the hospital and participants.

- **Sampling of hospitals**

Non-probability sampling was utilised to sample the hospital, non-probability sampling implies that not every element of the population has an opportunity for selection in the sample. Purposive and theoretical sampling was used (Polit & Hungler, 1999:247) to

sample the hospital since the researcher is knowledgeable about the setting to meet the information needs of the study.

Only one hospital was selected for the study. Selection of the hospital was based on the fact that it is the first accredited hospital to roll out ARV'S in the district, a regional hospital with bed occupancy of 561, and a high turnover of the sick and dying, and mostly PLWHA and those suffering from AIDS related infections. District hospitals and clinics in Vhembe refer clients for further management, and there is a step-down facility for palliative care.

- **Sampling of participants**

A non-probability convenience sample was used to select nurses who participated in the study. Convenience sampling entails using the most conveniently available people as study participants (Polit & Beck, 2004:292). In convenience sampling only those members available have a chance of being selected. Nurses present at the hospital and willing to participate when the researcher conducted the study were included in the sample. Nurses were grouped according to their categories to ensure homogeneity of the sample. Participants were both females and males.

- **Sample size**

Sample size depended on data saturation. Data saturation is described as repetition of data or no new information obtained during the course of a qualitative study that signifies completion of data collection in a particular phenomenon (Polit & Hungler, 1999:238; Streubert & Carpenter, 1999:22).

Table 2.2. Sample size

HOSPITAL							TOTAL
Professional Category	Prof nurses		Enrolled nurses		Enrolled nursing auxilliary		
Gender	Male	Female	Male	Female	Male	Female	
	0	9	2	2		2	
Clinical placement		VCT=3 Maternity=2 Medical= 4	Surg =1 VCT -1	1 Med 1-VCT		Med	
In-depth individual interviews		9	2	2		2	15Participants

2.4 DATA COLLECTION

Data collection is the method of collecting information, which is needed in the study. The researcher used in-depth individual interview to obtain more information from nurses on their experiences of care and support in caring for PLWHA.

In-depth qualitative interviews

In-depth individual interviews were used because they describe the essence of behaviour based on meditative thought and with the purpose of promoting human understanding (Morse & Field, 1996:21).

In-depth interview encouraged probing which increased detailed exploration and elaboration. A qualitative interview was chosen as a data collecting tool to gather a broad range of information from nurses on their understanding, perceptions and views with regard to care and support in caring for HIV and AIDS infections. The researcher used the central question to facilitate the discussions with the participants:

“What are your experiences as a carer regarding care and support to PLWHA?”

The broad question enabled the researcher to gain a better understanding of the experiences of nurses. Follow-up questions were asked to allow for deeper and more thoughtful responses from the participants (Rubin & Rubin, 2005:159). An audiotape recorder was used to record the interviews and the data was transcribed verbatim for analysis purposes (Henning, Van Rensburg & Smit, 2004: 75).

The researcher conducted the interviews in English and Tshivenda, and more information about nurses' needs, interests, attitudes, perceptions and opinions regarding care and support when caring for PLWHA was gathered, and the non verbal cues were observed during the interviews in order to capture the salient moments

The following communicative strategies were used during the interview process:

- **Scene setting**

This is a process of introducing the topic, purpose of the study and the role of the interview to the participant (Henning, Van Rensburg & Smit, 2004:75).

- **Clarifying**

During the interviews with nurses, the researcher asked the participants to clarify some concepts to get the meaning of some statements in relation to their experiences of care and support in caring for people living with HIV/AIDS (Henning, et al. 2004:75; Streubert & Carpenter, 1999:58).

- **Reflecting**

This is a process of summarising part of the conversation during the interview process to verify understanding between the researcher and participants (Henning, et al. 2004:75). The researcher repeated some statements made by nurses to verify if they were on the same level of understanding to provide clarity on the issues of care and support when caring for PLWHA.

- **Minimal responding**

The researcher encouraged the participants to express their experiences of care and support to PLWHA by listening freely without interrupting them and demonstrating respect (Streubert & Carpenter, 1999:58).

- **Probing**

The researcher asked probing questions during the interview sessions to encourage nurses to give clarity fill in missing information and kept the conversation focused on their experiences of care and support in caring for PLWHA (Rubin & Rubin, 2005:164).

Field notes

Field notes means describing as literally and accurately as possible that which is observed in the setting (Morse & Field,1996:91). It is a system for remembering, retrieving and analysing observations (Neuman, 2000:364) as they trigger the researcher's memory of what transpired during data collection.

The researcher took notes of observations that could not be picked up by an audiotape recorder, observations, key words and non-verbal cues were recorded in their presence and used as a basis for analysis (Wilson, 1993:222).

The following types of field notes were used:

Observational notes

These are descriptions of events experienced through watching and listening to participants (Wilson, 1993:222). The researcher looks for non-verbal cues from nurses as they relate their experiences during data collection and record them on a notepad. These were written account of what the researcher hears, sees, experience, and thinks about in the course of the interview.

Methodological notes

These are instructions to oneself, critiques of one's tactics, and reminders about methodological approaches that might be fruitful (Wilson, 1993:222).

Personal notes

These are notes about the researcher's reactions, reflections and experiences during interviews (Wilson, 1993:222) and assist the researcher to establish the influence of personal bias on the research process (Lincoln & Guba, 1985:281).

Theoretical notes

These are systemic attempts by the researcher to consciously derive meaning from all observational notes. The researcher reflected about what she has observed and experienced throughout the interview process, and provided meaning to the experiences and circumstances which would be fruitfully conceptualised in the study. The researcher managed to describe the experiences and circumstances within relevant literature (De Vos, 2001:285-286).

2.5 DATA ANALYSIS

Data analysis is the systematic organisation and synthesis of research data (Polit & Beck 2004:716). The purpose of data analysis is to impose some order on a large body of knowledge so that general conclusions can be reached and communicated in a research report.

Qualitative interview data was analysed by means of open coding method according to Tesch's steps in Creswell (1996:155). According to De Vos (1998:271) open coding is a process of breaking down, examining, comparing, conceptualizing and categorizing data. During this phase interrelation statements were generated based on the defined concepts. Data was also coded by an independent coder and other post graduate students. The concepts were analysed following the simplified steps of concept analysis by Walker & Avant (1995:39) and Rodgers (1989: 331).

- ***Getting sense of the whole.***

The researcher read carefully through the transcripts to understand clearly the information provided by nurses, whilst jotting some ideas as they came to mind in order to get sense in the transcripts.

- ***Picking up one interview document***

The researcher selected the most interesting interview, analysed and checked the meanings and wrote thoughts that emanated on the margins.

- ***Make a list of all topics***

A profile of topics was made and those that were similar were clustered as major, minor or unique from the interviews in order to formulate topics from data obtained.

- ***Abbreviate the topics as codes***

The researcher abbreviated the formulated topics as codes and wrote them next to the appropriate segment of the text, reviewing to check if new categories or codes emerged.

- ***Finding the most descriptive wording***

The researcher identified the most descriptive wording for the identified topics and turned them into categories, related topics were grouped on how they relate with various categories.

- ***Making the final decision on categorising and recording of data***

A final decision on the abbreviation for each category was made; data belonging to each category was assembled with codes written alphabetically and preliminary analysis was performed.

- ***Assemble similar category of data***

The data material which belonged to each category was assembled together and preliminary analyses were performed. The researcher was able to generate themes, categories and sub-categories from the collected data.

- ***Recording data***

The researcher recorded existing data.

2.6 LITERATURE CONTROL

Literature control was done with regard to the themes as well as related themes that emerged through the process of data analysis and was placed within the context of

existing literature. The identified themes were crystallising as either confirmation through literature, contradiction of the literature or as an emergent new insight that can contribute to existing literature. The results of the study were also discussed in the context of literature, see chapter 3 for more details.

2.7 MEASURES TO ENSURE TRUSTWORTHINESS

To ensure validity and reliability of qualitative data Guba's (1981:75-91) model of trustworthiness was used. Guba's (1981:75-91) model identifies four aspect of trustworthiness relevant to qualitative research, namely truth value, applicability, consistency and neutrality (Krefting, 1991:215). The four aspects will be discussed in detail.

2.7.1 Truth value through strategy of credibility

Truth value is a criterion that explains how one can establish confidence in the truth of the findings of a particular inquiry (Neuman, 2000:171) The researcher used this strategy of credibility to ensure that the findings of this study reflects the experiences of nurses regarding care and support in caring for PLWHA.

Credibility refers to the truth value obtained from the discovery of human experiences as it is lived and perceived by informants (Lincoln & Guba, 1985:301). It includes the following activities which were applied in this study:

- **Prolonged engagement**

The researcher engaged in prolonged interaction with the nurses during data collection to build trust and establish rapport with participants, uncover hidden information, with the interview lasted about 45-60 minutes so that participants could be able to express themselves freely. The researcher immersed herself intensely in the interview tapes by repeatedly listening to them in order to internalise the content of the interviews.

- **Persistent observation**

The researcher observed the participants to identify those characteristics and elements that were most relevant to the concept under study and focused on them so as to sort out irrelevancies (Lincoln & Guba, 1985:304). The researcher tentatively observed the nurses' behaviour during their working environment in the different units and this enabled her to observe occurrences of phenomenon and the interaction of the nurses.

- **Reflexivity**

Reflexivity was used to guard against being immersed within the participants experiences. A field journal was kept on all occasions to record the thoughts, feelings, ideas and other circumstances surrounding the study. The logistics and problems concerning the whole process were written down so that the researcher is made aware of biases and preconceived assumptions.

The researcher took notes of the salient and atypical events and explored them further as the individual interviews progressed, the identified elements related to

- **Peer debriefing**

Peer debriefing exposes a researcher on the other methods of enquiry of other experienced researchers. In this study the researcher exposed the research work to a colleague for constructive criticism.

- **Member checking**

Member checks were carried out by providing feedback to nurses on the findings to ensure that the researcher has captured the true experiences of participants. Participants agreed that the findings reflected their feelings and true meaning of what they experienced as caregivers when caring for HIV/AIDS infections.

Credibility determines that all findings are purely from the participants' perspective (Brink, 1996:124; Morse & Field, 1996:118).

2.7.2 Applicability through the strategy of transferability

Applicability refers to the extent to which the findings from the data can be applied to different settings and have meaning to others in similar situations (Creswell, 1996:300; Streubert & Carpenter, 1999:29). Purposive and theoretical sampling of the hospital due to the high patient turnover and roll-out of ARV's with a step-down facility, the population of fifteen nurses of all categories giving care to PLWHA, and convenience sampling was used to explore and describe the experiences of nurses caring for PLWHA in the context of HIV and AIDS. Nurses expressed problems physical, psychological and emotional strain, poor organisational support and lack of educational support. One participant had to say " *the workload is unbearable..., especially the medical wards, you go home extremely tired, and sometimes you can't walk properly*" another one said " *when managers visit the ward they are not there for nurses, but to see if patients have been cared for properly without asking if you are coping or operating with enough staff*". Lincoln and Guba (1985:316) note that transferability involves transferring the research findings to another similar context or setting and still preserves the meaning, inferences and interpretations from the completed research. In this study the researcher provided sufficient descriptive data of the findings and believes that the results can be applicable to different settings (Polit & Hungler, 1995:32; Morse & Field, 1996:118).

2.7.3 Consistency through the strategy of dependability

Consistency refers to whether the findings would be reliable/repeated if the study were replicated with the same informants or in a similar context or stability of data over time and over conditions (Creswell, 1996:299; Lincoln & Guba, 1985:316).

The researcher used the strategy of dependability to ensure consistency. Coding and recoding of the study findings was done. As qualitative research does not control the variables, but emphasises the uniqueness of individuals' perceptions, variations in experience, rather than expecting identical results (Krefting, 1991:216). In this study data was given to post graduate students for recoding and the findings were given to an

independent coder to compare similarities and differences. During data collection, questions were rephrased, responses paraphrased to confirm what the participant was saying and the recorder was replayed for the participant to confirm and the questions were phrased and rephrased around the central concept of providing care and support to PLWHA to ensure consistency.

2.7.4 Neutrality through the strategy of confirmability

Neutrality is the degree to which the findings are a function solely of the informants and conditions of research and not of biases, motivations and perspectives, signifying that the research procedure and results are free from biases (Krefting, 1991:216). The researcher achieved this through prolonged engagement, verification and reflection during in-depth individual interviews. The strategy of confirmability was used to ensure neutrality. In this study confirmability was supported by the data, findings, interpretations and recommendations that attest its coherence. The researcher and the supervisor who was an auditor reached consensus on the categories that emerged during data analysis.

2.8 ETHICAL CONSIDERATIONS

According to Polit & Beck (2004:717) ethics is a system of moral values that is concerned with the degree to which research procedures adhere to professional, legal, and social obligations for the study participants while Burns & Grove (2003:172) describe it as protecting the rights of human subjects, balancing the benefits and risk in the study, obtaining informed consent and submitting a research proposal for institutional review.

- **Permission to conduct research**

Ethical clearance was received from the North- West University. The proposal together with clearance letter was submitted to the Limpopo Provincial Ethical Research committee, for permission to utilise the hospital and participants which are the workforce. Permission was granted to conduct the study (see annexure attached).

- **Informed consent**

Informed consent ensures that participants are provided with adequate information regarding the study and that they have the power of free choice to decline participation or voluntary consent.

- Subject status- Participants were informed that data collected will be used in the study. Their responses were used for the purpose of the research only and that their responses could aid in the implementation or review of supportive interventions to nurses caring for PLWHA.
- Study purpose- The overall purpose was stated in clear, understandable terms, preferably 'lay terms'. The purpose is to develop and evaluate an intervention model to provide support to nurses in coping with caring for PLWHA.
- Type of data collected- data focused on experiences of care and support on issues pertaining to HIV/AIDS care, work based programmes, preventive services and environmental climate for support.

- **Voluntary participation**

Participants are regarded as autonomous beings with the right to make choices without being coerced. Participants were fully informed that they had the right to withdraw from the study at any time without fear of being victimised or penalised (Morse & Field, 1996:44; LoBiondo-Wood & Haber, 2002:277).

- **Respect for human rights**

The respondents were assured confidentiality, privacy and anonymity (Polit & Hungler 1995:118).

- **Privacy**

Burns & Grove (2003: 172) define privacy as the right of an individual to determine the time, extent and general circumstances under which personal information will be shared or withheld from others. The researcher ensured that self-respect and dignity of the participants were maintained throughout the study by not divulging raw data to other people except supervisors, the researcher did not to ask anything that was outside the scope of research and interviews were conducted in private rooms. Participants were also made aware on how the audiotape functioned so that they could stop the recording if they felt uncomfortable in recording some of the information they were about to disclose.

- **Confidentiality**

Confidentiality relates to how the researcher manages private information shared by participants, which must not be shared with others without authorisation by the participants. In this study the information given was not be linked to the participants or the health service, their identity remained anonymous as numbers were assigned instead of names, research data was coded and were explained that data would be accessible to the responsible persons only with permission of the participants (Burns & Grove, 2003:172).

- **Freedom from exploitation**

The right to protection from discomfort and harm was based on the ethical principle of beneficence, which holds that one should do good, and above all, no harm. The researcher avoided inflicting psychological harm by carefully considering the phrasing of questions (LoBiondo-Wood & Haber, 2002:273). Participants were assured that if they felt unable to proceed with the interview due to emotional strain, the interviews will be stopped immediately and counselling will be provided. During the interviews the researcher was continuously watching out for the participant's discomfort and no one was referred for professional intervention (Burns & Grove, 2001:196; Denosa, 1998: 2.3). Participants were allowed to ask questions after the interview and were given information on how to contact the researcher.

PHASE TWO

This phase involves conceptualisation, model development, piloting and evaluation.

2.9 CONCEPTUALISATION

In this phase, conceptualisation was done by defining the concept, identifying the attributes; interrelational statements were generated based on defined concepts, literature review, references, antecedents as well as by integrating the findings from phase1 (Chinn & Kramer, 1999:187; Walker & Avant, 1995:37).

Rodgers' (1989:331) evolutionary method and concept analysis by Walker & Avant (1995:37) was used. Using this approach allowed the meaning of the concept to be explored in order to improve communication and promote understanding of the experiences of care and support when caring for PLWHA in Limpopo province. Therefore, concept analysis provided clarification of a term or a concept in popular use or assisted in identifying phenomena (Rodger & Knafl 1993:78). The concept "support"

was analysed using Rodgers (1989:331) and Walker and Avants' (1995:37) method of concept analysis uses seven steps namely:

- ***Identify the concept of interest***

The identification of concepts was derived from the in-depth interviews of nurses' experiences regarding their care and support when caring for PLWHA. The concept "support" and other key concepts were identified from the data gathered in phase 1 regarding the needs, and expectations of nurses (Avant & Walker, 1995:39 and Rodgers, 1989:331).

- ***Determining the aims or purpose of analysis***

In this study the aim of the analysis was to explore and describe the concept "support" and its attributes so that a theoretical as well as an operational definition can be generated (Walker & Avant, 1995:39 and Rodgers 1993:78).

- ***Identify and select appropriate realms for data collection***

The target sample for this concept analysis comprised of qualitative studies from nursing, psychology and sociology that examined "support". Abstracts databases, dictionaries and other literature were searched and definitions found were described. A list of connotations was made.

- ***Identify attributes, references, antecedents and consequences of the concept***

Attributes of a concept are characteristics of that concept that appear repeatedly in the literature. The data from phase 1 aided in identifying the critical attributes and the

identified attributes were compared with literature in order to constitute the central attributes. Surrogate terms or relational terms were also captured during data collection and described together with their antecedents and consequences which were either negative or positive.

- ***Identify a model case of the concept***

The model enhances the degree of clarification by providing an everyday example which includes attributes of the concept. The model cases were identified in the interview data to understand the meaning of support as narrated by nurses who are caring for PLWHA.

2.10 MODEL DEVELOPMENT

In this phase a model were developed according to Walker & Avant (1995:25-30) using deductive, inductive analysis, synthesis and derivation strategies. Findings from phase two were analysed, clarified, using the existing body of literature and a conceptual framework was then developed using Dickoff, James & Wiedenbach (1968:422) element of practice theory.

- **Analysis**

Analysis is the resolution of a whole into parts for the purposes of clarifying, refining or sharpening concepts, statements or theories, and then examining the relationship of each of the parts to each other and to the whole (Walker & Avant, 1995:28). The researcher examined the relationship of the concept "support" with other parts to the whole, its process, dynamics, context and outcomes were refined so that each component was better understood, to bring out the overall outcome of the model. Inductive analysis was used during data analysis, conceptualisation and literature

control to fit meaningfully into the framework provided by concept analysis and participants.

- **Synthesis**

Synthesis is about combining isolated pieces of information together with findings of concept analysis to construct new concepts, new theory or new statement (Walker & Avant, 1995:28). Morse & Field (1996:105), synthesis begins when the researcher become familiarised with the setting, the researcher gained understanding of experiences of nurses with regard to their understanding of care and support in caring for PLWHA. Synthesis was applied during the conceptualisation of findings through describing and exploring the concept and analysing the experiences of nurses caring for PLWHA using Tech's method.

- **Derivation**

Derivation is about getting a way of explaining and predicting about some phenomenon that is poorly understood (Walker & Avant, 1995: 29). In interpreting the inputs of nurses as stakeholders, derivation were used to draw from other context how support in working environments or health institutions can be achieved. Caregivers/nurses brought out new perspectives about support in caring within their environment. The researcher familiarised herself with existing literature on support in health care settings and evaluated the usage of the concepts.

2.10.1 Conceptual framework

Furthermore concept analysis was integrated within a theoretical framework of Dickoff, James & Wiedenbach (1968:345) which provides the elements of a practice theory, which include the process, dynamic, context, stakeholders and purpose or outcomes to look at the activities within a theory. These phases formed the foundation for the

development of a model and the criteria for evaluation. The following are elements for model development: context, agents, patiency, dynamics, procedure, and purpose.

- **Context**

Activity is viewed in relation to other things, including persons or other activities, and to see the interrelation of these factors as constituting an organism, unity or total context of activity (Dickoff, James & Wiedenbach, 1968:426). The context within which the study was conducted was in a health care institution, a hospital in the rural district of Limpopo Province.

- **Agent**

The agents for this study are nursing service managers. The nursing managers in leadership position must possess certain characteristic that enables the development of support. Managers in institutions have a responsibility of creating and changing an organisational culture to be positive by creating a robust vision for the future of HIV/AIDS support programmes or interventions.

- **Patiency**

These are persons or (things) who receive action from agents and this activity contributes to a certain goal (Dickoff, James & Wiedenbach, 1968:426). Recipient in this study were nurses who are caring for patients within the context of HIV/AIDS. The goal to be achieved in such an activity is that nurses be supported and empowered within their workplaces.

- **Procedure**

The procedure is to emphasise the path, steps, pattern according to which activity is performed (Dickoff, James & Wiedenbach, 1968:426). The process of support in the model is the social exchange relationship between participants (nurses and managers) that need to develop a supportive work climate.

- **Dynamics**

These are driving powers behind the activity which can either be chemical, physical, biological and psychological for any person or thing functioning as an agent or part of the framework in realising the goal (Dickoff, James & Wiedenbach, 1968:426). These are the underlying powers that direct how the support process takes place, such as trust, honesty, genuineness, good communication and interpersonal skills.

- **Purpose**

Dickoff, James & Wiedenbach (1968:426) view purpose as an end point or accomplishment of an activity. The purpose for the study was to have a supportive and non-discriminatory work environment that promotes access to HIV/AIDS education, counseling, treatment and cares and empowered nursing personnel.

2.11 MODEL EVALUATION

Chinn & Kramer (1999:99-110) criteria for model evaluation was utilised to evaluate the model and to ensure validity, peers or colleagues were also requested to review the model to ensure validity and reliability. Theoretical validity was ensured by searching definitions and usage of support from existing models and theories from related literature.

- **Simplicity**

It refers to the minimal use of concepts and their relationships within each descriptive category to avoid misinterpretations (Chinn & Kramer, 1999:100). Model simplicity implies that the number of elements within each descriptive category, the concepts and their interrelationships should be kept minimal.

- **Generality**

It refers to the breath of scope, the scope of concepts and purpose within the educational programme and its applicability to other situations (Chinn & Kramer, 1999:100). Generality entails that the model can also be applied in other cooperate organisations or institutions as HIV/AIDS is affecting individuals, families and business organisations and workers are part of this broader community.

- **Clarity**

It refers to how well the intervention model can be understood as well as the consistency of conceptualisation (Chinn & Kramer, 1999:100). Semantic clarity is achieved through defining the main concepts in the model and structural clarity achieved through Dickoff et al. (1968:426) survey list.

- **Accessibility**

This refers to the extent to which the concepts are grounded in empirically identifiable phenomena (Chinn & Kramer, 1999:100). Accessibility addresses the extent to which the concepts within the model are empirically grounded and can be tested for its relationship and clarifying conceptual meaning.

- **Importance**

The extent to which the intervention model leads to valued goals in practice, research and education (Chinn & Kramer, 1999:100). Importance addresses the extent to which the model has the potential to influence nursing care, nursing education, nursing administration and research especially in the context of HIV/AIDS caring.

2.12 SUMMARY

This chapter focused on the research approach and design. The chapter detailed information on paradigmatic perspectives, research methods and design, ethical considerations and measures to ensure trustworthiness. An outline of data analysis, concept analysis, model development and model evaluation were given and will be described in detail in the following chapters.

CHAPTER 3

DISCUSSIONS OF FINDINGS AND LITERATURE CONTROL

3.1 INTRODUCTION

In this chapter an analyses of interviews conducted with participants will be provided. Interview data was analysed by means of open coding method. According to De Vos (1998:271) open coding is a process of breaking down, examining, comparing, conceptualizing and categorizing data. During this phase interrelation statements were generated based on the defined concepts. Graneheim & Lundman (2003:106) cited by Lynne (2006:2) maintain that qualitative data such as that developed from interviews or observations should be broken into meaningful units of content, the subsequent coding assist in understanding the meanings inherent in the language. Qualitative data was analysed using open coding method according to Tesch's eight steps in Creswell (1996:155). The language used was Tshivenda and some preferred to mix English and Tshivenda.

Interpretation of data was guided by Lazarus & Folkman (1984:141) transactional model of stress, appraisal and coping and conclusions drawn from the transactions between nurses and their working environment. The model proposes that stress can be reduced by changing the perceptions of the stressors, providing them with strategies to help them cope. Conclusions were drawn according to the three processes of cognitive appraisal which is primary appraisal, which serves as judgment of the encounter as stressful, secondary appraisal which serves as an evaluation of a particular coping strategy and reappraisal which is valuation based on new information obtained from environment or person in the circumstances (Lazarus & Folkman, 1984:141).

Participants described their experiences of caring for PLWHA in their workplace and the average time spent on each in-depth individual interview was about forty five minutes to an hour.

3.2 OBJECTIVE OF THIS CHAPTER

The objective of this chapter was to:

- Explore and describe the experiences of nurses caring for PLWHA in Vhembe district of Limpopo province.

In order to achieve the objective the following question was asked: What are your experiences regarding care and support to PLWHA? "This was followed by probe up questions to get more information such as " how is it to be caring for PLWHA; what kind of support do you receive, how do you cope with caring," can you elaborate on that, nodding the head, silence, paraphrasing to get more clarity.

3.3 DESCRIPTION AND REALISATION OF THE SAMPLE

- The sample comprised of nurses working in the different clinical areas in a hospital at the Vhembe district.
- Data saturation occurred after interviewing **15** nurses.
- This was shown by the repetition of the responses they were providing.
- Their ages ranged between 28 and 55 years.
- **9** of the participants were professional nurses, **four** were enrolled nurses and only **two** were auxilliary nurses.

The participants were Venda and Tsonga speaking nurses who have been practicing and rendering nursing care for more than 10years amongst the professional category and 10years for the enrolled and nursing auxiliaries. The clinical areas were chosen based on the fact that they had an increased turnover of patients admitted with debilitating diseases, HIV/AIDS related infections, increased number of deliveries in the maternity and patients requiring antiretroviral treatments and new cases being counseled on daily basis in these units. Nurses working in these units were in a better position to share their experiences of caring and support for PLWHA and how they were coping as they had daily encounters with these patients.

3.4. DISCUSSION OF FINDINGS AND LITERATURE CONTROL

Findings are discussed according to the themes, categories and subcategories which emerged during the interviews.

Table 3.2 below reflects a summary of the themes, categories and subcategories.

TABLE 3.2 Themes, Categories and Subcategories

THEMES	CATEGORIES	SUBCATEGORIES
1. Nurses experienced different problems as a result of caregiving role to PLWHA	1.1 Physical strain/ burden of care	• Increased workload • fatigue • Lack of human • Material resources
	1.2 Psychological/strain burden of care	• Fear of contagion • Loss of hope, helpless and frustrated • Feeling of insecurity • Feelings of guilt and self blame
	1.3. Emotional strain/burden of care	• Isolation and dissociation • Emotional stress • Problems associated with fear of disclosure • Fear of stigma and discrimination
2. Nurses experienced of problems related to lack of support by colleagues and managers in caring for PLWHA	2.1. Poor organisational support	• Lack of social support from managers • Lack of social support from colleagues

3. Nurses expressed their needs in assisting them to cope in rendering care to PLWHA	3.1. Insufficient educational support	• Lack of educational support • In-service training • Gaps in curriculum
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3.4.1 DISCUSSION OF FINDINGS

Caring for the very ill and dying can drain a person’s energy reserves leading to stress, burnout and depersonalization; it can affect one’s health and behavioral outcome. The themes that emanated from the experiences of the carers were the impact of caring on their personal health, their physical, psychological and emotional health, also problems related to lack of support and the need to be empowered in caring for PLWHA, nurses experienced different behavioral problems like absenteeism, withdrawal, guilt feelings and loss of hope emanating from the stress that they experienced in the workplace. The themes together with the subcategories will be described in details in the following paragraphs.

3.4.1.1 THEME ONE: NURSES EXPERIENCED DIFFERENT PROBLEMS AS A RESULT OF CARING FOR PLWHA

A person who is faced with caring, experiences problems associated with care giving and caregiver burden leading to stress of an individual. Caregiver burden is described as physical, emotional and social problems associated with care giving and having a subjective or objective impact (O’Neill & McKinney, 2003:2).The act of caring also leaves an individual with physical, psychological and emotional effects. Almost all the participants experienced the strain of caring in various ways. These will be discussed in the subsequent paragraphs. This theme emerged from the data that reflected nurse’s experiences of care. The following are categories identified from the theme:

- Physical strain
- Psychological strain

- Emotional strain

CATEGORY ONE: NURSES EXPERIENCES OF PHYSICAL STRAIN AS A RESULT OF CARING FOR PLWHA

The physical burden or stress arises as a result of the body's response to physical stressors like work. The physical causes of stress such as increased workload, high ratios of patients and prolonged hospital stay can lead to physical strain like fatigue and other physiological changes such as poor concentration, anorexia, changes in bowel movements and insomnia. Shortages of staff can place demand on the human system affecting the body negatively as one is not having adequate rest and when material resources are not available or are insufficient it impacts on one's psycho-social being resulting in behavioral changes such as alcoholism, depression since people display different coping mechanisms.

• Increased workload

The participants reported that their workload had increased. The perceived increase were an increase in tasks especially counselling and provision of ARV, an increase in patient ratios, having very sick patients with poor prognosis and staying for a long time in hospital and demanding more care because the disease presents itself in many ways and facing staff shortages. The following statements are ways in which nurses experienced increased workload.

Nurses explained how the workload had increased by describing their daily chaotic experiences: One registered nurse said *"Registered nurses have a lot on their hands, because we have to ensure that all intravenous treatments are administered to all patients, and patients on Intravenous(IV) treatments are many, we need to attend to the problems and those with problems should be reported to the doctor, whenever you have a patient who has changed condition, you must run up and down so as to be hasty in helping the patient."* other participants further explained that *"One staff nurse has to*

make sure that all oral medications in the wards as well as ARV's are administered equally to all patients".

Furthermore, *"mm...m, nowadays we are experiencing work overload because before administering ARV's you need to prepare meals, we start with giving them soft porridge and make sure that the time that has been scheduled should not be missed, because there are those who are given medication at 06h00 in the morning, at 07h00 and others at 08h00, and this increases the workload because the routine has changed ever since the scourge of HIV".* The sub-professionals also shared their concern on how they are burdened *"the workload is more especially in the mornings, ...mmm, bed making, bed bath, fixing, feeding and dusting, but after 16h00, the strain is felt by the one who is left behind.....AAH vhone ! (Exclamation and head shake)"*

One professional nurse had to say on behalf of her junior colleagues *" Only if they can increase the staff working in the medical wards, especially the category of nursing auxiliaries, really they are feeling the brunt due to fixing and bathing, even the staff nurses in administration of medications, unlike one person starting from ward 1 to ward 7."*

The workload could be compounded by the fact that HIV/AIDS patients need more attention and care than other patients without HIV/AIDS, and that patients usually come to hospital when they are at the advanced stage of the disease and are unable to help themselves and requiring nurses to actually do the activities of daily living for them. So the contact care time of one individual patient is twice or thrice that of non-hiv patients. The HIV epidemic has transformed the face of caregivers; the strains on those caring for PLWHA are enormous. Caring for an individual with AIDS-related disease is usually time consuming, burdensome, and unpredictable (Strydom & Wessels, 2006:4).

Nurses shared this concern that HIV/AIDS has impacted negatively on the bed occupancy rate and prolonged hospital stay as more patients were admitted with AIDS

related opportunistic infections, overcrowding increased the workload as the patients are weak, very sick and come with so many problems that need to be attended including psychological problems.

Another nurse said *"For instance, patients present with different kinds of diseases. It takes time for the disease to resolve and prolongs their stay in the hospital because it takes time for their symptoms to resolve."*

Another participant had this to say *"Patients are admitted in a critical stage, when they cannot help themselves, and they are admitted with these opportunistic diseases, most prevalent are TB meningitis, streptococcal meningitis, and they stay long because they are treated with Aphoceterin B that is supposed to be given for a duration of 14 days, but still you will find that there is no improvement"*. The participant further indicated that *"Ee.., another problem is that most of the diarrhoeas and TB are related to HIV/AIDS, when patients with such conditions are tested, they are usually found to be positive"*.

Chandra, Jairam & Jacob (2004:48) also reported that the prolongation of the disease course, uncertainty about overall prognosis, repeated exacerbations and remission in later stages of HIV disease have intensified the emotional and physical demands of care giving. Tawfik & Kinoti (2003:2, 2006:5) also indicated that HIV/AIDS have changed the landscape of health and disease and service needs; there is resurgence of diseases like malnutrition, tuberculosis and diarrhea, and other opportunistic diseases associated with HIV infection have a marked effect on hospitals and staff responsibilities.

One nurse complained of being overworked by the high patient ratios, fewer doctors and nursing staff *"...If you compare the 100 per month intake with the number of doctors and nurses who are taking care of them the workload is really too much.....ja.....but management is trying to allocate..... it's not enough"*. Here is

what the other participant had to say *"You will find that the numbers of patients admitted are 60 whereas the bed occupancy in the ward is 47, this is what causes stress"*.

There is gross overcrowding in the wards. Mkhabela, Mavundla & Sukati (2008:475) also indicated that VCT centers were overcrowded with six qualified nurses seeing about 100 clients for pre- and post-test while at the same time providing ART to more than 150 clients as a response to the 3 by 5 initiative. Furthermore, the ratio of nurses to population was 28:10 000, which was not guided by any policy framework.

The public health sector faces tremendous challenges of manpower as it is failing to conserve the human capital. Tawfik & Kinoti (2006:4) reported that local economic constraints and structural adjustment programmes imposed by international donor agencies and governance issue has led to many posts remaining unfilled for years in the developing countries. There is simply inadequate human capacity, generally the health personnel to population ratios in sub-Saharan African countries are higher than the rest of the world, in Mozambique in 2006, 3 physicians and 21 nurses catered for 100,000 inhabitants (Ayangwe & Mtonga, 2007:96). South African health care sector is not exceptional as there are still gross inequitable distribution of human and financial resources between the private and public sector.

Some nurses experienced undue workload when their colleagues were absent on sick leave and explained how they dealt with heavy workload and absenteeism *".... We work in such a way that even if one of the staff member is sick, we work as much as if she is present in order to push the workload"*.

HIV/AIDS impact on families, communities including personnel and affects the morbidity and mortality of those affected. Tawfik & Kinoti (2006:7) indicated that absenteeism due to personal or relative's illness and attending funerals is having an impact on the service

delivery and that the health sector may lose one fifth of their employees succumbing to HIV/AIDS over the next few years.

Absenteeism and the accompanying expectations that the remaining staff must shoulder the burden results in certain nursing categories acting beyond their scope of practice resulting in chronic fatigue and burnout which can in turn affect organisational functioning by contributing to employees' physical symptoms and reduced job performance.

Some nurses also expressed dissatisfaction with the workload as they were not happy being allocated in medical wards and HIV/AIDS clinic for prolonged periods *".... some refuse, but some are willing although most of the people they don't want to come and work here, they are afraid of the workload....., is too much", ... "They are afraid because of the workload....., work overload, they have realized that it is strenuous, they even verbalize it, they have experienced it that it is strenuous, they even verbalize it... Some nurses when allocated to medical ward they even resign or look for transfer"*.

Mkhabela, et.al. (2008:474) reported that nurses working at VCT centres in Swaziland do not work because of commitment and interest but through selection by employers and this may lead to stress and burnout especially when support system is not available. Pendukeni (2004:15) also reported that 90% of nurses working in a referral hospital in Namibia said that they were not prepared to deal with HIV/AIDS patients, as a result they looked for every opportunity to stay away from work, and 98% indicated that they could not cope with the caring of HIV/AIDS patients. Employees should be allocated according to their skills and preferences to prevent nurses from leaving the organisation because they are allocated to jobs that do not fall within their field of interest and specialization.

Dieleman, Bwete, Maniple, Bakker, Nemaganda, Odaga & Wilt (2007:212) reported similar findings that respondent's perceived increases in workload, an increase in tasks,

especially counselling and ARV provision, an increase in patients, having sicker patients which demand care and facing staff shortages. Mavhandu-Mudzusi, et al. (2007:255) reported that nurses who are trained to deliver VCT services are expected to do other nursing activities and are expected to cope with increasing levels of workload stress due to the high number of patients who come for VCT, as well as the increasing shortage of staff due to ill-health and death of colleagues from HIV and AIDS. The increased disease burden due to increased cases of illnesses such as tuberculosis, diarrhoea, pneumoystis carnii pneumonia in the form of opportunistic infections associated with HIV infection contribute to the length of hospital stay, with patients staying 14days and more.

From the participants' views it is understood that increased workload experienced by nurses may lead to burnout, because situational factors are more strongly predictive to burnout and this is manifested by the nurses voicing out their concerns about care giving role. Some of the nurses did not want to be allocated in medical wards; they would rather opt for transfer or resignations. The heavier workloads resulted in poor quality nursing care as nurses had many sick patients to take care and failed to give the necessary nursing care to patients who were continuously calling for help. The heavy workloads impacts negatively on care, thus the quality of care becomes compromised.

HIV/AIDS care has impacted negatively on the workload as patients stay in hospital longer than anticipated causing stress or strain on the nurses, thus failing to cope with the increased burden of work and resulting in stress, since perceived workload is significantly related to burnout in AIDS caregivers and can lead to reduced productivity, increased attrition, low morale and increased accidents.

Workloads continue to be a controversial issue as they vary on dramatic structural differences like location, staffing levels, infrastructure and resourcing because South African public hospitals occurs in diverse socio-economic context, like the rural areas where staff have to start their day with damp dusting, serving of meals, transporting

patients to x-rays, collecting treatments from pharmacy/dispensary and also other grey areas of their care where they have to draw blood from veins, insert intravenous infusions and even suture wounds unlike in other settings where nurses are able to concentrate on their core tasks and having other support staff to render the ancillary services.

- **Fatigue**

Physical fatigue is the inability to continue functioning at the level of one's normal abilities (www.medical-dictionary.the-free-dictionary.com/fatigue). Fatigue may be referred to as physical tiredness in humans manifested by exhaustion, lethargy and lassitude. It results in lack of energy, motivation and can usually result in physical bodily changes (Readers digest complete word finder, 1993:540).

Participants reported physical exhaustion due to straight shifts, skipping tea-breaks or shortening tea and lunch breaks. The following statements are ways in which nurse's experienced physical strain or fatigue:

A professional nurse working in VCT clinic indicated that “ *We are so overworked due to staff shortage that we knock off being physically strained, you will find that nurses knock-off being tired , and this leave them being stressed.*”

Caring for PLWHA is a demanding job that requires physical and emotional reserves that occasionally exceed those of even the healthiest persons. It imposes burdens that may compromise the nurses' health; symptoms of poor physical health are significantly associated with care-related demands and stressors.

Nurses experienced physical and emotional exhaustion that contributed to their negative attitude of placement in the medical wards “.... *if you have been allocated in the medical ward you will be placed there forever....., like forever.....mm.....m, but this time they have changed it on a 2 year basis, they have realized a person can get*

tired". Another one said: *"When you work in the medical wards, you go home physically tired...., you can't even walk properly"*.

Nurses as carers are prone to experience burnout when they experience work overload. Ross (2001:29) indicates that physical and psychological stress are some of the burdens accompanying the health of the care worker, as workers find themselves overwhelmed by what they experience physically and emotionally and this leads to emotional exhaustion, depersonalization and reduced personal accomplishment.

Nurses responded that at times one cannot take enough time to rest and eat as you want to push the workload for patients sake *"..... It is possible that you find yourself not taking the allocated time for tea and lunch breaks, for the sake of helping out the patients."*

Dieleman et al (2007:7) reported that 48% of respondents worked overtime regularly, they worked outside the normal working schedule, and staff skipped breaks, which indicates that nurses are compromising on their health.

From what has been described it is understood that the multiple tasks performed by nurses often result in neglecting their own self-care needs, like having a balanced meal, exercising and having time to relax. Symptoms of poor physical health are evident amongst nurses as they leave little time and energy for self care. This is also supported by O'Neill & McKinney (2003:5), who also reported that caregivers with high levels of subjective burden were less likely to eat a balanced diet, exercise and participate in stress management and health promoting activities, Dieleman et al, (2007:7) reported that almost two-thirds women caring for HIV-relatives had experienced at least one chronic physical symptom.

Some indicated that *"when the other staff member is off-sick, you have to put more effort to replace the one who is sick and close the gap so as to push the workload for patient sake"*, and this lead to compassion fatigue.

Fatigue is a state that can affect physical and mental activity and lessen the individual's capacity to work and perform his or her activities effectively and efficiently (www.medical-dictionary.the-free-dictionary.com/fatigue). Caring for PLWHA imposes burdens that compromise the health of the nurse, symptoms of poor physical health manifest among caregivers as they are associated with care-related demands and stressors.

Physical burden produces high levels of chronic stress resulting in depression and burnout. Rice (2000:590) cited Lazarus & Folkman (1984:141) indicates that stress is related to health outcomes and affects adaptational outcomes like functioning in work and social living, morale or life satisfaction and somatic health. The concept health broadly encompass physical, psychological (cognitive functional ability), morale and social (social functioning).

- **Shortage of human resources**

With the scourge of HIV/AIDS epidemic, there is still unequal and sectoral distribution, high vacancy and turnover rates of nurses due to resignations and migration from public hospitals to private hospitals and abroad and from rural areas to urban settings. The shortage of human resources places a burden on the already strained personnel and leads to inefficiencies due to lack of skilled personnel and deficiencies in nursing care as the hands are few.

The following are the voices of the participants indicating the scourge of HIV/AIDS on the human resource.

One participant said *".....Ee.....h! At the moment.... We are having a serious challenge of manpower. Ee.....!. it affects the whole multidisciplinary team, we have lack of doctors, lack of nurses especially those allocated specifically in the ARV clinic, ee.....e, since the roll out of ARV most of the people in our community are aware that*

there is treatment and you find that people who are supposed to serve them are few..... for instance in our institution our intake is more than 100 per month”.

There is a serious issue of global maldistribution of health workers; countries with the highest burden of disease have less skilled workers. Africa's health work force density averages 0.8 workers per 1000 population, significantly lower compared to other regions of the world with the Sub-Saharan Africa carrying for about 74% of global burden of communicable disease and AIDS-related illnesses (Anyangwe & Mtonga, 2007:94).

Zelnick & O' Donnell (2005:168) also reported vacant positions in KwaZulu Natal (KZN), with 51,67% vacant physician posts, 26.91% professional nurse posts and 26.17% posts for staff nurses with no replacement and of which 1,196 permanent professional nurses terminated employment.

Furthermore, there is insufficient adequately trained staff to deal with the disease, VCT trained professionals are few with limited hospital doctors having their hands full due to high patient ratios and juggling with different roles in the units. One nurse had to say “.... Sometimes we are faced with the challenge that most of the doctors are from the NGO, they are not from the institution, thus management do support us by allocating a doctor to come and work in the HIV/AIDS unit and provide services to patients.”

Among the key problems contributing to the shortages of staff are the insufficient training opportunities, Africa is lacking the facilities to train health workers, two-thirds of sub Saharan Africa have one medical school and 11 have no medical school at all. Data from Ghana showed that the country produced registered nurses at an average rate of 409 nurses per year between 200 and 2003 which worked out to one new nurse per 49 000 population per year (Anyangwe & Mtonga 2007:4; Munjanja, Kibuka & Dovlo, 2005:18). South Africa is also experiencing disparities in nurse training as most of the rural areas have no training facilities such as nursing colleges and universities. In Limpopo province according to South African Nursing Council statistics for 2000-2009, registered nurse throughput from both colleges and universities was 1 589 for the four–

year programme, and 3 053 for the bridging (2 year) programme, which worked out to one new registered nurse per 606 patients.

The critical shortage of human resource contributes to the key cause of poor quality health care and low productivity of health workers. *"We really experience emotional stress, when you realize that the patient should not have died if there were sufficient nurses because nursing care could have been properly rendered"*.

Shortages of manpower affect the quality of nursing care, because when nurses are few with many patients to attend to, it becomes difficult to really take individual time to listen to the concerns of patients and when nurses find themselves under such stressful circumstances they become impatient and nursing care declines.

The nurses reported that the workload is unbearable for them due to shortages of staff *"Mm.....m, there are increased number of sick patients and the staff is very limited, the rate of sicker patients is enormous"*.

The supply of health workers has declined due to HIV/AIDS, some nurses leave the clinical field and others leave the health service altogether, some are migrating to other professions and geographical settings with better incentives.

Staff shortages compounded by increased patient ratios and overcrowding in the units made it difficult for a short-staffed facility to provide quality care, resulting in frustrated and stressed nurses. *"Due to the pressure and high patient numbers, you will find that the bed occupancy is 47 whilst the patients are 60, this place us in a stressful situation, as some of the patients have to sleep on the floor, while you have to move other patients to other wards where there are empty beds, and you will find that other patients refuse to come off the bed when you request them to sleep on the floor so as to have a bed for the acutely ill patient. Sometimes when one is busy in the other cubicle there will be someone changing condition in the other cubicle by the time you rush there to help*

someone will also be needing your attention in the other cubicles leading to poor nursing care of patients

Bateman (2001:99) reported that the health committee of the Health Professions Council of South Africa (HPCSA) had to deal with increased number of cases against alleged impaired doctors related to factors such as long working hours without support, nursing personnel are not exceptional as annually there are nursing personnel who appears before the South African Nursing Council disciplinary hearing for providing poor quality care related to omissions in nursing care irrespective of the conditions they find themselves in. McIntosh & Stellenberg (2009:13), the quality of nursing practice is an ethical issue and professional registered nurses are accountable and responsible for the delivery of quality care and should therefore advocate for quality care.

Staff shortages were also affected by the attitudes of nurses towards placement in specific clinical units where they lacked interest or afraid of the workload. One nurse had to say *"some nurses when change list allocate them to medical ward they even resign or look for transfer."*

Mkhabela, et al.(2008:474) also reported that nurses worked at VCT centers not because of interest and commitment but through selection by employers which may lead to poor services, stress and burnout especially when support system for nurses are not available.

Human resource challenges manifest not only in shortages of health workers, but also in disparities in their distribution, poor training capacity, skills, skills mix deficits and weak management and supervisory systems. South Africa currently has fewer public health workers, including professional nurses, than it did ten years ago, the national health system is structurally characterized by public-private sector divide and this is reflected in large inequalities in the distribution of personnel. In 2005, of 99 534 professional nurses registered with South African Nursing Council (SANC) only 43 660 (43.9%) were employed in the public sector despite the fact that this sector caters for more than 80% of the population (van Rensburg, Steyn, Schneider & Loffstadt, 2008:3).

The private sector employs more than half of the country's nurses and two-thirds of the doctors with the number of enrolled nurses having dropped from 60 per 100 000 to 52 per 100, 000 and number of professional nurses has dropped from 120 per 100,000 to 109 per 100, 000. Furthermore, the shortages are reflected in migration and international recruitment of nurses, the impact of out migration is severe as scarce skill is lost as nurses take their skills and expertise into other types of employment (MSF report, 2007:8, ICN Press Release, 2004:2).

From what has been described it is clear that shortages of skilled human resource can impact negatively on the nurse. When nurses are overworked and having more roles they feel less motivated, put less or tardy work, and these leads to confusion and forgetfulness which can result in omissions in nursing care, the quality of care rendered will be compromised. Staff shortages contribute to fatigue, stress and burnout.

- **Shortages of material resources**

The participants reported shortages of material resources such as medical equipment, cot-beds and medications. The following statements are ways in which nurse's experienced shortages of resources when rendering care, since they are forced to operate with inadequate resources.

Accessing quality health care by patients becomes jeopardized when there is lack of resources available *"You will sometimes find that you communicate with an HIV patient to sleep well on bed, in order not to fall but in the long run he will fall from the bed and you must rush for help because cot beds are not enough to cater for all chronic patients in the ward"* (Low tone). Another participant said *"There is gross shortages of resources, you have to wait for the other persons when you need to use the item, like when you want to take vital signs, or you can borrow from another ward, and it retards the routine, moreover they are not enough and are of low quality, and don't last and not long you will realise that they are no longer in good condition"*.

To render effective and appropriate nursing care; accurate nursing diagnosis is necessary, so as to assess and make individualised care plans for those who are at risk of multiple infections and protect them from injuries but without resources it's difficult for making the right diagnosis about their vital data's especially such patients with low immunity who are at risk to multiple infections. Shortages of resources contribute to waste of time and also retard nursing care. King & McInerney (2006:79) also reported shortages of basic equipment (Baumanometers and Glucometers) and a tendency by hospital management to sanction the ordering of cheap and inferior quality of surgical supplies that has negatively impacted on the everyday work routines. This situation has negatively affected the ability of nursing personnel to deliver a quality service to their patients.

Furthermore, nurses felt irresponsible, guilty and emotional pain about not rendering the necessary care to patients, like omitting to administer medication to the critically ill patients. *".....Mm.....m that's for sure, isn't it we need to have resources, but you will find an HIV patient has being ordered to be given treatments and you find that antibiotics are out of stock, and that gives us stress because maybe if he had antibiotics he would be better"*. Nurses felt that shortages of medications retards the progress of the patient's prognosis, resulting in prolonged stay and increases the burden of caring resulting in stress and burnout. Similar findings were reported by Vhuromi & Davhana-Maselesele (2009:65) that the clinics ran out of pharmaceuticals and vaccines which made it impossible to render Integrated Management of Childhood Illnesses (IMCI) services.

Furthermore lack or shortages of resources made VCT counselors to work under difficult circumstances, here is what one had to say: *"Sometimes we are having challenges with the test kits, you will find that there is no medication to test with or there was an error in the packaging, sometimes they withdraw the test kits to say they did not meet the standardized requirements or whatever the reasons, it then becomes a*

challenge to validate the results of the tests that were done prior to the batch of test kits been withdrawn, apart from that it makes patients to say that s/he was not positive it was due to the unreliability of the test, only if it can reach the press" (pulling the face).

This seems to be the case in most VCT centres, Mavhandu-Mudzusi et al. (2007:257) reported similar findings of shortages of test kits and buffer solutions, and could not keep extra stock as it expired quickly especially buffers that expired 3 months before the test kits.

Mohale & Mulaudzi (2008:63) also found in their study done at Mopani district in Limpopo province that shortage of drugs and infrastructure was a constraint for caring for clients as the supply of drugs did not cover the number of clients at the facility, which was exhausted before the next order was due.

Generally, participants expressed that shortage of material resources constrained rendering basic necessities of care. During the interviews observational notes were kept and most of the taps/ basins in the cubicles were not provided with soaps or disinfectants and paper towels. It's a call for concern to maintain good hygienic practices to prevention of cross-infection and risk of contagion from body fluids. Shortages of medications also hampered the quality of care and delayed the prognosis of patients contributing to prolonged hospital stay and impacted on the workload leading to physical fatigue. Some patients fell from beds as there were no proper beds to cater for restless, disorientated patients thus nurses became frustrated, helpless, hopeless, depressed and were always anxious when coming on duty, not knowing what will transpire for the day. Typically nurses lost interest and commitment to work and felt guilty working under such circumstances.

CATEGORY 2: NURSES EXPERIENCES OF PSYCHOLOGICAL STRAIN AS A RESULT OF CARING FOR PLWHA

Hancock, Ward, Szalma & Ganey (2002:502) cited Lazarus & Folkman (1984:141) that psychological stress is a case in which individuals appraise their environment as taxing or exceeding their resources or endangering their well-being. The negative effects of stress are most likely to occur when individuals view an event as a threat, and when they assess their coping skills as inadequate for handling the stressor.

Psychological stress occurs when our minds perceive an inability to cope with a challenge of some kind. It also goes along with physical stress, as prolonged psychological stress causes physical changes in our bodies.

Most of the participants experienced psychological burden of caring as shown by fear of contagion, loss of hope, helplessness and frustration feeling of insecurity and feelings of guilt and self blame.

- **Fear of contagion**

The participants expressed feelings of fear related to becoming infected at work, that they are vigilant and taking measures to ensure that they do not get infected. Some stated the problem of contagion related to multi-drug resistance due to non-compliance with treatment and admitting patients with AIDS related conditions especially tuberculosis (TB). The following statements are ways in which nurse's experienced fear in the workplace:

Nurses felt that they were at risk of being infected as they had inadequate information about the people they treated *"We are at risk of contracting diseases, like when a patient has TB, or has defaulted treatment and developed multi-drug resistance..., it means we can also get the disease and it make us to be fearful that we can contract the disease "*. One indicated that *"We encouraged one another to eat porridge (vhuswa) in*

the mornings before commencing with the activities of the day to built resistance, I did not to eat in the morning (laughing), but now lately I eat porridge''.

Nurses are concerned as most patient are received in the wards prior to be diagnosed with tuberculosis whilst others already knowing their status but concealing it to the nurses. Tuberculosis is the leading cause of death in South Africa and the trend needs to be seen in the context of HIV epidemic, as it accelerates the course of HIV, the coinfection rates with an HIV prevalence of almost three-quarters among people with incident of tuberculosis, with nurses not excluded as they are part of the broader community (<http://www.avert.org/aidssouthafrica.htm>). Tawfik and Kinoti (2006:8), reported that HIV prevalence among health workers in South Africa is high and called for the introduction of antiretroviral programme targeting them, in addition there is a need for the development of a new policy regarding placement of infected health workers in tuberculosis (TB) wards.

Nurses felt that they were at risk of being infected due to intentional exposure by some patients. Here is what one had to say: *".... Sometimes giving care is not pleasing as some patients are uncooperative and not listening to instructions you will find them messing the whole place, taking out drips and so on, like he or she want all of you contaminated by his/her secretions and wanting to touch everyone around"*.

Nurses were concerned with the behaviour of other patients who place their lives at risk by being uncooperative in their care. Ehlers (2006:660) also indicated that some HIV+ persons are believed to spread the disease on purpose so as not to die alone, the so-called "vengeance belief/theory" since nurses are easy targets for such purposeful infections.

Nurses felt that they were at risk of being infected as most nurses were not adhering to the use of personal protective clothing in the work environment. A professional nurse indicated *"By advising one another to wear protective clothing because we may not*

know which patient is HIV+ or negative, even though some you can observe by their symptoms, so we delegate someone everyday to ensure that everyone has put on a protective clothing by delegation."

Nurses could be at risk due to ignorance or lack of knowledge about the patients' status. Awusabo-Asare & Marfo (1997:274) also reported the inability to identify infected persons due to lack of facilities, and the fact that the risk of contracting the disease might be very low if nurses adhere to basic safety measures applicable to other diseases, such as the use of gloves for invasive procedures, disinfecting, proper handling of specimens and adequate disposal of used items.

Nurses reported negative perception towards PEP, here is what one participant had to say *"It is because people present with a variety of symptoms from the side effects of ARV's, some believe that they were not ill, they started becoming ill after commencing treatment....., you see, for example when you are light in complexion as yourself, then you start becoming darker(literary speaking, then you become a center of attraction)(loud), ...Does the situation not result in stress?, you just start getting rash when you know that you have a smooth skin"*. Similar situation occurred with physicians, another one said *"I can still remember an incident of two doctors who cut each other during an operation, they literally refused to be tested (laughing)"*.

Nurses were sometimes reluctant to report needle prick injury, it was a dilemma as others were reluctant by their side-effects, or that at times the patient is tested and the patient might test negative whilst the nurse test positive. Antiretroviral agents were associated with adverse side effects, including diarrhea, nausea and headaches. Data from U.S. National Surveillance System for Health Care Workers and the HIV Post – exposure Prophylaxis Registry indicated that nearly 50% of U.S health care personnel report adverse events while taking PEP, and as a result, about one- third stop taking the drugs (Zelnick & Donnell, 2005:172).

The possibility of becoming infected is a major concern for nurses. Various authors have reported nurses fears of becoming infected in the course of their professional duties, the risk of acquiring nosocomial (hospital acquired) transmission because of inadequate implementation of universal precautions, the lack of reliable infection control programmes and unavailability of sterilizing equipments (Hall, n.d).

The fact that the disease is still incurable and that nurses are usually not familiar with the status of their patients might also increase their fear of infection. In South Africa the status of patients remains unknown to nurses unless he chooses to disclose and this increases the risk of contracting HIV infection in the workplace (De Villiers & Ndou, 2008:6, Ehlers, 2006:657). Some HIV+ persons are believed to spread the disease on purpose and nurses are easy targets as they put up intravenous infusions, administer injections and also coming in contact with body fluids and fear of contracting the disease is further exacerbated by difficulties in maintaining adequate infection control practices.

The findings indicate that there is a possibility of contracting the infection. The fear of contracting multi drug resistant infections from patients is due to the difficulty to protect themselves from getting tuberculosis, as all patients are admitted in the medical ward before they can give out a sputum specimen or start treatment, so the risk of getting infected before the patient starts treatment is high and this fear may result with physical or withdrawal from PLWHA, resulting in clients being deprived the necessary care whilst causing stress, anxiety and discomfort for the nurse and the patient.

- **Loss of hope, helplessness and frustration**

Participants felt hopeless as a result of poor prognosis of patients, prolonged hospitalization, denial of their status, rejection of patients by their relatives and

perceived death. The following statements are ways in which nurse's experienced a sense of hopelessness in the workplace:

Most participants lost morale and felt depressed when they thought that there was no further help to give to patients when death was inevitable. *"....We are badly affected, psychologically we are affected, because you also place yourself in the position that you will also be packed due to these things, because I am also exposed to these things on daily basis, therefore there is no guarantee, to tell the honest truth it is really giving us a bad feeling at times"*. Another nurse said: *"Sometimes you care for the person of your own age group, when s/he is still well and not yet become emaciated and so on, but maybe s/he failed to cope with the diagnosis and dies, it also makes you think that tomorrow you might find yourself facing a similar situation"*.

Nurses reported feelings of emotional drain, including being stressed and overwhelmed by the deteriorating health and inevitable death of their patients. They experienced difficulties in dealing with their own emotional reactions. Dageid et, al (n.d) also reported similar findings among home-based carers that sometimes seeing symptoms of their patients made them cry, caring for the terminally ill or dying patients, who literally died in their hands was traumatizing.

Helplessness and frustration is a state that frequently results when the events are uncontrollable and working environment not conducive to the mental wellbeing of the nurse. Nurses felt helpless as they could not maintain the medical care of PLWHA.

"....The conditions are not treating us well; the work circumstances are very unbearable..... Especially during the night, because these patients (pause) behave like..... like,..... Psychiatrics. You will find them going up and about the whole night, screaming and wanting to abscond and you need to give him all the attention, whereas there are also other patients who need to be cared". Furthermore, they felt more frustrated by the inefficient care they rendered as resources were inadequate, and placed patients at risk of injury. Nurses had no total control of the situation, as one

nurse further reiterated that *"..... some jump out of the cot beds, and we end up placing their bedding on the floor, so as not to experience problems, once we realize that he is becoming a problem, we place them on the floor, knowing very well that patients are not allowed to sleep on the floor but due to pressure that if he ends up hurting himself you are supposed to write statement"*. (sad look, shrugging shoulders)

This is a dilemma for the nurse, to keep herself out of lawsuits and being found accountable for misconduct of "duty to take care", the nurse rather live with a clear conscience of letting patient sleep on the floor. Most of the nurses felt that they were not able to provide quality of services as the work situation was too inflexible and unpredictable; there was little support from management. Nurses lacked a sense of professional accomplishment. Dielemam et al. (2007:4) reported that staff would be discouraged from working because of low motivation and stress, which are influenced by HIV/AIDS and by the general working conditions and this would contribute to low performance of the health system.

- **Feelings of insecurity**

The nurses' experience of the work situation was unpredictable and frustrating as you cannot anticipate how your day will turn out to be, you are forever anxious and tense about the outcome of day. Night nurses described how they frequently had to struggle with difficult, confused patients, and participants expressed their plight even after reporting to the responsible authorities.

".....This very week when coming on duty at 19h00, we found a patient with an uncontrollable and unexplainable behaviour, sometimes you find that you are even forced to run away as the patient will be threatening, ee..... (loud voice and agitated look) as you are running for help, when he hurts you, you are just hurt, nothing happens, when you are not hurt nothing is said and I haven't seen them taking any actions whatsoever".

Nurses also need to feel secure at work, but at times they are threatened by the patients they are supposed to serve. The South African health sector has among the highest incidence of violence in the world, recent research indicates that 61% of the surveyed health sector personnel have experienced at least one incident of physical or psychological violence, with women more vulnerable, whilst ambulance staff are reported to be at great risk, nurses are three times more likely to experience violence in the workplace than other occupational groups (Ijumba,n.d)

Another nurse had to say *"some abuse us verbally, they use abusive language"*. King & McInerney (2006:74) also reported that nurses in the Durban metropolitan area experienced violence in the workplace. The episodes of violence ranged from verbal abuse, malicious gossiping and intimidation, to actual physical assault. The most frequent sources of verbal abuse and assault experienced were from patients and their relatives at both public and private institutions.

Kgosimore (2004:13 as cited by King & McInerney 2006:72) reported that workplace violence has become a daily occupational hazard in South African context; similarly the Democratic Nursing Organisation of South Africa (DENOSA) has noted an increased number of complaints from nurses who have suffered abuse in the workplace from both medical and nursing colleagues, patients and the public.

- **Feelings of guilt and self blame**

Nurses experienced guilt and self blame when they felt that the care they rendered seemed inadequate as they were always in conflicts with patients to adhere to treatment protocols of health care system as patients' continually defaulted treatment or took it haphazardly by the influence of some cultural practices contributing to poor prognosis.

Nurses found themselves challenged by the conflicts that arises between them and the traditional health care system and patients belief system *"There are so many things that*

they encounter when they are discharged from here, such as the hearsays that such a person is efficient in curing the disease, then the person stop taking treatments. Sometimes you will find ee....., that there are people who claim to be able to cure this illness, they even come to the hospital and request to help their clients while been hospitalized, so we then have to explain to them that when the patient is in hospital you cannot help the patient when he is still under our care as the patient need to continue with hospital treatment". Some participants blamed themselves for unnecessary deaths occurring in the unit. "We are stressed by the workload, stressed by shortage of staff, and stressed by seeing patients dying unnecessary deaths just because of inadequate staffing". One nurse indicated that "We sometimes find ourselves torn in between as the patients does not want his relatives to know about his status, because once they find out they abandon the patient even when he is being discharged and you then have to refer the patients to the social worker because the patient will be disparate".

Smit (2005:24) reported that nurses verbalized feeling of helplessness when conditions failed to improve with treatment and also when clients were unable to perceive their situation. Mkhabela, et al. (2008:475) also reported that the environment at VCT services was often described as depressing, nurses experienced fatigue, grief associated with loss of control, and feeling of guilt and unworthiness, furthermore, they experienced difficulty in thinking, concentrating and making decisions. Depression is characterized by loss of interest and pleasure in activities (wordnetweb.princeton.edu/perl/webwn?s=depression).

Interpersonal conflicts occurring between nurses and the family or community in the caring of patients on discharge and complying to treatments causes a lot of stress due to varying perceptions of issues related to HIV causes, treatment and care. Ehlers (2006:659) reported that nurse's form bridges between the traditional and formal (western) health care systems in African countries, however referral from one to the other health care system might cause conflicts for nurses should the patient's condition

deteriorate. Thus the nurses need to teach the patient not to take any medication in addition to ARV's.

PLWHA may not be able to understand the fact that they are immuno-compromised, which means that they need to take medication for the rest of their lives and that the disease does not result from witchcraft or bad spirits.

Brouwer, Wolffers & Sebagalls (2000:538) reported that caregivers experienced feelings of helplessness and despair due to emotional difficulties occurring in the fourth stage of the disease such as cognitive impairment, memory loss, confusion and disorientation which makes the carer's life difficult and demanding.

The understanding of the participants' views indicate the fact that constant exposure with HIV infected persons disrupts nurses equilibrium and lead to stress, there are intrapersonal and interpersonal factors contributing to stress, the caring process, like conflicts with relatives and the community. These leads to general feelings of depression, helplessness, and hopelessness, the participants expressed feelings of failure in the work situation like when the condition of the patient does not improve, relatives abandoning the patients and conflict with the indigenous health system.

Folkman & Lazarus (1980:222) state that stressful situations are not static events, nor that individuals do not respond similarly to stressful events. They conceptualise that coping is a dynamic process to the presenting situation, the stage of the encounter and is influenced by one's cognitive appraisal of an event. Nurses did not perceive stressful situations similarly, as most participants indicated feelings of hopelessness, helplessness, frustration and having being in conflict with the community and the health system and sometimes being insecure in the workplace and all these contributed to stress, burnout and depersonalisation.

CATEGORY 3: NURSES EXPERIENCES OF EMOTIONAL STRAIN AS A RESULT OF CARING FOR PLWHA

Most of the participants experienced emotional burden of caring as shown by feeling isolated, dissociated, emotional stress, fear of disclosure and fear of stigma and discrimination. Participants were trying to cope emotionally with the situation by either ignoring the feeling or talking the problem out with colleagues and at times referring the matter to the seniors.

- **Isolation and dissociation**

One participant responded that the mere fact that you work at the VCT centre, other health workers do not involve themselves in rendering care to patients that are infected. Here are what nurses had to say: *"We are experiencing a great gap when it comes to involving everybody in the care of contributing something to a colleague or patient, it is then that you will realize that it is meant for a specific set of people, the others are just observers....., they are not involving themselves at all"*. Furthermore, the nurses working in HIV/AIDS unit are labeled by their area of placement and the patients are attached an identifying label linking them to a sign or negative term to PLWHA and this isolates them. *"like when a patient is in need of assistance for minor complaints that are not HIV related since s/he is known to be HIV+, s/he will be directed the HIV unit whereas everybody can be of assistance, it does not relate to nurses only, even in the out-patient department when a patient who is on ARV's or known to be HIV+, has other medical complaints s/he is referred to ARV clinic, even when the complaints can be treated in the general clinic"*.

HIV/AIDS has been treated as a moral rather than a medical issue; the way in which the disease has been described and classified reflects the social and cultural prejudices that made the disease shameful in the first place. Effa-Heap (1997:529) also reported

that known cases of HIV/AIDS are stigmatised by society in which they live by identifying the person concerned in terms of stigmatising attributes which override other characteristics and social roles. It spreads to the whole person and spoils the persons' identity, devalues the person and leads to outright rejection, all which results in reduced opportunities.

One nurse indicated that their colleagues look at them with a certain connotation or label and working with PLWHA have changed the way others viewed them *"Heei..... our problem..... pertains to issues around discrimination..... and.... It looks as if people feel that you belong somewhere, you are no longer one of them.....when you are placed in HIV/AIDS unit, and feel that you are trained better to care for PLWHA and they cannot...., or what can be the cause, I don't know or maybe is it because people don't want to be associated with such people, they are afraid of being infected, I don't know"?*

Poindexter (2005:69) reported that caregivers experienced courtesy stigma or associative stigma, resulting in individuals being isolated for caring for PLWHA and that resulted in stress, similarly nurses in the study experienced some form of isolation, marginalization and association by their area of placement.

- **Emotional stress**

Most of the health workers are feeling emotionally drained, are overwhelmed and could not deal with their own emotional reactions. *"I also feel very stressed, especially after counseling and the client is failing to accept and start crying, when the patient denies and undergo those stages, even yourself as a nurse you do experience the emotional pain and end up placing yourself in her situation, it really affects us".* Some nurses identified themselves with the clients and experienced loss and emptiness after death of their clients. *"It is emotionally painful when a patient dies just because he could not come to terms with the diagnosis and failed to accept the condition".*

When nurses experience interpersonal conflict over an extended period of time, they are more vulnerable to burnout. Nurses working in the HIV/AIDS units tend to identify

strongly with their clients, become stressed from providing extra-emotional support and suffer stigma both in and out of hospital due to their chosen vocation. Therefore, a relationship with an HIV-infected patient could create a higher risk of burnout in health care staff than a relationship with any other patient (Visintini, Capanini, Fossati, Bagnato, Novella & Maffei, 1996:185). Repeated exposure to death and dying, fear relating to attachment and loss, profound feelings of loss and grief can lead to loss of professional objectivity (Bellani, Furlani, Gnechi, Pezzota, Trotti & Bellotti, 1996:208). Due to the triple threat of HIV/AIDS health workers have to cope with psychosocial stress of offering palliative care to increasing numbers of dying patients along with caring for their own sick family and relatives. These factors lead to increased low morale, burnout and absenteeism and affect motivation and performance (Tawfik & Kinoti, 2006:10, Gueritault-Chalvin, 2000:153 Bellani et al, 1996:215). Another nurse said *"We don't have a place to relieve stress, debriefing was once done but not for all wards mostly people working in the Termination of Pregnancy(TOP) services, we don't know the criteria that management uses in deciding who should be debriefed"*. Mkhabela, et al, (2008:276) reported that nurses had no structure in place to assist them with their emotional burdens, as one had to shoulder them and go home with emotional pain.

- **Fear of disclosure**

Some participants indicated that it is better to remain silent than to disclose. *"Ee.....e people do not feel free to disclose because of stigmatization, we are still gossiping about a person without supporting him, there is a lot of gossiping that is why people are not disclosing, because even if you disclose the whole community will know, people do not know what confidentiality means"*. Moreover professional nurses also contravened their ethical responsibility of professional secrecy as one reported, *"(Laughing).... There is no professional secrecy..., we start hearing it from the chief professional nurse, deputy managers.... , we hear about it from the teams of calls, there is a lot of gossip going on during weekend calls."* Some participants indicated that there is no system in

place to assure confidentiality. *"It is better if there can be members that are appointed to deal with staff that is HIV+, a person who will be able to can promote confidential information of nurses."* One professional nurse indicated that the environment is hostile and does not promote disclosure. *"Like myself if ever I can discover that I am HIV positive, the way I hear others being talked about, it leaves me no option but not to disclose"*.

Pisal, Sutar, Sastry, Kapadia-Kundu, Joshi, Joshi, Lesli, Scotti, Bharucha, Suryavanshi, Phadke, Bollinger & Shankar (2007:35) also found that the concept confidentiality was nearly absent amongst nurses, the notion that health providers need to maintain the level of confidentiality, except when needed for patient care, was lacking, especially among senior nurses. Nurses also expressed their need to learn about confidentiality and consent.

The risks of disclosure are greater in situations when employment, reputation, and community acceptance are placed in jeopardy (WHO, 2006:1). Suzanne & von Zinkernagel (2008:416) also indicated that it is difficult for nurses to practice what they teach and to take basic steps toward health that they counsel for their patients. In resource poor areas, the problems of confidentiality for nurses are acute, and many do not seek these services for fear of having their HIV status revealed.

- **Stigma and discrimination**

HIV/AIDS related stigma refers to the prejudice, discounting and discrimination directed at people perceived to have HIV and AIDS (UNAIDS 2000:1).

Nurses reported negative consequences in caring for PLWHA of perceived stigma and internalised shame.

“The situation sometimes is unbearable because of the gossips and it makes the person to feel uncomfortable emotionally, and it is these gossips and hearsays that do not stop that are the major problems”.

Due to stigma associated with the disease the patients as well as the carers are always discriminated against and these results in feelings of discomfort and uncertainty for the caregiver as s/he is not able to control the situation. Poindexter (2005:69) supports that caregivers experienced courtesy stigma or associative stigma, resulting in individuals being isolated, hidden, fearful and stressed.

This results in PLWHA reluctant to share information pertinent to the assessment, planning, implementation and evaluation of their care, furthermore it affects their experience of illness and the care they ought to receive and generates fear of rejection thus preventing individuals from disclosing their status (Olenja, 1999:189). Rassool (2003:235) also reported that shame associated with HIV/AIDS discourages individuals from seeking VCT and treatment and fears and taboos surrounding HIV and AIDS are translated into silence despite the individual and community consequences thus slowing prevention efforts. Cloete (2008:131) revealed that a negative organizational context can influence job performances of HIV and AIDS infected individuals, including a decreased self concept, violated psychological contract and reduced commitment.

The findings explain that stigma associated with the disease affects the patients as well as the nurses rendering care. Caregivers and patients are always discriminated against and these resulted in feelings of discomfort and uncertainty for the caregivers as they were not able to maintain the situation. The stigma attached to the disease impacted on behavior of health workers as they could not talk openly leading to gossips and the use of coded languages when PLWHA were referred to. Discrimination and stigmatization continue to occur within the workplace despite the existence of legislation, and these impacts negatively on the individual 'self-concept, emotional and psychological well-being. Thus if individual distrust confidentiality or fear discrimination they are less likely to utilise workplace support. There was no system in place of debriefing and support for

all the nurses, provision for debriefing and support was once scheduled for those nurses in Termination of Pregnancy (TOP) services, but did not sustain.

Lazarus (1966, 1991 transactional model in Rice, 2000:590), indicates that emotion is an important construct. Emotions that are considered to be stress emotions include, but not limited to anxiety, fear, anger, guilt and sadness. Lazarus & Folkman (1984:144) explain the power of cognitive theory of emotions that thoughts precedes emotions, emotions are shaped by the thought process, and can in turn affect thoughts. The primary appraisal of threat and the specific meaning of the situations trigger a particular stress emotion consistent with meaning.

3.4.1.2 THEME 2: NURSES EXPERIENCED PROBLEMS RELATED TO LACK OF SUPPORT BY COLLEAGUES AND MANAGERS IN CARING FOR PLWHA

Poor organisational support

Perceived organisational support is a social exchange relationship that results from exchanges between an employee and his or her employing organisation (Baranik, Roling & Eby, 2009:3). Organisational support is concerned with the commitment of the organisation to the employees, and activities taking place in the organisation and current situations can influence employees' performance and sense of well-being depending on how they view the environment (Aube', Rousseau & Morin, 2007:484; Lephoko, Bezuidenhout & Roos, 2006:29). Based on the researchers' observations and interactions with nurses, nurses appeared to be discontent with several aspects in their work environment such as heavy workload, insufficient resources, absence of communication structures, and lack of development activities. Almost all the participants experienced lack of support in various ways. These will be discussed in the subsequent paragraphs. The following are sub-categories identified from the theme:

- **Lack of social support from managers to nurses caring for PLWHA**

Social support relates to the extent to which managers take into consideration the personal welfare of employees (Lephoko, et al. 2006:29). Social support is the individual belief that one is cared for and loved, esteemed and valued as a person (Cobb, 1976:312). Social support can be in two forms namely perceived support and provided social support or received support which is more objective. Perceived social support deals with interaction between individual and social variables.

Some nurses emphasized the need of organizational support, which included the presence of a supporting manager and opportunity to provide input into policy decisions. *“Ever since I started working in the department of HIV/AIDS there is no single support that I have seen coming from management. You just work and work, without ever seeing management coming to understand if you are encountering any problems, or what can be done in order for us to be assisted, support you have to provide it yourself so as to be able to cope with the situation that you encounter on daily basis. You work January to December without ever having a single day that management can arrange a meeting with nurses working in the HIV unit, to hear them out and support them”.*

A health care environment where one spent long hours giving care has numerous stressful incidents, and support system is required. Moola, Ehlers & Hattingh (2008:80) also indicated that there was no system in place to support, listen or talk to, such a person who does proper counseling. The authors maintains that the integration of professional and peer interventions improves identification and clarifications of emotions and that debriefing and defusing support systems should be accessible to help resolve cumulative prolonged stress reactions.

A need for a supportive practice environment was expressed by most participants. *“There is nowhere where we are getting support, ee....e because we lack such kind of support as: employees, to discuss with us issues relating to HIV/AIDS, for there is no support that we get”.* Furthermore it was apparent that they perceived lack of emotional

support and counseling in the workplace. “ *Ee....e there is nowhere to relieve stress, you only can relieve stress while discussing with colleagues, talking about the problems that we encounter, otherwise you can take leave*”.

There is a need for a supportive practice environment; most participants expressed the perceived lack of support. Mkhabela et al (2008:276) also reported that feelings of isolation and dissatisfaction were expressed by nurses working at VCT centers. The indicated that there's no structure in place to assist them, one has to shoulder all the problems for clients and self, sort them out, at the end of the day go home with that burden.

But others complain that efforts and concerns go unnoticed by management lack of support, “*When management come to the ward, she is not there for nurses, she is there for the patients, to see if the patients are well cared for....., are they receiving adequate care?, failing to know if nurses are operating with adequate staff and if ever they are coping with the situation.....*”? (Looking depressed and pressing fingers).

Lephalala, Ehlers & Oosthuizen (2008:63) reported that nurses needed more recognition to satisfy their needs for reputation, prestige and respect from others, which could lead to increased self-esteem and job satisfaction. However lack of satisfaction of esteem needs leads to feelings of inferiority and discouragement, affecting job satisfaction negatively. The authors further indicated that if the organization does not provide a culture of recognition and promotion then nurses might leave their jobs. The professionals and sub-professional nurses demonstrated low satisfaction with the compliments and or acknowledgement they get from doing their job, since this requires no special resources but simply an oral acknowledgement such as “that was a job well done, keep it up” (Selebi & Minnaar, 2007:59).

Another participant further commented that support from management was not forthcoming; as nurses sometimes experience abuse from communities *"We were chased by a confused patient during the night and called the security who came with the policeman to rescue the situation. Eventually the cell phone of the patient was said to be missing, and we were requested to write a statement...., how would you know about that when you were running for your life, what if other patients took it or visitors., In the true sense of the word, nurses are not adequately supported in the workplace, they support the community, because they are afraid that the community will take them to court..... since then we don't know how far has the matter gone, ever since we were told to write a statement (low tone)"*. Furthermore poor advocacy by management was displayed in this manner, *"if ever there can be a mistake or an incident they don't consider how it happened, they only consider what you ought to have done, which is highly impossible to do that....mmmm... instead of standing by you they won't"*.

The findings concur with De Villiers & Ndou (2008:13) who also reported that management consequently blamed the nurses if something happened to the patients. Nursing practice standards are based on setting, promoting and controlling standards of nursing and midwifery. The Nursing Act No 33 of 2005 and regulations 387 Acts and Omissions aim to protect the public from unsafe practices and incompetent practitioners since the quality of nursing care is an ethical issue. McIntosh & Stellenberg (2009:12) also indicated that employers are legally responsible for harmful or negligent acts of employees, implying that they have a legal liability to provide adequate facilities, staff and equipments for all of their clients. Nurses reported negative incidents implying that management failed to monitor the quantity and quality of nursing standards in order to intervene timeously. Muller, Bezuidenhout & Jooste (2006:492) agree that employers are responsible for monitoring the competence of health care workers and should actively intervene when the care is below acceptable standards, of which managers failed to give operational support.

Several nurses have adopted a culture of silence as a coping mechanism. "... Aa..., *It is an ongoing thing, when you encounter problems you report but the response you get will be "let's just try working (**kha ri zame u shuma**) and nothing further will be done to assist you"*, whilst some relied on their spiritual belief "*....because we are serving the community, you just work wholeheartedly*". And some showed dissatisfaction with management in relation to communication hiccups of bureaucracy. "*... It is just because we as nurses in the wards don't have access to the nursing service manager; we communicate to the unit manager to say we feel we are not coping but there is nothing being done except "let's try our best."*"

Nurses were dissatisfied with the management factor in the organization as there was lack of openness between managers and nursing staff. Lephoko et al.(2006:34) reported that staff at selected hospitals in Mpumalanga was also not satisfied with management approach. Only two hospitals illustrated their satisfaction with the management factor as managers were implementing participative management styles resulting in feelings of responsibility towards the organizational goals and objectives and create better working relationships. Management's approachability and open communication cultivates good interpersonal relationships.

Management is also judged as falling short with regard to assisting them to deal with concomitant pressures arising from heavy workloads, they don't get involved in the daily occurrences of the work settings "*..... The is nothing that is being done, even if the staff that is sick and absent from work there is no means to replace them, once on sick leave, you will just have to bear the workload until her sick leave is over. Furthermore some indicated that "Mmm..., it's very stressful, you just work because you are on duty and serving the community, when there are problems management is not supportive, like in Peads Surgical there can be eight patients, instead of transferring the patients to medical wards and distributing the nurses to assist in medical wards, they will tell you, until then when change list is due, and nurses will be seated most of the time. In the*

real sense a person will be tired and worn out". Managers did not display feelings of emotional support that could improve their morale. "They just say work nurses, you will be rewarded in heaven, this is what you have been called for, there is nothing that you can be supported with".

Human resources makes the organization what it is and good staff selection and placement enables the individual employee to be productive and achieve job satisfaction. Booysen (1993:47) indicates that a schedule of staffing, the total number of beds, and the maximum number of beds which can be staffed should continuously be monitored, evaluated and controlled since failure can lead to discontent, demotivated staff and staff attrition.

Most of the participants experienced lack of social support when caring for PLWHA as shown by feelings of loss of affection, anxiety, insecurity, isolation and poor advocacy. They further expressed the need for support, they indicated that there was no structure in place to assist them, when you encounter problems or challenges you have to shoulder and sort them by yourself. The participants reported more negative comments than positive.

However one nurse was full of praise for her manager. *"Ee.....r, we do get support from management, she does involve herself, ee.....r maybe it is because our manager was a project coordinator when the whole thing started, she understand what it is happening in the unit as such, thus when we request any assistance she does by all means to provide us".*

Most of the participants indicated that HIV+ staff members that have disclosed to management were assisted to access ARV treatment. One professional nurse said *"As an institution we are getting support from management, ee....e the way we treat our co-workers, I mean our colleagues who are HIV+, we don't want them to come to the HIV clinic per se, but they are being cared for in the occupational health nurse office..... Ja,*

so there are designated doctors, they are not supposed to be seen by each and every doctor in the institution. There are doctors who are seeing them, so whatever they need is being attended to by the occupational health nurse and the two doctors in the hospital, so they make their consultation there....., they collect their medications there....., everything is being done by the occupational health nurse”.

All the participants were not aware of any policy guidelines to support staff members living with HIV/AIDS. Dieleman et al. (2007:12) also reported that in Ugandan hospitals none of the hospital had written a policy to prevent and mitigate the impact of HIV/AIDS and to support positive staff. Workplace support programmes require an integrated approach and should be comprehensive, and should be able to provide clear objectives and responsibilities while being concise to cater for key issues within the organization, moreover it should include the benefits that are available.

- **Lack of social support by colleagues**

When people work as a team they build good relationships, respect one another, become accountable to each other and share information, thus they have a common vision which guides their actions and contributes to effective and efficient delivery of nursing care. Nurses reported the following statements when asked about their relations with colleagues.

It is not always the case when nurses work well together, because some cannot handle work frustrations? One said “..... *Negative attitudes are always prevailing especially between the night and day staff, there is always no good relations because those on day duty put the blame at night staff, same with night staff, they blame those on day duty..... , ja....., that how it is when people are working” (low tone).*

However one nurse indicated that they worked as a team, supporting one another " ... *but the staff that is allocated at that particular time, for instance, day duty, you find that you get along well and very supportive of each other.*

Selebi & Minnaar (2007:59) also reported that nurses were moderately satisfied (58,6%) with the way they get along with their co-workers. However, sub-professional nurses demonstrated low satisfaction (43, 64%) with the way that their co-workers get along with one another.

Ackerman & Bezuidenhout (2007:68) indicate that job dissatisfiers such as inadequate working conditions and pay, ineffective company policies, poor interpersonal relationships and unsupportive supervisors result in work being experienced as dissatisfying and can result in negative consequences. The employees may react by leaving the organization, they may wait passively for the conditions to improve or by passively allowing conditions to worsen, their resentment would be evident by absenteeism, reduced effort and increased error rate.

Furthermore nurses worked at VCT centers not because of interest and commitment but through selection by employers which may lead to poor services, stress and burnout especially when support system for nurses is not available (Mkhabela, Mavundla & Sukati, 2008:474).

The findings were also supported by Dieleman et. al (2007:12) that none of the hospital in the survey had written a policy to deal with HIV-positive staff with HIV positive staff continued working until they were too ill, as they did not come to the open whereas staff known by management to be HIV positive received free treatment, treatment of opportunistic infections, and counseling. In addition they could be given lighter duties and private rooms in the hospital for admission.

Generally support of nurses was very low, the work environment was stressful and unsupportive, as most nurses felt they were no longer able to provide proper care

mainly due to the factors over which they had no control such as staff and material shortages, an increase in patient turnover and the different diseases that are masked by HIV/AIDS. Furthermore the organisational climate was not supportive for colleagues to disclose, access treatment freely and there was poor communication and feedback mechanisms in place which left nurses isolated and anxious about outcomes of daily occurrences of events in their workplaces.

Social support has been shown to enhance esteem and provide stress related interpersonal aid and is beneficial to the well-being; it meets important human needs for security, social contact, approval, belonging and affection. Thus hospitals should be equipped with the necessary infrastructure and logistics to increase nurses' social and task support. Managers should support staff by offering stress management programmes and counseling to help nurses cope in caring for PLWHA.

3.4.1.3 THEME 3: NURSES EXPRESSED THEIR EXPERIENCES OF NEEDS IN ASSISTING THEM TO RENDER CARE TO PLWHA

Insufficient educational support

Educational support is the necessary tool of empowering nurses to be able to render effective and efficient nursing care. It is thus imperative for management to ensure that nurses are continuously inducted, and that work-based support programmes are in place. Nurses expressed how uncoordinated the educational support is, that people attend only when the workshops are at hotels, with the lower category of staff rarely included.

- **Lack of educational support to assist nurses in their care giving role**

Most of the participants experienced lack of educational support when caring for PLWHA. They further expressed the need for mentoring, and empowerment, as there was no structure in place to educate them.

Some nurses felt that they lacked sufficient knowledge about the disease and the disease process *".... People don't have relevant and complete information, you might think that people are informed by the media, like radios, but you still find that people are not well- informed, even nurses inclusive".*

One nurse further said that the problem might be that you perceive people as having information on HIV/AIDS whereas the information on HIV/AIDS is incomplete or inadequate. *"I think the main problem is....., information is there.....ee..... or maybe not, you might think that people are having the information, and is not the case."*

Dijkstra, Kangawaza, Martens, Boer & Rasker (2007:637) in a study done in a South African state hospital reported that 41% reported average or lower on perceived HIV/AIDS knowledge, 26% had incomplete basic HIV/AIDS knowledge, which was compatible with Shisana and Simbayi (2002:online) and Shisana; Rehle, Simbayi, Parker & Zuma (2005:online). Moreover nurses around the world have repeatedly reported a knowledge deficit regarding HIV/AIDS. Furthermore 72% stated insufficient counseling, 38% stated that the information on HIV/AIDS was not accessible to everyone. These findings imply that the current workplace education and counseling are insufficient.

One VCT trained nurse reported that some nurses lacked skills in rendering care to PLWHA.

A nurse working in the VCT clinic reported *"Staff members do not have the necessary knowledge, really.... , they lack knowledge....., because when you visit the wards from HIV side, you will find that a patient has been mismanaged with regard to his*

medications and his complaints were not attended to accurately because nurses have not been trained for that .”

Bond 1990 cited in Effa-Heap (1997:534) indicated that 70% of nurses felt that they should receive specialized training in order to safely carry out the nursing care of HIV/AIDS patients regardless of where they work. The nursing of HIV/AIDS patients requires special skills. They include the identification and management of specific clinical problems, counseling techniques, the administration of patient care and the ability to communicate effectively with individual patients, families and communities. Effa-Heap (1997:530) indicates that staff caring for HIV/AIDS patients needs to acquire new attitudes, knowledge and skills as they become immersed in the multi-disciplinary problems of AIDS care and prevention. They should be ready to learn from personal experience and from their colleagues.

- **Poor In-service training**

One of the participants reported that nurses are ignorant and reluctant to attend courses to be developed on HIV/AIDS issue. *“Employees need to be blamed because when there are in-service training, you will hear a person saying haa..... it’s about HIV, I am not going, you find that they take it for granted, meaning that what the information that is been shared he won’t be able to understand and know about it”*. She further reiterated that *“Eee.....e, most of the people don’t involve themselves, they say it’s for those who have been trained for VCT, and even if you are not trained in the meantime you should be caring well for the patient so that by the time you undergo training, you are building on the information you got whilst attending in-service training.”*

HIV/AIDS has impacted the health care system and the educational needs of nurses need to be reviewed due to their changing roles, thus nurses have lifelong learning needs. In-service training programme should facilitate the attainment of standards of care and help nurses acquire skills and knowledge necessary to fulfil their role expectations. Swansburg (1995:165), states that the acquired knowledge should enable

the registered nurses to be more receptive and adaptable to changes in their roles and contribute to employee satisfaction and improve morale. It is in this light that managers should have a policy in place of educational programmes and induction courses that are supposed to be attended by nurses, and should be made compulsory or nurses should receive credits on the skills and job-content knowledge acquired.

Mkhabela, Mavundla & Sukati (2008:476) concur with the findings that nurses at VCT services expressed the need for increased knowledge; the participants recognised that they were at different levels of knowledge and skills in performing their duties. Most participants emphasized the need for in-service training and continuing education.

- **Gaps in curriculum**

Participants in the study did not have the necessary knowledge of caring for PLWHA and this was evidenced by poor quality care rendered to patients. Here is what one VCT trained nurse had to say *“When you visit the ward you will find that the patient has been mismanaged, and the complaints of the patients are not taken seriously even when they are genuine or the patient complaining of the side-effects of the medications , since the nurses don’t have the necessary knowledge”*

Furthermore Das 1998:1155 cited in Walusumbi & Okonsky, 2004:93) revealed findings done at Calcutta in a maternity hospital that 48% of nurses had full and correct information about HIV, 30% thought HIV to be a blood test for AIDS, 40% were aware of routes for transmission and methods of prevention. Most thought AIDS to be a disease in which quality of life deteriorates (14%) as there is no treatment (32%) and death is inevitable, most of them have heard about AIDS first from TV and consider TV, newspapers and doctors as important mediums of acquiring further knowledge.

Participants in the study lacked sufficient training with matters related to HIV/AIDS; they reported that there were no educational programmes scheduled by the institution to inform nurses on matters concerning HIV/AIDS. Only nurses trained as VCT counselors are the ones that received updates occasionally, the majority being the professional

nurses with less enrolled nurses undergoing VCT training and nursing auxiliaries are not trained but still there is nothing in place for this category of nurses and most of the basic nursing care are being rendered by them. The nursing of HIV/AIDS patients requires special skills like identification and management of specific clinical problems, counselling techniques, the administration of patient care and communicating effectively with patients, families and community groups. Staffs caring for HIV/AIDS patients need to acquire new attitudes, knowledge and skills as to render care to clients. It has been asserted that accurate and broad knowledge base about HIV/AIDS along with an in-depth understanding of HIV/AIDS could increase non-judgmental, quality care of the patients as knowledge deficit about HIV/AIDS nursing care could affect the outcomes of care. It is therefore imperative that the different categories of nurses be appraised by bridging knowledge gaps and the nursing education fraternity must recurriculate to infuse HIV/AIDS in all modules amongst all categories since it's a socio-political problem.

Appraisal about the stressfulness of a situation is based on the belief that persons have social resources at their disposal to aid them if needed. Demands of the situation and preferences and desires of the stressed individual as well as the relation between support provider and recipient help determine one's satisfaction with support received from a member of a support network. The notion of "fit" between what is wanted or needed in a stressful transaction and what is offered or provided is important, and is central to coping (Pierce, Saranson & Irwin, 1996:503).

3.5 CONCLUDING REMARKS

Concluding remarks are presented according to Lazarus & Folkman's transactional theory of stress, appraisal and coping and the ways in which people can cope in stressful situations which are primary, secondary and reappraisal (Lazarus & Folkman, 1984:142). The transactional model provides a clear understanding that it is the nature of the thought process of the individual that determines their perceived mastery, the

notion that one can influence the course of the stressor reflects the cognitive dimension of personal competence and control.

Primary appraisal

Primary appraisal is when the person evaluates the implications of the stressor as nurses in the study indicated feelings of fatigue, being overworked, hopelessness, helplessness, emotional burden, fear of contagion, lack of confidentiality, guilt feeling and self blame and discrimination. Being able to identify stressors in the environment is a first step that leads to a favorable solution.

Secondary appraisal

Secondary appraisal is judgment of what might be done; it serves as an evaluation of benefits and consequences of a particular coping strategy. The nurses were able to appraise the stressors by evaluation of the environment relative to the salient personal standards like values, goals, commitments to determine whether the environment was harmful or beneficial to the person. Nurses saw the need to be provided with support, they wanted recognition and appreciation and adequate resources and the educational need to be able to care for PLWHA. This cognitive evaluation of the options one can use for coping can either be emotion- focused or problem-focused and can lead to favorable or unfavorable resolution or no resolution and possibly to reappraisal. Nurses were emotionally drained and needed support and debriefing which was very limited, but continued to give care to PLWHA as some nurses distanced or dissociated themselves with these patients and avoided to be allocated in the units whilst others felt content about their patients who got better in their care. Problem-focused coping alters stressors by direct action and is more probable when conditions that are appraised are amenable to change and include learning new skills, finding alternative channels of gratification, or developing new standards of behaviour.

Reappraisal

Reappraisal is successive valuation that is based on new information obtained from the environment and or person during the circumstance. When nurses starts being aware of their self and redefining values, goals within their environment their attitudes changes and the conditions within the environment change favorably.

3.6 SUMMARY

This chapter focused on discussion of results, literature control and findings revealed that burdens of caring for PLWHA were enormous. Research has shown that caring for PLWHA is time-consuming, burdensome and unpredictable. The stress that nurses experienced in their course of duty made them vulnerable to varying degrees of physical, psychological and emotional distress. Shortages of both human and material resources, skilled personnel, fear of contagion, difficult patients, prolonged hospitalization, increased workload, stigmatization and discrimination, poor social and educational support reported by participants has revealed that situational factors or job-inherent factors are the cause of stress amongst nurses. It was also noted that support from management and colleagues was lacking as managers were not listening to their plight by providing adequate staffing levels and resources and also appreciating and acknowledging their services, there was no formal structure in place to address HIV/AIDS issues in the workplace.

Cognitive appraisal and coping are pivotal in the understanding of stress. Within this framework, cognitive appraisal is the process of categorizing an encounter, and its various facets, with respect to its significance for well-being (Lazarus & Folkman 1984:141). Empirical findings revealed that nurses' coping strategies were mostly emotion-focused and negative psychological states were observed such as fear of contagion, depersonalization, guilt feelings and emotional stress. Nurses showed lack of

support amongst themselves as there were gossips about staff members that were thought to be infected and lacked confidentiality.

CHAPTER 4

DESCRIPTION OF RESULTS OF CONCEPT ANALYSIS

4.1 INTRODUCTION

In this chapter attention is given to concept analysis. Concepts are linguistic representations or mental images of phenomena that are necessary for effective professional communication (Duncan, Cloutier & Bailey, 2007:294). Walker and Avant (2005) and Rodgers (1989) in Duncan et al. (2007:295) indicated that concept analysis is a process of operationalising a phenomenon so that it can be used for theory development or research measurement that evolve over time, never fixed, but create a useful understanding of the shared meaning of a concept within a specific context. Chinn and Kramer (1995:78 , 1999:74) define concept as a complex mental formulation of experience that are extracted from life experiences, clinical practice or research and the aim of analysis is to clarify, refine or sharpen the concepts, statements or theories.

Concept analysis was conducted from a theoretical perspective of Rodgers and Knafl (1993:77-90) and the empirical perspective from the experiences of nurses with regard to their understanding of support when caring for PLWHA in the health care services in order to improve morale, job satisfaction and professional growth with the aim of developing a model of support for nurses to cope in caring for PLWHA in Limpopo Province. Dickoff, et al. (1968:423) was used as a guide in identifying key concepts, categorising and integrating the concept within the theoretical framework and provide the following elements in their framework being process, dynamic, context, stakeholders and purpose.

4.2. METHOD OF CONCEPT ANALYSIS

The theoretical method of concept analysis to describe the meaning of support when caring for PLWHA in health care services to promote staff morale, job satisfaction and

professional growth was done following Rodger and Knafl's evolutionary method of concept analysis. This evolutionary method of concept analysis involves the following primary activities:

- Identify the concept of interest and associate expressions.
- Identify and select an appropriate realm (setting and sample) for data collection.
- Collect data regarding the attributes of the concept, along with surrogate terms, references, antecedents and consequences.
- Identify concepts related to the concept of interest
- Analyse data regarding the above characteristics of the concept.
- Conduct interdisciplinary or temporal comparisons.
- Identify a model case of the concept.
- Identify hypotheses and implications for further development (Rodgers & Knafl, 1993:90).

4.2.1 Identification of the concept of interest

Providing support to nurses caring for individuals with HIV/AIDS is the central concept. It has shown to be useful in other disciplines such as sociology, epidemiology, psychology, medicine and education (Stoltz, Anderson & Wilma, 2007:1481). However in spite of its everyday use the meaning of the concept may vary depending on the discipline. The concept support is used repeatedly within nursing particularly in relation to family carers or family caring, palliative care, stress and burnout amongst nurses. Stoltz, Andersson and Wilma (2007:1487) defined support as entailing the provision of tangibles such as information, education, economic aid, goods and external services, furthermore it entails necessary qualities such as individualization, adaptability, lastingness, room for verbalizing emotions as well as symmetrical exchange between involved parties. The current status of knowledge concerning support within nursing leaves more interesting questions unanswered, like there is an important lack of studies seeking a deeper understanding of the experience of support as it is lived. Therefore, there is a need for conceptual clarity of the concept in order to arrive at a theoretical

definition that would direct the description of a model to support nurses caring for PLWHA in health care services. The participants in the study experienced different burdens of caring in their care giving roles; the scourge of HIV/AIDS has impacted negatively to the health care services and nurses as carers expressed how work overload, increased patient ratios and shortages of resources has contributed to physical, psychological and emotional strain. Participants expressed the need to be supported in different and unique ways so as to be able to cope with the current situation in their workplaces. Therefore the concept "Providing support to nurses caring for individuals with HIV/AIDS" was central to the development of a model. Descriptors of support have been explained as follows from dictionaries, thesaurus and encyclopedia.

4.2.2 Definition of the concept support

Support means "to bear, sustain weight of something" (<http://www.thefreedictionary.com/support>). It can mean to hold, keep someone from falling, sinking or failing or to provide someone with a home or necessities of life". Support can mean to enable someone to last out, give strength to, encourage". It can mean "to endure, withstand, tolerate, bear out or tend to". Support can also mean "to give help or countenance to, back up, second, to speak in favour of or be actively interested in". Support can be about assisting a person by one's presence, giving moral or psychological support" (Merriam-Webster dictionary,1986:2297, Readers digests Oxford Complete Word finder, 1993:1563 and Readers digest Family word finder, 1977:778). These definitions appear to vary depending on the use of the concept as per discipline thus altering its conceptual meaning, but from the above definitions the concept can be presented as tangible, concrete dimension of care as well as intangible, abstract dimensions of care. Support can also be defined as the total level of assistance or any services given (Cummings, 1996:86). Thus support is what happens in meetings between human beings, co-created, as opposed to a service given and received and social support could be the umbrella term of choice (Stoltz, Andersson & Wilma, 2007:1482).

Cora & Alwyn (1997:379-379) describe support as an array of social exchanges which involves encountering support, recognizing support and feeling supported and further provides the different types that will be described in the subsequent paragraphs.

Social support

Social support is a concept that is generally understood as help from other people in a difficult life situation. Cobb (1976:302) defined social support as the individual belief that one is cared for and loved, esteemed and valued, and belongs to a network of communication and mutual obligations. Jacobson (1986:252) defines social support in terms of resources that meet needs, social relationships through which an individual's needs are met, or both. Furthermore the author cited Caplan (1974) who described it as a system of formal and informal relationships and groups through which an individual receives the emotional, cognitive, and material support necessary to master stressful experiences (House 1981:25; Cohen & Wills, 1985:313) in Jacobson (1986:252) differentiate the primary aspects of support as emotional support which refers to behaviour that fosters feelings of comfort and leads an individual to believe that he or she is admired, respected and loved, and that others are available to provide caring and security.

Nurses as caregivers in these difficult situations need the type of support to feel cared and loved, esteemed and valued and belonging to a social network of supportive nurse managers within a supportive organisational climate. Chiou, Chang, Chen & Wang (2009:419), indicated that social support can be divided into two categories, perceived and received support.

A distinction can be made between the quality of support perceived and provided social support, perceived support is the person's appraisal of the available support, it's about satisfaction that is subjectively measured and is about the interaction and social

variables unlike received support which refers to the actual and substantial social support.

Perceived social support

Kath, Marks & Ranney (2010:644) defined perceived organisational support (POS) as global beliefs concerning the extent to which the organisation values their contributions and cares about their well-being. Perceived organisational support develops because people have a tendency to assign human like characteristic to their employing organisation.

Baranik, Rolling & Eby (2010:367) defined POS as a social exchange relationship that results from exchanges between an employee and his or her employing organisation. When employees believe that the organisation is committed to them, they feel obliged to be committed to the organization. POS mediates the relationship between the leader – member- exchange and work attitudes and behaviours.

Eisenberger, Huntington, Huntington & Sowa (1986:501) argued that an employee's perceptions of organisational support are shaped by attributions made regarding the motives and sincerity of their organisation's actions, rewards and policies. Thus nurses as carers need to have a balanced relationship with their managers. Managers must cast their motives in a favourable light and be seen as genuine and sincere so as to increase employees' beliefs that the organisation is acting in their best interest. It is believed that optimal support exchange requires clear communication of needs as well as the ability of the support provider to meet the expressed needs. So it is important for managers to open communication so that nurses can be able to raise their concerns and expectations when caring for PLWHA.

It is the person's appraisal of the available social support; it is the interaction between the individual and social variables and can be subjectively measured. Perceived social support can better predict health outcomes and distress, because when a person

perceives adequate support and believes that the support would protect him/her, a threatening effect might not become stressful (Chiou, Chang, Chen & Wang, 2009:419). When nurses experiences adequate support, to feel that the organisation or managers are having their best interest at heart, they tend to identify themselves with the organisation, leading to job satisfaction and involvement.

Shore and Shore (1995) in Treadway, Hochwarter, Ferris, Kacmar, Douglas, Ammeter & Buckley (2004:496) explain that POS relates to the perceived fairness in the attribution of organisational actions to be supportive, like fairness in resource distribution signals that the organisation is concerned for the welfare of its employees. Support is seen to mediate various relational processes such as turnover as it glues positive work experiences and positive behaviors and attitudes that benefit the organisation.

Received social support

It is provided support that can be objectively measured. Chiou et al. (2009:419) refers it as to actual and substantial social support and has a positive effect on the care giver burden, but does not seem to have the same effects over a period of time. Nurses in the study felt that the social support received from management was limited as managers were not providing the necessary resources for them to render adequate care to PLWHA; there was no structure in place to support them when they were burdened and overwhelmed by their circumstances in the workplace. There was limited training and mentorship on issues of HIV/AIDS as not all nurses were involved in AIDS caring, only those who undergone VCT course were the ones that were continually updated with new trends and developments.

Types of social support

There is a general consensus that social support moderates stress and health consequences, individual have needs that are supposed to be met through the interactions in a variety of relationships, and if needs are unmet the person experiences distress. Jacobson (1986:253) argues that a person must have supplies, provision of supplies is equivalent to the satisfaction of interpersonal needs and inadequate provision of psychosocial supplies leads to distress. The following types of social support will be discussed hereunder.

Emotional support generally comes from family and close friends and is the most recognised form of social support; it includes empathy, concern, caring, love and trust (Dalgard, n.d.). Caregiver burden is characterised by persistent hardship and stress; negative experiences resulting in the provision of care, therefore a system should be put in place for nurses caring for PLWHA to get assistance with matters that affect their physical and mental states such as social support groups or counselling services. These types of services should be made accessible to nurses so that they can get professional treatment; if such services are not available managers should refer nurses for their well-being. From the empirical findings participants indicated that there is no system in place where one can relieve oneself of the stress and tension experienced from caring, debriefing sessions are necessary for nurses to relive part of their experience in a supportive environment.

Appraisal support involves the transmission of information in the form of affirmation, feedback and social comparison from family, friends or co-workers (Dalgard, n.d.). Nurses as employees perceive support to be particularly high when the organisation provides the appropriate resources such as rewards, developmental opportunities and feedback. Empirical findings indicated that nurses needed to be commended for caring under stressful conditions by their supervisors, managers and colleagues and their efforts be recognised by provision of incentives and that they be provided with

knowledge to care for patients and be able to communicate with those affected. Zagenczyk, Scott, Gibney, Murrell & Thatcher (2010:128) also reported that human resource practices such as rewards, developmental experiences and promotions are an indication of the organisation's respect for the ability of employees.

Informational support includes advice, suggestions or directives to assist the person to respond to personal or situational demands (Dalgard, n.d.). Health service institutions should have policies and directives and procedure manuals on how HIV/AIDS workplace issues are handled when caring for PLWHA, and nursing personnel should be periodically updated on new trends. Zagenczyk et al. (2010:129) indicates that employees process social information that they acquire through direct interaction with cohesive ties. Social information processing results affects how job-related perceptions of events are interpreted in the organization. One network tie through which social information is exchanged is the advice ties that shares job and organisation related information. Advice givers are influential since they have high task mastery and organisational knowledge; as a result coworkers trust that they have the ability and competence to provide help. HIV/AIDS as a social problem also creates a problem among nurses as to how they interpret and evaluate the organisational climate concerning HIV/AIDS issues. Managers must ensure that nurses are continuously given job related information so as to render better services by identifying resourceful persons in the organisation. Like the participant indicated " *People don't have relevant and complete information, you might think that people are informed by the media, like radios, but you still find that people are not well- informed, even nurses inclusive*". Cognitive support refers to information, knowledge, and or advice that helps the individual to understand his or her world and to adjust to changes within it "(Jacobson 1986:252).

Evidence suggests that advice ties between employees result in organisational stability because they facilitate work related information transfer, which serve to coordinate

activities in the organisation and reinforce organisational norms. Informational support can also be enhanced by coaching and mentoring neophyte nurses and the newly appointed staff by fostering positive attitude, enhancing a sense of professional identity in line with organisational values. Peer group support, mentoring relationship and friendship fosters positive self regard and build trust in the employees. Baranik et al. (2010:368) indicate that role modeling helps those being mentored to explore personal concerns that may interfere with their ability to feel comfortable in the organisation.

Instrumental support is the most concrete direct form of social support, encompassing help in the form of money, time, in-kind assistance and other explicit interventions on the person's behalf (Dalgard, n.d.). Nurses need to be supported with more concrete forms of social support like free medical consultations or subsidised medical insurance, appropriate nursing shifts or breaks and rest rooms, meal coupons, protective clothing including material resources to plan nursing care of PLWHA. Empirical findings also revealed that nurses needed to be supported by extra staff to ease the workload and material resources like protective clothing and pharmaceuticals. One participant had this to say " *Our colleagues who are HIV+ we don't want them to come to the HIV clinic per se, but are....., they are being cared for in the occupational health nurse' office..... Ja, so there are designated doctors, they are not supposed to be seen by each and every doctor in the institution. So whatever they need is being attended by the occupational health nurse and the two doctors in the hospital, so they make their consultations there....., they collect their medications there..... , everything is being done by the occupational health nurse for them. Furthermore "What I have learnt is that those who may need some shift in placement, they move them to specific wards where the activities are a bit lighter for them to cope and recover". This is an in-kind type of assistance that signals to employees the extent to which the organisation cares about their well-being.*

4.2.3 Identification and selection of an appropriate setting

In the evolutionary approach, setting refers to the time period examined and types of literature included in the analysis (Rodgers & Knafl, 1993:80). The sample was selected from a population of literature published in nursing, psychology and social work that dealt with support in family caring, informal and formal caregivers, gerontology, oncology care and HIV/AIDS. The appropriate context of this study pertains to the support as experienced by nurses in health care services or institutions when caring for PLWHA.

4.2.4 Collection of data regarding the attributes of the concept, surrogate terms, references, antecedents and consequences

The researcher reviewed the literature through a library search to identify as many uses of support; the search was combined with additional search terms used for purpose of directing the searches towards the context of HIV/AIDS, nurses and health services, family care givers and palliative care. Sources like dictionaries, encyclopedia, the internet, journal articles and books were reviewed in order to clarify the meaning of support for nurses caring for PLWHA in health service settings. The search term "support" was directed towards formal and informal caregivers. Saturation point was reached after the defined concepts from nursing; psychology and sociology were exhausted and shown to be overlapping. Afterwards similar citations of "support" were converged.

4.2.4.1 Identification of defining attributes

The attributes of the concept constitute a real definition, as opposed to a nominal or dictionary definition that merely substitutes one synonymous expression for another (Rodgers & Knafl, 1993:82-83). The researcher identified the uses of the concept found in literature related to vocational behaviour or organisational behaviour and human decision process to arrive at defining attributes. Various authors attempted to describe

support as that which occurs between formal/trained caregivers and the family carers and the cared for persons, or an intervention and outcome in the same trial (Cummings, 1996:87; Marziali, Donahue & Crossin, 2005:380). Stolz et al, (2007:1484) illustrated the multiplicity of the meaning by highlighting the prefix and suffixes used in relation to support like appraisal, available, community service, conjugal, direct, educational, emotional, esteem, family, financial, fiscal, friend, general, indirect, informal, intimacy, instrumental, nursing, perceived, respite, social and workplace.

Treadway et al. (2004:497) attribute support in organisation as meeting needs for approval, esteem and social identity, recognition and reward. Organisational support is valuable for nurses to feel part of the organisation, to belong, be recognised /appraised and rewarded and this will lead to job satisfaction.

Availability of a supportive work climate/ organisational culture

Support is seen to be influenced by interpersonal relations, recognition and rewards and social network and social influences which are discussed in the subsequent paragraphs.

- **Interpersonal relations**

Workplaces are characterised by interactions or social exchanges that take place among humans in interaction. The human relation stresses a concern for interpersonal relationships and focuses on how needs of an individual employees can be harmonized with that of the organisation. The main focus of individual needs is the improvement of workers' morale. Burns & Grove (1998:436) indicate that the social context of work life is relevant to the motivation of workers, and that the human relations have an influence and authority on the participation of important and relevant matters.

- **Recognition and rewards**

Individuals need to feel that they are getting fair treatment in terms of their contributions to the job; they need to feel that they are treated fairly when they compare themselves with others, because inequity creates tension and when employees perceive themselves as trusted, valued and contributing to the organisation it develops positive work attitude and high level of job performances. Nurses as carers also need fair treatment in the allocation of resources when caring under strenuous conditions and need to be appreciated and recognised for the care they are rendering and incentives given for their performances.

- **Social networks and social influence**

Employees tend to rely on co-workers as opposed to managers or even objective information to understand norms, standards and impressions of the organisation (Zagenczyk, Scott, Gibney, Murrell & Thatcher, 2010:128). Nurses as employees' belonging and esteem needs can be satisfied by social attachments and group membership involving co-workers, supervisors, family and friends. Cohesion occurs when a direct relationship such as friendship or advice relationship exist between employees. Advice ties are instrumental relationships through which employees share job- and organisation related information and this results in organizational stability and reinforce organisational norms.

4.2.4.2 Identification of surrogate terms

Surrogate terms are means of expressing the concept other than the word or expression selected by the researcher, meaning that the concept can be expressed in many ways (Rodgers & Knafl, 1993:83). One way of illustrating the multiplicity of meanings existing in the support literature were concepts such as appraisal, available, educational, informational, general and instrumental (Stoltz et al, 2007:1484). Some of these concepts were identified during data collection with support being portrayed as a tangible service that can be received such as a ward visit, provision of resources,

provision of incentives, advocate or intangible where the support appears to be created, such as opportunity to share emotions, experiences, to verbalise, voice and express.

4.2.4.3 Identification of references

The reference indicates the actual situation to which the concept support is applied (Rodgers & Knafl, 1993:82-83). It assists in identifying the scope of the concept to enhance its clarity and effective application. The researcher explored various support programmes in literature and derived a support process which will be adapted according to Dickoff's theoretical framework. The support process can occur as **initiation phase**- need analysis, formulation of support objectives, involvement of stakeholders (multidisciplinary) and resources; **execution /implementation phase**- development of a support structure, the operational process of mobilising the strategic plan to meaningful objectives that are achievable and measurable, and **sustenance**- monitoring and evaluating the support process by periodic review and feedback mechanisms.

4.2.4.4 Identification of antecedents

The antecedents of support when caring for PLWHA in health care services would be aspects that would precede the process of support (Rodgers & Knafl, 1993:83). Nurses caring role is burdening and leads to physical stress, strain, psychological and emotional problems that result in ill-health. For this study, the support required were identified as self-awareness, respect, empathy, tolerance and good interpersonal and communication skills, willingness and courage amongst participants. The organisational antecedents were commitment to organisational culture, values, vision, and mission and, administrative and clinical commitment to HIV/AIDS issues and existence of a meaningful relationship. These antecedents of support will be described in the following paragraphs.

4.2.4.4.1 Participant's characteristics

(I) Self awareness and self concept

Self awareness is when we focus our attention on ourselves, we evaluate our current behaviour to our internal standards and values, furthermore various environmental cues and situations induce self-awareness (Phemister & Crewe, 2004:4). Thus self awareness is about getting in touch with one's behaviour and learn more about self when caring for clients with diverse health problems in different settings. Self awareness results in silent moments of epiphany as the self realises and becomes aware/conscious of the reality of HIV/AIDS pandemic. Self awareness brings a better understanding and the opportunity to change one's behaviour and the things in the environment.

Self concept is the way one perceives one self and is influenced by the social concept which is one's perception about how one is regarded by others and the self- ideals, how one would like to be (<http://thesaurus.yourdictionary.com>). The self concept plays an important role in the social perception process by which we as nurses form impression of others (PLWHA). A strong self-concept allows nurses to confront new experiences without feeling threatened. Thus support process requires the critical "self" to be able to change perceptions towards PLWHA and those affected by the disease.

(ii) Respect

Respect and trust are core values in the process of nurturing support. Respect is paying attention to and taking seriously the other person. Trust is a psychological state comprising the intention to accept the vulnerability based upon positive expectations of the intentions or behaviour of another (Kim, Kurt, Dirks, Cooper & Ferrin, 2006:49 and Gilson, Palmer & Schneider, 2005:419). Respecting and trusting each other is about shared experiences, it encourages teamwork and offers an ethical frame for

understanding one another and the organization. When individuals feel that they are treated fairly well with respect they are more likely to trust each other and represent each other's best interest. Nurses who trust and respect one another work together and behave in ways that do not cause harm to PLWHA. Everybody needs a little respect, and we need to demonstrate respect in the workplace to avoid insensitive situations. Actions are powerful ways of showing disrespect, to avoid these we need to treat PLWHA with courtesy, politeness and kindness. Never insult people, name call, disparage or put down people or their ideas, treat all people the same and implement policies and procedures consistently. Treating people differently can constitute harassment or a hostile work environment.

(iii) Empathy

Geer, Estupinan & Manguno-Mire (2000:101) explains empathy as the ability to understand and identify with another person's point of view, the capacity to experience the same feelings as another. The importance of empathy in the support process is the ability to perceive PLWHA's point of view, experience their emotions and behave compassionately so that they can also be able to express their needs. When nurses are empathetic, it builds the trust and respect that PLWHA are regarded as human beings and not dismissed lightly or thoughtlessly.

(iv) Courage and assertiveness

Merriam Webster's dictionary (1986:522) states that courage is the quality of mind or spirit that enables a person to face difficulty, danger or pain, without fear. Thus courage, encourage nurses to act in accordance with one's believe in caring for PLWHA. Assertiveness is a form of communication in which needs and wishes are stated clearly with respect to oneself and the other person in the interaction, and is when nurses take

courage to communicate their needs, they experience greater job satisfaction and commitment when caring for PLWHA.

(v) Communication and good interpersonal relations

Communication and interpersonal relationships can be indicators of a supportive process, since maintaining a reciprocally social and emotional interaction among PLWHA and others, the organisational environment can impact positively on organisational behaviour. It is in communication where the exchange of messages, conveying information, ideas, attitudes, emotions and opinions between nurses caring for PLWHA and the organisation that nurses can create an understanding or co-ordinate activities relating to, initiate and support HIV/AIDS issues in the workplace.

When people work as a team they build good relationships, respect one another, become accountable to each other and share information, thus they have a common vision which guides their actions and contributes to effective and efficient support network.

(vi) Willingness and commitment

Support requires that all parties involved in the process are motivated and willing to work together to reach the set goals. When nurses are willing and committed to the support process when caring for PLWHA, they are more likely to rise above the challenges they face. Willingness enables one to consciously choose, and when one exercise his/her power of choice and committing passionately to caring and creating a supportive environment, they experience commitment to the organisation.

4.2.4.4.2 Organizational characteristics

(i) Organizational vision, mission, values, culture, climate

The organisation's vision, mission, values, culture, and climate guide the behaviour and social responsibility of the organisation towards PLWHA and those caring for them. These attributes offer a framework for creating a meaningful work environment for nurses. When nurses perceive the organisational goals positively, when those infected and affected by the disease are treated with respect and dignity, and those caring for them are provided information or rationale for how decisions that affect them are made and these lead to commitment of nurses to link their personal goals with that of the organisation.

(ii) Existence of a meaningful relationship.

Managers should create a supportive work environment that enables the employees to accomplish their work in meaningful ways. Maintaining good interpersonal relations amongst lines of management and different sectors of the workforce fosters interactional justice. Flexibility should be possible within formal systems of organisations. Positive relationships with superiors, peers and subordinates within the work setting leads to effective alliances, and when employees have access to power tools that enable them to accomplish their work in meaningful ways it influences their behaviour and attitudes and the overall purpose of the organisation will be visible.

(iii) Administrative and clinical commitment to issues of HIV/AIDS

Organisations do not operate in vacuum, within organisations are different strata's of the workforce, and for the goals of the organisation to be realised there should be a collaborative process, supported by all structures involved. Management must support the processes by ensuring that the employees are having the necessary resources. Management and employees should be committed to each other, to ensure that

HIV/AIDS issues in the work place are mobilised, management should provide resources like, access to information on issues of HIV, support initiatives on prevention, promotion and care in the workplace.

4.2.4.5 Identification of consequences

Consequences are defined as events occurring following a concept (Walker & Avant, 1995:45). The consequences of support when caring for PLWHA in health care services were identified as job satisfaction and organisational commitment whereas the negative consequence results in organisational cynicism. Participants perceived support as being both positive and negative. Treadway et. al (2004:497) indicated that perceived organisational support should produce a felt obligation to care about the organisation's welfare and to help the organisation reach its objectives since it will meet needs for approval, social identity recognition and reward. Perceived organisational support has been linked to a myriad employee work outcomes such as organisational commitment, job satisfaction, reduced turnover, job performance and organisational citizenship behaviour (Chen, Aryee & Lee, 2005:458).

Some participants in the study reported high managerial support and felt obliged to give the best of their care to patients even when working under strenuous conditions like one participant said *"you work in such a way that you need to push the routine for the sake of the patients"*, another one said *"even when others are absent from work, we provide our services as much as we can, so as to fill the gap of the other member"*, these are signs of commitment. The obligation created by decreased perception of organisational support will lead to decreased organisational cynicism, decreased levels of job satisfaction and organisational commitment. For those participant who perceived support as being less or absent indicated statements as *" when managers visit the wards they are not interested in how the nurses are, how they are coping under such risky situations, are there enough resources..." they are only there for patient care.*

Baranik, Roling & Eby (2010:368) indicates that when employees believes that the organisation cares about their well-being, they will feel obliged to help out the organisation which is reflected by increased affective organisational commitment. Job satisfaction is typically seen as one of the antecedents of organisational commitment since individuals need to feel satisfied with their job before they can feel committed. Job satisfaction and organisational commitment have unique predictive relationship with turnover intentions, as intent to quit is perhaps the strongest predictor of actual turnover, like participants indicated that *"some resign or even look for transfer when they are allocated in medical wards or HIV/AIDS units due to increased workload"*.

Decreased job satisfaction and organisational commitment are positively related to turnover intentions.

- **Job satisfaction**

Lock (1976:1300) in Treadway et al. (2004:500) defined job satisfaction as a pleasurable or positive emotional state resulting from the appraisal of one's job or job experiences. When the degree of the employee's appraisal level of support is unfavorable, the employee will experience more cynicism towards the organisation as a whole, and for those possessing cynical attitudes are likely to feel mistreated and abused at work, as expressed by this participant *"Mmm...., it's very stressful, you just work because you are on duty and serving the community, when there are problems management is not supportive, like in Paeds Surgical there can be eight patients, instead of transferring the patients to medical wards and distributing the nurses to assist in medical wards, they will tell you, until then when change list is due, and nurses will be seated most of the time. In the real sense a person will be tired and worn out"*.

When the manager provides the needed support and resources, the employees will in turn reciprocate. Sluss, Klimchak & Holmes (2008:459) also concur with the notion that employees perceive support to be high when the organisation provides appropriate resources such as rewards, developmental opportunities and the like, and when the organisation values their contribution and cares about their well-being due to positive

resource allocation. Thus support increases the employee's feelings of obligation and positive reciprocity.

- **Organisational commitment**

Organisational commitment is thought of as the strength of attachment to the organisation and comprises compliance or instrumental attachment, identification or desire to affiliate and internalisation or agreement between individual and organisational values. When employees perceive that they are supported, they tend to be committed to and identify with the organisation as well as help the organisation succeed (Zagenczyk et al, 2010:128). This is how the participant displayed her commitment *"Eer...., let me say that we do get support from management, she really involve herself so much, eer..., maybe it's because our manager was a project coordinator when the whole thing started, she really understand what is happening in the unit in that she takes all the effort to attend to our requests"*. Likewise, support given by supervisors and management affect the support and sends a strong signal regarding the organisation's positive or negative orientation towards them.

- **Negative consequence: Organisational cynicism**

Employee cynicism is an attitude characterised by frustration, hopelessness and disillusionment, as well as contempt towards the distrust of the organisation (Anderson, 1996:1395). Treadway et al. (2004:499) defined organisational cynicism as a feeling of disdain towards an organisation that manifest itself in feelings of despair, contempt and frustration. The participants in the study also experienced the same feelings, *"It is an ongoing thing, when you encounter problems you do report but the response you get will be let's just try working (**kha ri zame u shuma**) and nothing further will be done to assist you"* another one had to say *"They just say work nurses, you will be rewarded in heaven, this is what you have been called for," there is nothing that you can be supported with"*.

Cynicism is likely to surface when it is perceived that the organisation is not concerned about the socio-emotional needs. In this regard nurses may feel that they are offering their organisation their talents, diligence, or other positive work-related contributions, only to have their efforts ignored.

4.2.5 Identification of concepts related to the concept of interest

Support is widely used every day and remains a complex concept, however its meaning vary depending on the discipline. Related words to the concept of support may aid in understanding and facilitate effective communication of the intentions or objective of support. Support has been related with terms such as advocate, backup, assistance, encouragement and providing means. These concepts have different meanings when used in other context.

- **Back up**

Additional personnel who provide assistance, auxilliary, reinforcement, reserve, substitute. Standing by as an alternative or auxiliary (Word.Reference.com. Dictionary of English - Online).

Care giver burden is stressful and can lead to physical as well as emotional exhaustion. HIV/AIDS has impacted negatively on the health services that nurses needed backing up, thus volunteers were recruited to *give assistance* or *aid* by *providing* Voluntary Counselling and Testing (VCT) and home-based carers provided care and discharge plan.

- **Assistance/ Aid**

An activity of contributing to the fulfillment of a need, or furtherance of an effort purpose. It is an act of assisting, aid, help (Word Reference.com. Dictionary of English: Online). Care giving role can result in negative outcomes like neglect of physical health resulting in chronic conditions or withdrawal symptoms thus nurses need to be assisted with services such as Employee Assistance Programme (EAP). It is services offered by employers to their employees *to help* them overcome problems that may negatively affect job satisfaction like counselling services or work-based intervention programmes (Barker, 2003:141; Heery & Noon, 2001:560).

- **Encouragement**

It is the act of giving hope or support to someone, human action, human activity. Expression of approval and support, morale building, morale booster (Word Reference.com. Dictionary of English - Online). Individual employees need a bit of praise or encouragement, to be acknowledged of their care giving role and managers need to *maintain* good interpersonal and open communication, by always being visible to give praise. Perceived support increases job morale and commitment.

- **Provide means**

It is the provision of what is desired or needed especially support for or sustenance. To procure supplies or means in advance, to take measures beforehand in view of an expected or possible future need (Macmillan dictionary.com). Nurses as carers need resources to adequately render their care giving role, when resources are not sufficient or adequate it leads to low productivity, decreased morale and burnout. Managers should ensure that they provide needed support and resources so that employees can reciprocate effort and commitment.

4.2.6 Analysis of data regarding the characteristics of support

The content analysis of the literature was done using reasoning strategies such as analysis, synthesis, inductive and deductive strategies, retroduction, inferences and derivation (Chinn & Kramer, 1995:63-67; Walker & Avant, 1995:28-29). An inductive approach was used where empirical data from the participant’s experiences of support was analysed according to Tesch’s (1990:145) method of data analysis. During this phase the central and related concepts were defined, interrelational statements generated. A list of essential attributes from empirical data was compiled and compared with those emanating from literature review, and integrated in order to determine a list of essential attributes. These essential attributes were then organised and reduced by developing categories and sub-categories that would meaningfully define support of nurses in caring for PLWHA in health care services.

Table 4.1 Concept analysis of support as experienced by nurses in health care services according to three categories and their related attributes and consequences

CATEGORY	SUB-CATEGORY	ATTRIBUTES
ANTECEDENTS	(i) Participants	Trust and respect, empathy, tolerance, good interpersonal relations and communication, self awareness and courage, willingness and teamwork.
	(ii) Organisational	Existence of a meaningful relationship, compatible organisational culture, mission, vision and values, Administrative and clinical commitment to issues of HIV/AIDS

PROCESS	Initiation	Planning
	Implementation and execution	Development of a common course of HIV/AIDS support in the workplace. Formulation of support objectives , need analysis, networking, and collaborating with other stakeholders Shared and joint responsibility, allocation of roles, coordination of activities with other department/sectors. Reflection and feedback Evaluation
OUTCOME	Commitment and empowerment of carers/nurses, personally and professionally towards HIV/AIDS support	

Process of a support structure

Phase 1: Initiating a support process

- Developing a common course of HIV/AIDS support in the workplace.
- Formulation of support objectives, need analysis- available resources and challenges, effective, communication, facilitation and clarification of supportive intervention and expected outcome of support.

Phase 2: Execution and implementing a support process

- Operationalisation of the strategic plan for support
- Shared and joint responsibility, allocation of roles, coordination of activities with other department/sectors, team work.

Phase 3: Evaluation of a support process

- Monitoring, feedback and review of team performance
- Reflection

4.2.7 Identify a model case of the concept

The role of the model case is to enhance the degree of clarification by providing an everyday example which includes the attributes of the concept (Rodgers & Knafl, 1993:86). In accordance with the evolutionary view of concept analysis, model cases were identified rather than constructed. The model cases were identified in the interview data collected in order to understand the meaning of support as narrated by nurses who are caring for PLWHA in health services. The following model cases illustrates the defining attributes of support.

Reflecting the tangible attributes of support

Participant: *Hoh.....!. We do support each other, because we **understand** that HIV/AIDS is there, so we **encourage** one another to protect ourselves, but from families it is difficult as most families are not aware or have not accepted the fact that their relative is HIV+ and some patients do not even disclose knowing that they will also lack support from their homes (**antecedents**).*

Participant: *By **advising** one another to wear protective clothing because we may not know which patient is HIV+ or negative, even though some you can observe by their symptoms, so we delegate someone everyday to ensure that everyone has put on a protective clothing by delegation (**antecedents**).*

Participant: *She is supported when she is sick, **they are usually there** for her, and they make sure that she takes treatment from the HIV clinic (**antecedents**).*

Participant: *I mean our colleagues who are HIV+ we don't want them to come to the HIV clinic per se, but are....., they are **being cared for** in the occupational health nurse' office..... Ja, so there are designated doctors, they are not supposed to be seen by each and every doctor in the institution, there are doctors who are seeing them (antecedents).*

Participant: *Eer....., we also **involve** the psychologist,*

*...we also involve the social workers....., those who may **need counselling** we just **refer** them.....there (process).*

Participant: *Ah....., we haven't encountered such a situation, but what I have..... learnt..... while working in that situation, those who may need some **shift in placement**, they move them from a specific ward to the ward where the activities are a bit lighter, and they are not prone to infections like Tuberculosis and so on, so the..... the supervisors and management..... the person may let them know or make them aware that he is in this situation, they move them (process).*

Participant: *Er....., no....., in that case it is being explained to the person....., there is that agreement between the employee and the supervisor..... Ja..... It is also there to address the problem of sick leaves, er..... exhaustion..... and er..... you find that maybe the person is working in a busy ward he will end up distressed, not coping with the situation and will not be working for most days, so if they move them to lighter wards it **helps them to cope and to recover** but it is not for everyone, only those who willingly disclose to the supervisor, they don't have problems if the condition is known, even by the nursing service manager (outcome).*

Participant: *Ja....., when it comes to that, I think we need some strategy where we can involve each and every person, by that I mean all the people in the institution, **we need to involve them**..... because at the end of the day they also come across with those people or **participate in the care** of those infected, maybe..... if maybe we can have like..... ee.....r **giving of information or small group discussions like the in-service training where maybe** people can be..... allowed*

to gather..... , raise their questions and concerns and..... be addressed, maybe..... that will help **(process)**.

Participant: Ee.....r, let me say we do get support from management, she really **involve** herself, ee.....r maybe its because our manager was a project coordinator when the whole thing started, she **understands** what is happening in the HIV unit, therefore whatever assistance we request she ensures that we get it. (thuso inwe na inwe **vha zama nga ndila dzothe uri vha ri itele** (antecedents).

Participant: Hm.....m, believe that if we can start with making sure that every person is made..... I believe we haven't yet made a breakthrough to disseminate **information to every person** concerning HIV/AIDS, maybe we can start with dissemination of information around issues of HIV/AIDS to every person who enters through the hospital gate..... So that they know what is happening around HIV/AIDS **(process)**.

Participant: Ee....r, I believe that there can be a **relief and change in the attitudes of people**. I believe that it will also be **simpler for those who need to be tested to test**, ee...r and **those who feel to disclose must feel free to disclose**, and be given support, **and support one another (ri supportane nga tshashu)** (outcome).

Participant: Another issue that I forgot is that there is EAP, which is head on to **assist**, in the support of employees, when it pertains to HIV/AIDS **they involve themselves**. When we have meetings they also come and talk about the **role they play** concerning HIV/AIDS, and matters pertaining to leave days **(process)**.

The contrary model cases of support and individuals unwinding their minds.

Participant: "Ever since I started working in the HIV/AIDS department, since I arrived, I have not seen a single support coming from management. It's just to work.... , and work....., there can never be a day where you will see management coming, to enquire if you are not experiencing any problems?, to say things could be done this way.... or that way.... , so that we can be assisted, support is for yourself, you need to give yourself the support to be able to cope with the situation that you continually

experience at that time. You work January to december without a day where they can say let's have a meeting with nurses working in HIV, and hear them out (ri pfe who!), and support them (ri vha supporthe who!). "

Participant: *"Management in the true sense when they come, they do not come for nurses in the true sense, they are there for patients, to see if the patients cared for?, are they getting all the cared needed?. Forgetting to realise that nurses that are giving care to the patients, if they are working with adequate staff?....., if they are coping..... with the situationi.....? even without wanting to know of any other things..... like dis.. advantages, such as infections".*

The description of results emerged from empirical findings and literature to clarify the meaning of support in caring for PLWHA within the context of health care services.

4.3 THEORETICAL DEFINITION

The definition was derived from clarifying the empirical meaning of support; synthesis was used to collate the theoretical and empirical meaning of support. Support means a network of mutual exchange that is based on honesty, rewards and policies that values the contributions and cares about the well-being of its employees.

4.4 SUMMARY

The chapter focused on concept analysis from a theoretical perspective of Rodger & Knafl (1993:77), the concept support was defined from both theoretical and empirical data. The results of concept analysis revealed three categories which gave a clear understanding of the definition of support for nurses to be able to cope in caring for PLWHA. The description of the theoretical definition emanated from the identified attributes. Chapter five will discuss model development.

CHAPTER 5

THEORETICAL FRAMEWORK OF A MODEL OF SUPPORT FOR NURSES CARING FOR PLWHA

5.1 INTRODUCTION

The purpose of this chapter is to describe a model to support nurses when caring for PLWHA in health care service institutions. The identified concepts of support within the caring context of HIV/AIDS will be conceptualised using the six elements of practice theory as described by Dickoff, James & Wiedenbach (1968:434) namely the context, agent, recipient, dynamic, procedure and the purpose.

5.2 ELEMENTS OF PRACTICE THEORY

Table 5.1: Schematic theoretical framework for providing support

In what context is the activity performed?	Context: HIV/AIDS care in the health care institutions(organization)
Who performs the activity?	Agent: Nursing service managers
Who is the recipient of the activity?	Recipient: Nurses
What is the energy source of the activity?	Dynamic: Power imbalance, leadership style and communication and listening skills from nurse managers
What is the guiding procedure?	Process: Providing support through the support process.
What is the end point of the activity?	Purpose: Empowerment and committed nurses.

5.2.1 Context: HIV/AIDS and the health services

Dickoff et. al (1968:426), see context in relation to other things, including persons and other activities related to it. The context is constituted by the nursing cadres' cultural context, values, legislation and policies in the work environment (organizational culture) and the era of HIV/AIDS impact within which support is expected to take place. From the empirical findings it was identified that the working environment lacked confidentiality, trust and support of its nursing cadres, there was poor dissemination of HIV/AIDS education, guidelines/policies and failure to initiate support interventions for nursing cadres caring for PLWHA and living with the virus.

5.2.1.1 Organisational culture

Organisational culture is a system of shared meaning within an organisation that determines to a large degree, how employees act or behave. The organisational culture influences the nature and outcomes of performances and can as well influence the provision or influence of support interventions. The organisation's vision, mission, strategy, goals and values give guidelines to norms and behaviour including social responsibility to the community and wellbeing of employees. Organizational climate is determined by the management leadership style and the employee's subjective impressions of the work organization (Booyens, 1998:202). The current health situation, HIV/AIDS pandemic is impacting on the organisation and influences performance and sense of wellbeing of nurses. Activities or trends occurring within organisation can affect the interaction of employees with those in managerial position leading to a climate that is threatening or positive. Based on the empirical findings nurses were over burdened by several aspects of their work environment, the burden was shortages of human and material resources, increased workload and fatigue, discrimination, poor communication, lack of social and educational support from management. Thus nurse managers have a responsibility to make the organizational climate supportive and satisfying to create a sense of wellbeing amongst personnel. Therefore, policies and procedures are necessary to ensure a supportive organisational climate. Successful

organisations are characterised by strong values and strong guiding vision that communicates what behaviour is appropriate and/ or inappropriate. When the values are widely shared across the organisation and are reflected in the everyday actions of employees at all levels and collectively, then there is a strong culture.

Defining characteristics of an organizational culture

According to empirical findings, the preconditions necessary for support includes an organisational climate that's able to build trust, respect and maintain a meaningful relationship with its employees, and an environment that is receptive and displaying commitment to HIV/AIDS issues in the workplace.

The organisation should be able to provide effective support to employees who are living with HIV/AIDS, provide a stigma free work environment and provide a model to other organisations and to the community of effective HIV/AIDS workplace policies. The organisation should acknowledge that HIV/AIDS is a societal problem that requires a proactive intervention and must commit itself to contain and manage the pandemic by respecting the human rights of nursing personnel who are infected with, or affected by HIV/AIDS, foster an ethos of living positively with the disease and encouraging voluntary counseling, testing and accessing treatment. When there is strong shared values and high commitment that is visibly demonstrated by management, nursing personnel are more likely to be satisfied and display higher levels of organisational commitment.



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Figure 5.1 Context: Regulations and Policies within which support in the health service institution is to take place.

5.2.1.2 Legislative framework

Employment Equity Act, No 55 of 1998

The Act extends the quest for a just and equitable society to the elimination of HIV-related discrimination and securing equity and redress for people with disabilities, with the submission that PLWHA fall within the ambit of people with disabilities, especially after the onset of AIDS (Ngwena, 2000:97). The focus is on elimination of unfair discrimination so as to create equal opportunities for PLWHA. The Act prohibits mandatory screening of individuals unless the labour court justifies such testing (Employment Equity Act, No 55 (1998). The health services as state organisation have an obligation to prevent discrimination on employment practices and policies, including recruitment, selection criteria, appointment process, job assignments, performance evaluations and promotions (Cloete, 2004:41). Positive workplace practices ensure safe and healthy environment and are able to build an individual nurse psychological contract and self- concept.

The Occupational Safety Act No 85 of 1993

The Occupational Health and Safety Act no 85 (1993) states that all organisations must provide and maintain a workplace that is safe and without risk to individuals' health. Organisations must eliminate potential hazards; provide training and instruction to enhance safety and health. The organisation is compelled to provide an environment that is safe and hazard free to all individuals and it can be argued that the employer has a legal as well as a moral obligation to provide a supportive environment for employees living with HIV/AIDS and caring for PLWHA. The environment should include programmes on safety measures, opportunities for growth and security, protection of constitutional rights and social relevance and social responsibility. The health service sector where the nurse is rendering care should provide training and education about infection control procedures in context of the workplace accidents and first aid, universal precaution to reduce the risk of exposure to body fluids, use of protective clothing, and

correct procedure in event of exposure to body fluids, counselling and referring nurses to appropriate services which can effectively respond to their needs.

The Labour Relations Act No 66 of 1995

The same can be said for provisions of the Labour Relations Act that prescribe unfair labour practices, including unfair discrimination, it condemns discrimination and embraces PLWHA as an integral part of the workforce.

ILO Code of Practice on HIV/AIDS and the world at work

The International Labour Organisation (ILO) stipulates key principles for managing HIV and AIDS in organisations (ILO, 2001). These principles include treating HIV and AIDS like any other serious illness, protection of human rights and dignity, education, full participation in policy development, and access to acceptable, care and support for HIV or AIDS infected individuals (ILO, 2001).

South African Department of Labour's Code of Practice

The Code's primary objective is to ensure that individuals with HIV infection are not unfairly discriminated against in the workplace. It is based on the principle of promoting equality and non-discrimination between individuals with HIV infection and those without, the creation of a supportive environment so that HIV infected employees are able to continue to work under normal conditions in their current employment for as long as they are medically fit to do so. HIV/AIDS Technical Assistance Guidelines (TAG) on the code of good practice helps employers and trade unions on how to deal with HIV-related discrimination and to respond to the impact of HIV/AIDS in the workplace, by providing guidelines that protect human dignity and ensuring safety in the workplace.

Constitution of South Africa Act, No108 of 1996

Unfair discrimination on any basis, including an individual's HIV or AIDS status is considered illegal in terms of the constitution Act No 108 (1996). Section 9 of the constitution provides that every person is entitled to equality before the law and equal protection of the law, and prohibits both the state and any person from unfairly discriminating directly or indirectly against another person on various grounds, although HIV/AIDS is not listed as a ground on the equality clause, but the constitutional court finds that discrimination on the basis of HIV status is unfair discrimination in terms of the equality clause (HIV/AIDS TAG, 2002). Thus nurses as care givers are protected by the law from being discriminated on the basis of their status and of caring for PLWHA.

Patient's rights

The White Paper on the transformation of public health services and delivery was introduced in 1997, it entails Batho Pele. It provides a policy framework and a strategy for the transformation of the public service to ensure that patients receive effective and efficient health care. Thus management or nurse managers are therefore held responsible for the management of nursing care. Searle (2000:268) states that managers should ensure that nurses are provided with safe working environments to deliver quality patient care.

Concluding statement in relation to Labour statutes and the Constitution with regard to HIV/AIDS and support in the work place

The Constitution of South Africa promotes human dignity, equality and respect of human right and labour laws require organisations or institutions to provide nurses as caregivers safe working environment that supports and foster professional and ethical values by maintaining a climate of mutual trust, respect, sharing ideas and assertiveness towards HIV/AIDS issues. Supportive intervention model can encourage

nurses to demonstrate moral and ethical responsibility towards PLWHA, colleagues, co-workers, in matters regarding the impact of HIV/AIDS in health care service institution.

South African Nursing Council

The HIV/AIDS policy of the South African Nursing Council, the body that oversees the licensing of all nurses, states that patients have “a right to confidentiality”. The ethical and professional codes of practice guide nurses towards maintaining a trusting relationship and providing care that promotes the wellbeing of their patients, including the obligation to meet the health care needs of PLWHA, and apply ethical principles while caring for them.

Department of health’s national policy on testing for HIV, states that the information regarding results of the test must remain fully confidential, and may not be disclosed in the absence of any overriding legal or ethical duty with the individual’s fully informed consent.

Concluding statement of the South African Nursing Council and the Department of Health (DoH) with regard to HIV/AIDS and support in the work place.

In South Africa, nurses are ethically bound to keep their patient’s HIV status confidential, and the DoH which is the employer for the public health care system oversees to implementation of its national occupational health policy which includes: safe needle disposal and reporting of blood-borne pathogen exposure, antiretroviral PEP, and compensation for workers who contracted HIV and other blood-borne diseases at work.

5.2.2 Agents

The agents for this study are nursing service managers, who are responsible in providing support to nurses who are providing care and support to PLWHA. According to theoretical and empirical findings, support within health care institution can only occur in a positive environment that is non-judgmental and non-discriminatory. The nursing managers in leadership position must possess certain characteristic that will create a supportive environment. Participants reported that the organisational climate should display openness with frequent feedback, trustful relationship, should uphold ethical and professional values; there should be involvement of all workers, even clinical managers and provision of information regarding the disease. It is therefore important that managers in institutions should be responsible for creating and changing an organisational culture to be positive by creating a robust vision for the future of HIV/AIDS support programmes or interventions.

5.2.3 Recipients

Recipients in this study are nurses who are caring for patients within the context of HIV/AIDS. The agents and recipient are in a direct relationship of engaging each other in the support process. The goal to be achieved in such an activity is that of nurses being supported and empowered within their workplaces. Nurses as recipients and managers as agents should also possess certain characteristics for the support process to be successful such as self-awareness, trust, respect, good interpersonal relations, communication skills and team work.

Defining characteristics of managers (agents) and nurses (recipients)

HIV/AIDS not only causes human suffering, but also jeopardizes economic growth, social stability, and job performances, thus organizations should respond to the pandemic with the aim of preventing transmission while reducing the impact through a

concerted collaborative approach with nursing personnel and other government and non-governmental organisations.

The involvement and participation of management in the formulation of a support strategy gives the nursing personnel a sense of relevance and enthusiasm in the development or initiation of a supportive intervention. Sustenance of this supportive intervention requires practical and visible support for the needs and resources required, so management should include HIV issues within their strategic plans and budget. During this encounter nurse managers and nursing personnel should develop a sense of team spirit and be committed to the realisation of a supportive environment. Self-awareness, mutual trust, respect and good interpersonal relationships are the key features to the development of this support process.

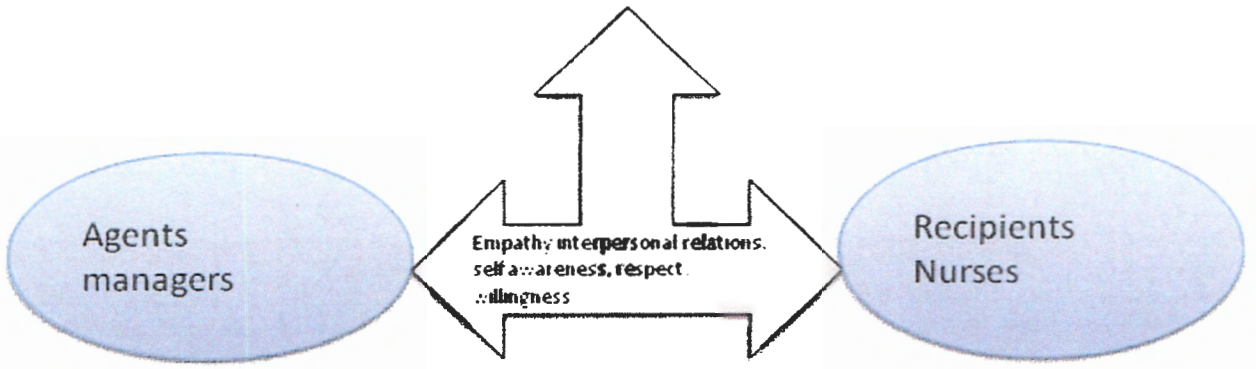


Figure 5.2 Agents and recipients

5.2.4 Dynamics

These are driving powers behind the activity which can either be chemical, physical, biological and psychological for any person or thing functioning as an agent or part of the framework in realising the goal (Dickoff, et al. 1968:426). Support is viewed as a service that can be given or received, appearing as a formal service between human

beings, and occurs when nurses share emotions, experiences, acquired knowledge and feelings and current on goings in their lives to the dedicated managers.

The dynamics of this study are power imbalance, leadership style, effective communication and listening skills. Support interventions should be characterised by a trusting relationship, decreasing power imbalances so that nursing personnel are not threatened by organisational protocols, so as to develop a climate of working together as a team to realize the shared values and vision of providing effective support to nurses living with and caring for HIV/AIDS.

- **Power imbalance**

The differences involved in the power balance between the participants can affect the development of a supportive environment positively or negatively. Managers have the responsibility of driving the objectives of the organisation and that can only be accomplished by involving the nurses in the process and remove barriers that can hinder social exchange. Managers and nurses must assume equal power relations for realization of a support workplace.

- **Leadership style**

Leaders are judged by how much style they display in communicating their decisions, how they express behaviors, which contributes to the interpretation of theses behaviors by others and subsequently their effectiveness. Managers must possess the ability to effectively understand others at workplace and use the knowledge they have to influence others to act in ways that enhance the organisational objective of creating a supportive and conducive non-discriminatory environment.

Participatory management can facilitate the development of a supportive climate as both parties will be engaging with one another in the decisions that affect issues around

HIV/AIDS in the workplace. Transformational leadership takes a visionary position and inspires people, and is focused on helping every member succeed, encourages creativity among followers, fosters supportive relationships and keeps communication open so that employees feel free to share their ideas. Effective leadership need to be challenging, by being motivational so that employees belief in themselves and take action to eradicate discrimination and negative attitudes or changing the culture of the organization to be tolerant and supportive to PLWHA. Motivation is driven by emotions and a motivational leader must make sure that the employees have a strong emotional commitment to realising a supportive non-discriminatory work environment, motivating employees' makes them become more productive and creative.

- **Trust**

Trust has been defined as willingness of a party to be vulnerable, or the intention to accept vulnerability (Treadway et al, 2004:497). The willingness to be vulnerable appears to be based on expectations about the motives (norms and values) of the parties in the relationship. Supervisors or managers who give individualized support and fosters acceptance of group goals are more readily trusted by subordinates. Similarly availability, consistency, discreteness, fairness, integrity, loyalty, openness, promise fulfillment have been found to facilitate the development of trust in supervisors. The frequency of increasing interaction has been found to increase trust as have the quality and type of communication (Doney & Caannon, 1997; McAllister 1995 & Sekhar, Chandra, & Anaiah, 1995 as cited in Treadway et al. (2004:498). Trust is promoted through a social exchange process where both employee and organisation interpret the behaviours of the other to determine whether reciprocation is necessary.

Thus nurses who are burdened by HIV/AIDS caring need to feel that they are part of the larger organisation and take their socio-economical needs into consideration. Another participant indicated that: *"there is no professional secrecy, the gossip starts at management level, we get the information during weekend calls, you will hear them*

talking that so and so is HIV positive. So it makes one to think that if this is how it's been done, especially by senior personnel, it makes you think twice."

Trust is an essential condition for the establishment of social exchange; it requires trusting others to discharge their obligation. Management's concern and care about the well-being of an employee will convey information about the organisation's benevolence and good will lead to perception of trustworthiness in the eyes of the employee (Chen et al, 2005:459).

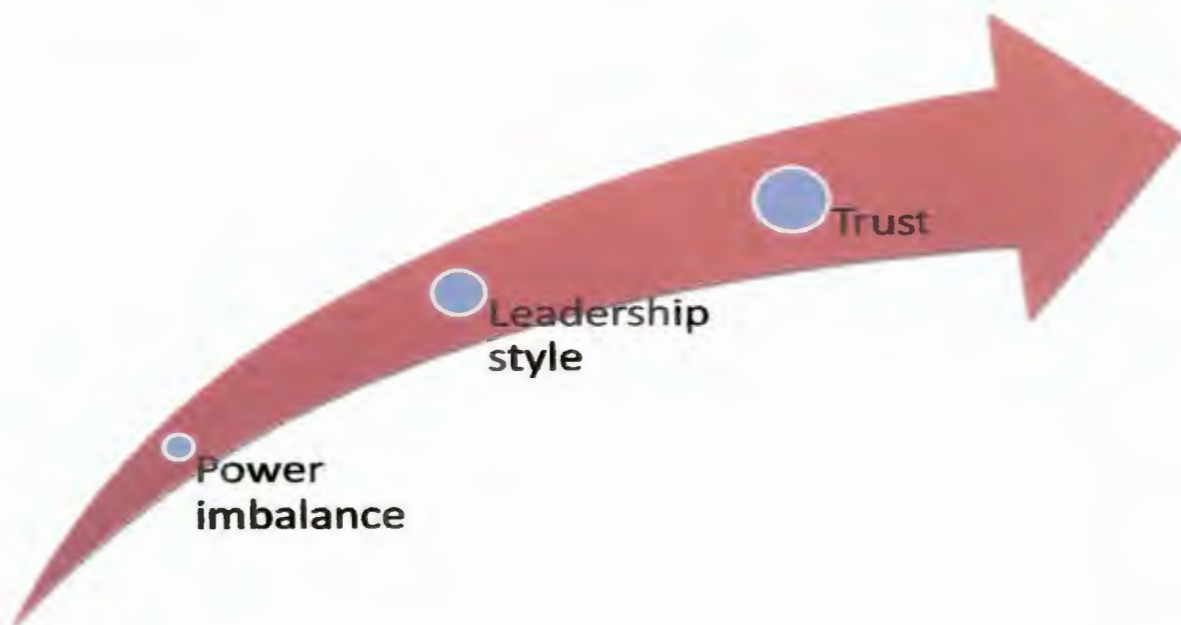


Figure 5.3 Dynamics of support

Tway in Heathfield (online) defined trust as the state of readiness for unguarded interaction with someone or something, and that trust is a construct of three components, the capacity for trusting, the perception of competence, and the perception of intentions which is the perception that actions, decisions are motivated by mutually-serving rather than self-serving motives.

Trust within the working environment is necessary in that the PLWHA and those caring for PLWHA feel able to rely upon one another and experience teamwork. The integrity

of the leadership is the critical factor in promoting a trusting work environment by developing skills of all employees, current supervisors in interpersonal relationship building and effectiveness. Management should confront hard issues in a timely fashion, and protect the interest of all employees, by not talking about absent employees, nor allow others to place blame, call names, or point fingers. Trust is built and maintained by small actions over time, trust is about character, we are trusted because of our way of being, so trust is about telling the truth, even when it is difficult, and being truthful, authentic and trustworthy with all employees.

5.2.5 Procedure

The procedure is to emphasise the path, steps, pattern according to which activity is performed (Dickoff, et al, 1968:426). The activities that were viewed as important in the support process of nurses caring for PLWHA were identified as self-awareness, mutual goal setting, interactive communication and facilitation skills, role modeling and role identification. The process of support was derived from the empirical and theoretical findings, the first step being (i) initiation phase (ii) execution/ implementation phase (iii) sustenance phase. The process of support will be detailed as follows.

From the empirical findings it was clear that nurses/caregivers needed to be assisted with necessary knowledge, skills and resources to be able to identify and manage specific clinical and psychological problems related to HIV/AIDS care.

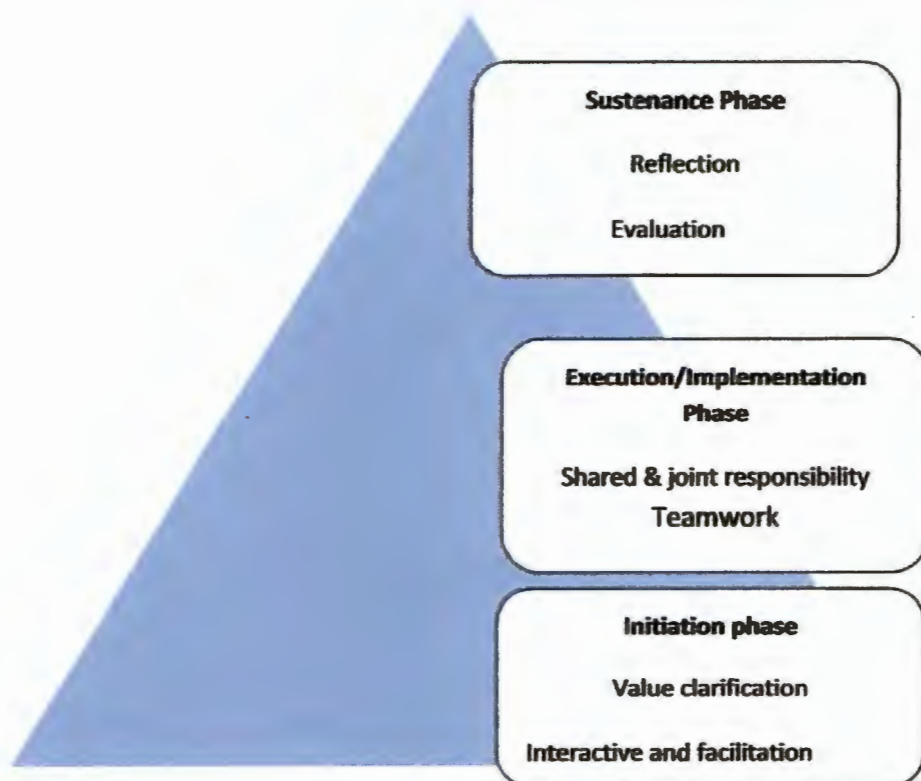


Figure 5.4 Process of support

PHASE 1: Initiation phase

In order to ensure that people are served effectively, sound preparation is essential for the initiation of a support intervention. The managers should meet with the nursing personnel and outline the purpose of the support intervention programme together. During this session nursing personnel and managers should both examine their values with regard to HIV/AIDS caring, each individual member should do a self- introspection of their own attitudes, behaviours towards PLWHA or nurses infected or affected. The organisation should also assess its readiness or commitment to matters related to HIV, what it has in place and what is lacking. Representation of all nursing cadres and different sectoral managers should be adequate, so that all involved will be responsible for ensuring the development of the support process. During this phase the participants can be asked to write down their expectations of the programme as a starting point and the aims and topics for the programme discussed. Thus value clarification, self-

introspection, self awareness, mutual goal setting and interactive communication and facilitation skills were important in laying the foundation of the support process.

Value clarification and self –awareness

Values account for the impact on the person's cultural and personal values. Both managers and nursing personnel may value the initiation of a support strategy/intervention. However, their conception of what is a support intervention/strategy may vary, for nursing personnel may be hiring additional staff, but for managers might mean reorganizing the delivery of health care. Self awareness results in silent moments of epiphany as the self realizes and becomes aware/conscious of the reality of HIV/AIDS pandemic.

Interactive communication and facilitation skills

Effective communication and facilitation is essential for the co-operation between persons and for co-ordinating everyone's contributions. Communication and facilitation requires that participants share mutual interaction and are able to provide feedback. The facilitator should be clear, by using simple and exact language, so as to encourage feedback. The key elements to good communication and facilitation are honesty in what you are trying to communicate, knowledge of the subject, trustworthy, reliable and competent.

Effective communication and listening skills

Communication involves the exchange of information, thoughts, ideas or emotions among people. Effective communication is essential during development or initiation of a support strategy as nurse managers and nursing personnel can be able to share and exchange pertinent information relating to their concerns and aspirations. During this exchange of information, management should be transparent and give practical examples for everybody to understand and be on board, communication should be clear and well interpreted, for everyone's understanding on how the process of support will

unfold. Human beings are sensitive to body language, facial expression, posture, movement, tone of voice and more, so to effectively communicate, these interpersonal communication dynamics must match the words. These communication dynamics can help to emphasize the truth, sincerity and reliability of the communication, same as when they can undermine your communication. Since communication is shared meaning, the words must say the same message as the other interpersonal communication dynamics. Listening refers to the agents and recipient's ability to listen to each other and learn from one another through this social encounter and will be in a better position to build mutual relationships that will make them realize their goal of building a support structure and creating a supportive work environment.

Mutual goal-setting

Mutual goal setting makes employees and management to be goal- orientated and it improves employee's satisfaction and morale. Through participative management individual employees are involved in the decision-making process, the more likely they are to understand and be committed to it.

PHASE 2: Execution phase and implementation

It is during this phase that the structuring of a support process begins. In the previous phase interaction was characterised by exploration of their own life situations and their involvement in the support process as participants became aware of their similarities and differences amongst them but were willing to accept each other sufficiently to continue together. During this phase members determine what needs to be done in order to realise the achievement of the aims and goals, the members are now focused on accomplishing the objectives. Co-operative planning and joint decision making are necessary for formulation of a strategic plan for accomplishing the goals of the support strategy, mapping the process and members are allocated roles and responsibilities. Norms, standards, policies and deadlines are set during this phase.

Implementation of a support process should be hands on; members should role model process by encouraging full participation and bringing everybody on board, by sensitising, reaching out and empowering individuals, nursing community and service staff in the hospital by disseminating information relating to HIV/AIDS awareness, employment policies challenging stigma and discrimination, health issues such as prevention of contagion and workplace safety and mainstreaming HIV/AIDS in organizational programmes. Strong identification with group members, shared leadership and teamwork enhances the feeling of trust and acceptance and taking ownership of the support process.

For the process to be operational, strategic objectives should be broken down into specific, realistic and measurable objectives. Allocated tasks and responsibilities should be allocated to those with knowledge and skills and moreover they must have interest and passion. These team leaders should be regularly capacitated through coaching and mentoring in their respective roles and tasks to be able to deliver and build a sense of group identity and emotional connectedness.

Shared leadership and joint responsibility

The managers and personnel are engaged in shared leadership and joint responsibility through effective two way communication and consult each other before decisions are taken and implementation of decisions are shared by everybody and participants exhibit high morale and responsibility. The final strategic plan of the support process should be communicated to everyone in the organization for inputs and recommendations.

Teamwork

Effective team work requires strong communication skills on behalf of members and when everybody participates, the greater the likelihood of superior performances

because the group works as a collective, make consensus decisions and are committed to the decisions. Conflicts, ill-feelings are dealt with openly.

PHASE 3: Evaluation/Sustenance phase

Monitoring and evaluation of the support process should be co-ordinated in a structured manner by all the parties involved to determine if the goals were realized. Variables or indicators should be determined to measure its progress because evaluation is about assessing, judging and appraising and members can be able to give feedback through questionnaires, reflection and also periodic review of the programme itself. Has the support interventions/strategy addressed the critical HIV/AIDS workplace issues such as respect for human dignity and provision of a safe work place environment and moreover developed an HIV/AIDS workplace policy and empowered nursing personnel on HIV/AIDS issues.

Feedback

Feedback surveys are conducted among personnel to determine their view points regarding the impact of the support intervention/ strategy, were the short-term and long-term goals realised. The survey results are fed back to the employees and discussed so that solutions can be sought.

Reflection

Reflection is about making sense of the experiences the participants have had, sharing their ideas and experiences. Reflection can be achieved by having round table discussions or involving personnel in an informal group discussion so that they are able to discuss issues or activities in the support strategy/intervention.

5.2.6 Purpose

Dickoff, et al. (1968:426) view purpose as an end point or accomplishment of an activity. The purpose for the study is to have a supportive and non-discriminatory work environment that promotes access to HIV/AIDS education, counseling, treatment and care and empowered nursing personnel. The model that has been developed will be a guiding tool for health care institutions or organisations on how to support personnel living with and affected by HIV/AIDS. All nursing personnel should be able to experience a supportive work environment that promotes disclosure, provides access to VCT, provision of ARV's.

Support is perceived as empowering because nursing personnel receiving support tend to perceive the organisational goals positively, when those infected and affected by the disease are treated with respect and dignity, and those caring for them are provided with information or rationale for how decisions that affect them are made and these lead to commitment of nurses to link their personal goals with that of the organisation.

Empowerment is a process that enables growth and development where nursing personnel are enabled to make independent decisions like going for a voluntary counseling and testing, accessing treatment when necessary, be able to prevent further transmission of the disease by acting responsibly and having the emotional intelligence of maintaining a meaningful relationship with those affected or infected by eliminating discriminatory practices. Empowerment also enhances knowledge, skills and attitudes towards a supportive workplace environment that is based on open communication, honesty, participation and commitment. Equipped with knowledge and skills nursing personnel will have confidence in implementing nursing care to PLWHA and be able to make critical and rational decisions in conflicting situations like overriding confidentiality and patient's rights to non-disclosure.



Figure 5.5 Outcome/purpose of support

5.3 MODEL DEVELOPMENT

5.3.1 Structure of a model

The researcher considered the form and structure within which all concepts fitted in a coherent, unified structure and consideration was given to assumption of the model, concept definition and relational statements as outlined by Chinn & Kramer (1991:107) .

5.3.2 Assumption of the model

The researcher made assumptions regarding the support between managers and nurses in health institutions to promote a supportive workplace for nurses to be able to cope in caring for PLWHA.

- The nurses and managers have their own beliefs and values about the support process in the organization.
- The organisational climate and attitudes of both managers and nurses can influence the support process.
- Nurses as carers have a need of belonging and recognition, a need to be supported.
- High quality manager-nurse social exchange is assumed to provide appropriate basis for initiation of support process.
- The support process creates new meaning and understanding among participants towards caring for PLWHA.

5.3.3 Concept definition

Concepts were identified through the process of concept analysis and from experiences of participants. These were then defined and clarified through Dickoff et al. (1968:435) six elements of conceptual framework.

Provision of support to nurses caring for PLWHA- Provision of Support means a network of mutual exchange that is based on honesty, rewards and policies that values the contributions and cares about the well-being of its employees.

Context- The socio-cultural context in the health service setting/ institution of caring, with different professional groups and operating in an organizational culture that is affected by legislation, values and organizational beliefs. The organizational context is tasked with an obligation of creating a supportive work climate for those recipient/ nurses.

Agents- These are managers who are supposed to initiate a support process, by displaying the ability of understanding at work, and influence others to act in ways that enhance organizational objectives.

Recipients- These are nursing cadres who need to be supported and empowered when caring for PLWHA.

Procedure- The process of providing support, which is the social exchange relationship between participants that need to develop a supportive work climate.

Dynamics- These are the underlying powers that direct how the support process takes place, such as trust, honesty, genuineness, good communication and interpersonal skills.

Outcome- The purpose for the study is to have a supportive and non-discriminatory work environment that promotes access to HIV/AIDS education, counseling, treatment and care and empowered nursing personnel.

5.3.4 Relational statement

Relational statements provided links among and between the concepts within a model. As concepts were identified, ideas about their relation emanated and the following relation statements were formulated for model to support nurses to cope in caring for PLWHA

- Support process can be initiated when participants understand the need of belonging and identity (perception of oneness with the organization).

- Dynamics drive the exchange process between nurses and managers.
- Psychosocial support enhances a sense of professional identity and competence.
- Organizational support increases ones feelings of self-worth and self-esteem.
- Perceived organizational support is related to job satisfaction.
- Job satisfaction is related to organizational commitment.
- Supportive organizational climate is inversely related to organizational cynicism.

5.3.5 The nature of the structure

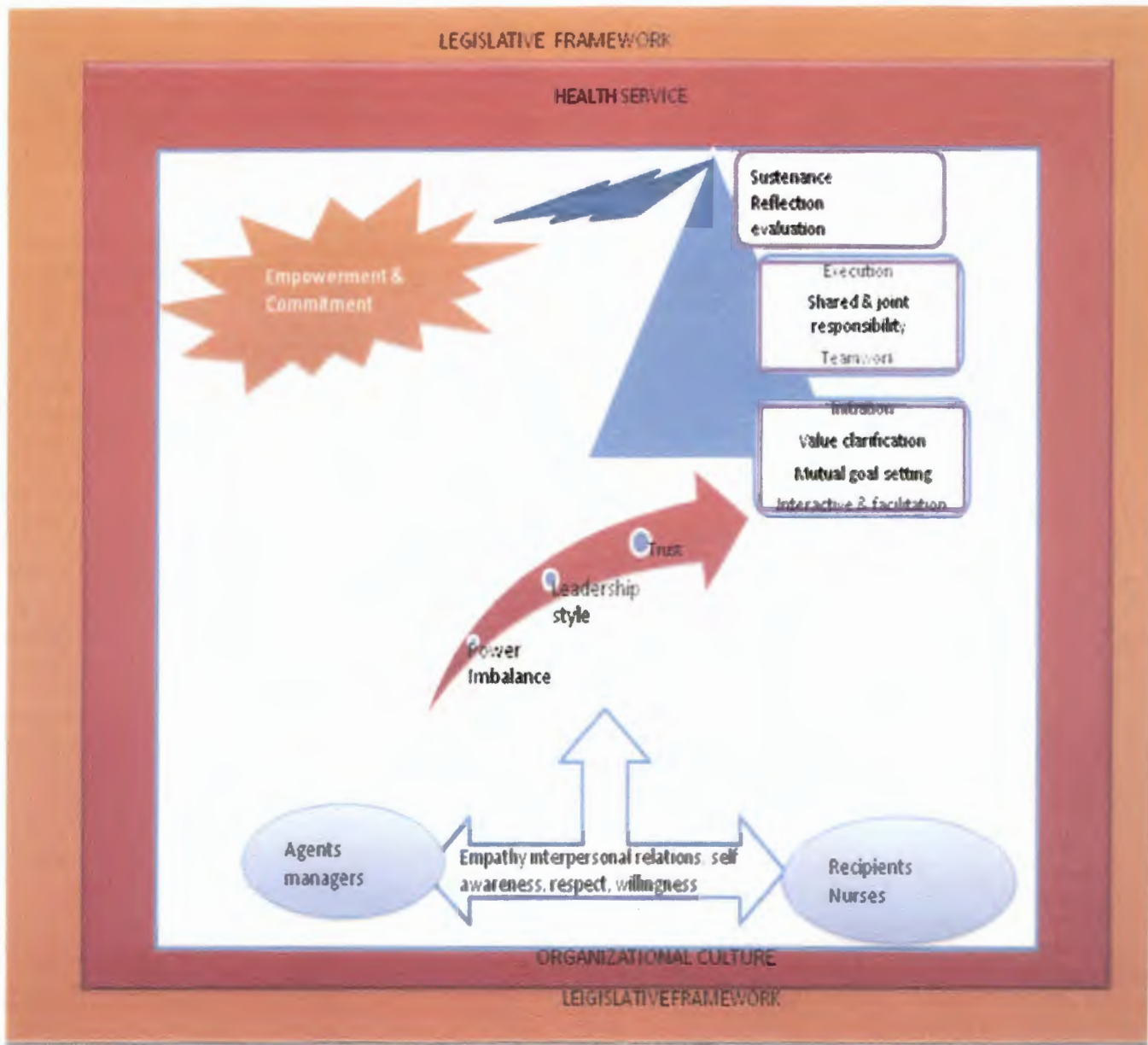


Figure 5.6 A model to support nurses to cope in caring for PLWHA

5.4 EVALUATION OF THE MODEL

Evaluation of the model was done according to Chinn & Kramer's guidelines (1999:99-110) which are:

- **How clear is the model?**
- **How simple is the model?**
- **How general is the model?**
- **How accessible is the model?**
- **How important is the model?**

The five questions for critical reflection and evaluation of the model are discussed as follows:

5.4.1 How clear is the model?

In addressing this question, semantic clarity was achieved through defining the main concepts in the model, semantic consistency was maintained by using the concepts consistently with their definitions, usage and assumption of the model, structural clarity was achieved through Dickoff et al. (1968:426) survey list and structural consistency. The researcher analysed the concept support and together with empirical evidence from participants the concept laid a foundation to model development. The attributes, connotations and relational statements were searched from different literature and databases in the field of sociology, nursing and management assisted to make the concept clear and assisted in development of the framework, and consistency were maintained throughout the study by the use of the major concept. Structural clarity was achieved by the concept map that was derived from concept analysis and it provided meaning on how support to nurses caring for PLWHA in health services can be achieved for them to be able to cope.

5.4.2 How simple is the model?

Model simplicity implies that the number of elements within each descriptive category, the concepts and their interrelationships were kept minimal.

5.4.3 How general is the model?

The generality of the model relates to the breadth of scope and purpose, a general theory can be applied to a broad array of situations. Empirical evidence revealed that nurses lacked support in their workplace and burdened by the scourge of HIV/AIDS, thus the model was developed to assist health institutions to initiate a supportive non-discriminatory workplace. The model can also be applied in other cooperate organizations or institutions as HIV/AIDS is affecting individuals, families and business organizations and workers are part of this broader community.

5.4.4 How accessible is the model?

The model would be made accessible in the libraries, published in accredited journals and workshops and seminars will be conducted to nurses and managers in health institutions. The Provincial department of health in Limpopo will also have access to the model and it will be applied and evaluated since accessibility also addresses the extent to which the concepts within the model are empirically grounded and can be tested for its relationship and clarifying conceptual meaning.

5.4.5 How important is the model?

The question addressed the extent to which the model has the potential to influence nursing care, nursing education, nursing administration and research. Due to the scourge of HIV/AIDS that has impacted on the health services and care giving role, nurses experienced tremendous amount of stress and burnout. Empirical evidence

revealed that nurses lacked support, needed information and resources in helping them to cope in caring for PLWHA. The model would assist in providing support to nurses so as to ease the pain of caring and promote a supportive work climate that is non-discriminatory.

5.5. SUMMARY

The study focused on the description of the model, overview, purpose and its structure. The model was described according to Chinn & Kramer (1991:107) under definition of concepts, relational statements, assumptions and evaluation. The next chapter focuses on the description of guidelines to operationalise the model and evaluate its applicability.

CHAPTER 6

GUIDELINES TO OPERATIONALISE THE MODEL

6.1 INTRODUCTION

Organisations have a legal obligation to provide a safe working conditions for its employees, understanding this aspect could assist in understanding the influence of work based support programmes on the productivity and morale of individual caring in the context of HIV/AIDS, thus this chapter describes the guidelines to operationalise the model which are collective actions to reduce the impact of HIV/AIDS on the individuals and organisation.

6.2 GUIDELINES TO OPERATIONALISE THE MODEL

Operationalisation is an activity to oversee if the model can be instrumental, or that it can be operational. Chinn & Kramer (1995:101) indicate that the final step in theory development is deliberate application of a theory. The guidelines will be presented according to the model as presented based on Dickoff et al. (1968:423) elements of practice theory.

6.2.1 Guidelines to establish a supportive context

6.2.1.1 Organisational culture

- Guidelines with regard to organizational attributes focus on organisational values, vision, mission which are essential for a supportive work climate.
- Support should be displayed by a meaningful trusting, relationship where there is equal power sharing to realise or achieve the said vision of the institution.
- Support should be based on a compatible culture, which displays the culture of caring, respect with the principle of ubuntu and batho-pele principle amongst its employees.

- The organisation must be conversant with relevant legislation so as to make support a best practice principle.
- Support should be facilitated by managers and display or model and remodel it to the employees in the institution.
- Organisational culture should encourage the perceived relationship between the organisation and its environment.
- Managers and nurses must acknowledge the impact of their behaviour on organisational culture.
- Organisational culture should create appropriate system of shared meaning to help people work together towards the desired outcomes.
- Organisational culture should focus on the human side of organisational life.

6.2.1.2 Legislative framework

Constitution of Republic of South Africa Act No 108 of 1996

- The promotion of equality and non-discrimination between individuals with HIV/AIDS and other comparable health/medical conditions.
- Individuals must not be unfairly discriminated against in the allocation of employee benefits.

Respecting the rights

- Legal right to privacy and confidentiality.
- The right to receive medical care and social support
- The right to be treated with respect and dignity
- Compensation for occupationally acquired HIV/AIDS.
- Not to be dismissed on basis of HIV/AIDS status.

Labour laws

- Creating a safe working environment for all employees and employers

- Developing procedures to manage occupational incidents and claims for compensation.
- Introducing measures to prevent the spread of HIV/AIDS.
- Developing strategies to assess and reduce the impact of the epidemic upon the workplace.
- Supporting those individuals who are infected or affected by HIV/AIDS to continue working productively.

Professional body

South African Nursing Council

- Critical review and redesign of nursing curriculum of different nursing courses.
- Nursing programmes should empower nurses to achieve learning outcomes where nurses can apply critical thinking skills. Make rational decisions when encountering complex clinical situation in an HIV/AIDS context.
- The programme must equip nurses with knowledge, skills and emotional intelligence to make clinical judgement and rational decisions relating to HIV/AIDS care.

6.2.2 Guidelines for agents and recipients

6.2.2.1 The agents

- Managers should provide a climate where employees will feel a sense of belonging and identity with the organisation.
- Trust and respect should form the basis for a meaningful supportive workplace that is manifested by social exchange.
- Maintaining good interpersonal relations and effective communication skills the employees will be able to engage in the support process.

- Support should promote social member-exchange where employees learn from each other, share and disseminate information regarding issues pertaining to HIV/AIDS.
- Managers should display emotional intelligence and maturity and relate with employees well so as to understand behaviour and work cooperatively.

6.2.2.2 The recipients

- They should have a positive approach to participate in activities within the organisation to support the process.
- Self-awareness is a critical factor; they should clarify their values and have an understanding for the common course of the support process.
- They should form part of the broader organisation and engage in the activities, a sense of belonging will drive the process.
- Should show interest in the process of facilitating the process, team and team spirit are essential.
- Should be pro-active and be involved in teamwork and the development of support groups within the organization.
- They should continually update themselves with relevant and new information pertaining to matters surrounding HIV/AIDS.

6.2.3 Guidelines regarding the dynamics of support

The guidelines for the dynamic of support are described as follows:

6.2.3.1 Power imbalance

- Modify organisational structure and design, changing of existing norms and culture, example, breaking a culture of mistrust between the members of the organisation may be exacerbated by a line structure that discourage vertical communication.

- Modify organisational systems and procedures by decreasing more formal means of communication and changing the culture to improve communication.
- Redesigning of the physical environment, e.g. the reserved parking space or top floor office buildings and separate executive dining space for managers hampers open participation and culture.

6.2.3.2 Leadership style

- Dynamics needed for support is an interpersonal style that combines social perceptiveness with the capacity to adjust one's behaviour to different situational demands.
- Leadership should inspire trust, confidence, and genuineness and be influential and take control.
- Leadership should recognise and encourage achievement.
- Leadership must have an understanding of others at work.
- Leaders should have the necessary knowledge and skill to influence others to enhance personal and /or organisational objectives.
- Leadership should allow employees to establish goals.
- Leadership should develop plans to help employees to grow and develop on the job.
- Leaders should build networks and social capital, and provide scarce resources to their followers.

6.2.3.3 Trust

- Develop skills of all employees in building effective interpersonal relations.
- Supervisors must act with integrity and keep commitments.
- The manager must confront hard issues in a timely fashion.
- Managers must protect the interest of all employees.

- Managers must display competence in supervisory and other work task, must know what s/he is talking about, and admit if she doesn't.
- Exhibit empathy and sensitivity to the needs of staff members.
- Manager must increase interaction, be available and receptive.
- Manager must be consistent, fair, loyal and discreet.

6.2.4 Guidelines regarding the supportive process

6.2.4.1 Phase 1: Guideline for initiation of support

This phase focuses on the development of a supportive intervention strategy through outlining the strategic mission, vision, values and objectives and how activities will be achieved through interactive facilitation and team work from a diverse group of employees to achieve the expected outcome of the supportive strategy.

Value clarification

Participants, managers and nurses need to evaluate their own values, beliefs, expectations and meanings in relation to caring for PLWHA, and realising the goal of a supportive workplace that is non-discriminatory.

Interactive facilitation and mutual goal setting

- The planning should be interactive and inclusive of all stakeholders.
- A realistic action plan should be developed with agreed activities, outputs and targets.
- Scheduled time and meetings should be prepared and the resources needed to implement activities.
- Regular progress should be reported to establish if everything is according to plan.

Phase 2: Guidelines for execution of support

Shared leadership and joint responsibility

- The leadership structure must be willing to participate in their roles.
- Team members should be experts in their areas, or must accept tasks that are best suited for their skill and knowledge
- Those in leadership position should have the necessary knowledge, skills, administrative and managerial skills and good interpersonal relations.
- Team leader should have a political skill.

Teamwork

- Treat each other with dignity and respect
- Transparency: avoid hidden agendas
- Be genuine with each other about ideas, challenges and fears
- Trust each other, that issues discussed will be kept in confidence
- Team members should cooperate and tolerate one another.
- Team leaders should be able to instil confidence and promote positive morale try to build team spirit.
- Allocation of roles should be done openly with all team members being involved.
- Teams should work jointly with each and complement each other to facilitate to work towards a common goal.
- Division of work to be accomplished can be broken down into specific, measurable and attainable objectives in order to realise the broader objective.
- Come prepared to meetings and projects so as to demonstrate value and respect for time and convenience of others.
- Don't let ineffective relationships and interactions sabotage team work, strive to improve and achieve the team's strategic goals.
- The overall responsibility, authority and accountability will remain with the team leaders, and should be presented in writing.



- Ongoing assessment and evaluation of team performance should be monitored, so as to identify gaps.

Phase 3 Sustenance

Reflection

Reflecting with team members to analyse how the process unfolded.

Evaluation

- Development of an instrument or questionnaire for people to evaluate
- Suggestion box for people to make inputs
- Staff meetings to get feedback from all cadres of nurses

6.2.5 Guidelines related to the cyclical nature of the process

The support process is a cyclical process that starts from self- awareness that is achieved through value clarification, and the support is a process since participants perceive support differently. Continuous engagement is necessary so as to keep track of gaps or deficiencies in the support process.

6.2.6 Guidelines in terms of the purpose or outcome of the model

The purpose of the model describes the outcome the model will achieve; promoting support in the workplace nurses will be empowered and committed in caring for PLWHA. The following are guidelines

- Cohesion should be maintained by direct relationship or advice relationship between employees.
- Similarity in perceptions and beliefs or attitudes.

- Goals provide standards, individual goals must be congruent with organisational goals.
- Employee's behaviour is relevant to achieving organisational goals, competencies, and skills.
- Felt obligation by every employee to care about the organisation's welfare and to help the organisation reach its goals.
- Nurses should be empowered with knowledge and skills to be analytic and able to solve complex problems in their clinical area.
- Nurse's critical and analytic skills should be continuously nurtured and developed by attending seminars, workshops and conferences.
- Active participation of nurse educators, clinical nurse specialists and practitioners should be encouraged during mortality and morbidity meetings, in-service trainings in discussing critical incidents in the units to facilitate creativity and open-mindedness.
- Regular scheduling of seminars and workshops to develop an inquisitive and enquiring mindset.

6.3 SUMMARY

The chapter focused on the operationalisation of the model. Guidelines were described according to Dickoff et al. (1968) theoretical framework. The next chapter which forms the final chapter to the study will focus on justification, conclusion and recommendations.

CHAPTER 7

CONCLUSIONS, LIMITATIONS, JUSTIFICATION AND RECOMMENDATIONS

7.1 INTRODUCTION

Health care services exist within a broader society and are thus the heart of the pandemic's impact. The health service as an organisation must ensure that their own nurses /carers who may be affected or infected have the necessary support for survival and growth. Therefore putting workplace support programmes in place does not only contribute to the social responsibility of combating HIV/AIDS, but it improves the operationalization of the organisation to its core business with high morale staff. Most organizations still have either no, limited or inappropriate mechanisms in place to deal with HIV/AIDS. Employees who are HIV+ and those caring in this context, that are burdened by the pandemic should be supported since when they lack this support their quality of life will not improve, and thus their job performance.

This study focused on gaining an understanding of the experiences of nurses regarding care and support when caring for PLWHA. By doing so it is hoped that managers in health institutions will see the benefits of initiating and implementing workplace support for nurses to be able to cope with the impact of the pandemic.

The chapter focuses on conclusions, limitations, conclusion, justification recommendations and areas for future research.

7.2 EVALUATION OF THE STUDY

The study is evaluated against its rationale, purpose and objectives.

7.2.1 Rationale of the study

The public health care system is resource constrained in most countries and the crisis is further compounded by the impact of HIV/AIDS pandemic. The effects of the disease include increased burden of disease, increased service need associated with caring for

HIV/AIDS itself, and the inadequate capacity to respond to these needs which lead to excessive workload and burnout, high worker attrition.

7.2.2 Purpose of the study

The purpose of the study was to develop a model to support nurses to cope in caring for PLWHA. The experiences of nurses were explored and compared with relevant literature which formed the basis for conceptualization. Concept analysis was done using the evolutionary theory of Rodger & Knafl (1993:77-90) and Dickoff et al. (1968:426) was used to develop the model whereas Chinn & Kramer (1991:101) was used to describe the model.

7.2.3 Research objectives

The study addressed the following objectives

Objective 1 Explore and describe nurse's experiences of support and care to PLWHA.

The objective was met during the first phase of the study where in-depth individual interviews of nurses were done at their respective work place and observational notes were kept to capture the salient moments that occurred within the environment. Data was analysed using Tesch's method in Creswell, (1990:145) and themes, categories and subcategories emerged. Literature control was done and enhanced dense description of the experiences. The findings revealed the following:

Theme 1: Nurses expressed different problems with regard to caring for PLWHA.

The categories included physical strain, psychological strain and emotional strain, resulting from work overload, fatigue, shortage of human resource and shortage of material resources:

- Burden of HIV/AIDS caring on the carers/ nurses

Literature and empirical findings found that HIV and AIDS increased the demands of caring, it overstretched the demands of the health system. Shortages of human and material resources ascribed to HIV/AIDS compromised the quality of care, shortages of staff resulted in poor quality care, nurses were failing to cope with the increased workload, thus they experienced stress. The stress that nurses experienced included physical, psychological and emotional, and it impacted the individuals negatively. The physical burden of caring was manifested by fatigue, decreased strength, loss of appetite while emotional and psychological stress manifested by anxiety, fear, isolation and dissociation, emotional pain, including stigma and discrimination.

Theme 2: Nurses expressed their experiences of lack of support from managers and colleagues

The category included poor organisational support that was related to lack of social support from managers and colleagues

- Poor organisational support

The study indicated that nurses lost work morale which resulted in job dissatisfaction. Loss of morale resulted in feelings of hopelessness and helplessness by the increased workloads and poor support and recognition by colleagues and management. Lack of supportive supervision by management to ensure that the work environment was adequately staffed with enough resources, and hearing out the aspirations and needs of nurses. Social support was lacking for nurses as carers, instrumental support was lacking as they experienced shortages with equipments, pharmaceuticals and did not have a way of relieving their stress, they talked about their encounters amongst themselves, shared their experiences with colleagues, the debriefing sessions were erratic and only group sessions were provided, there was no personal or one-to-one encounter and only those who were VCT trained were the ones attending the debriefing sessions and this lead to depression and burnout. Lazarus & Folkman (1984:221) indicated that an individual's coping strategy is self-control, nurses /carers were able to put a brave face to conceal their emotions, pains and anxieties when they treated

PLWHA, irrespective of the circumstances they found themselves in, but not everyone has potential as most nurses were stressed, burnout and dissatisfied. Few nurses searched and found meaning in their caring role as they remained committed to their caring role, but majority lacked job satisfaction. Provision of instrumental support helps in minimising distress and emotional experiences.

Theme 3: Nurses expressed their experiences of the need to be assisted with coping with care to PLWHA.

The category included poor educational support that was due to insufficient educational support, poor of in-service training, gaps in curriculum

- Lack of knowledge and skills in managing PLWHA

Nurses had inadequate knowledge in rendering care to PLWHA, as most nurses felt helpless when patients in their care changed condition, when they were affected mentally by the illness, not adhering to treatments and dying in their care. Nurses only had basic AIDS knowledge and only those that were VCT trained were the ones being updated on new trends and changes pertaining to HIV/AIDS care. Nursing auxiliaries were just rendering care without them being prepared. In-service training matters were lacking in the institution and staff members were reluctant if not ignorant to attend to matters relating to HIV/AIDS.

The data drawn from these findings formed the basis for concept analyses and model development.

Objective 2- Conceptualisation

The concept that was central to the study was support, and was analysed according to Rodger & Knafl (1993:77-90) evolutionary model. Support was seen to be lacking by most participants and the following attributes were necessary for support to take place: self- awareness, mutual trust and respect, good interpersonal relations, open

communication and listening skills and participative leadership. The sample of data was collected from articles in accredited journals, dictionaries, thesaurus, and books. A theoretical definition was derived from these definitions and the description of experiences that directed in the development of a model.

Concepts were also searched from other related disciplines to have an understanding of the concept. Surrogate terms, antecedents, consequences and related terms were described to clarify the concept. Analysis of the concepts was done according to three categories that led to model development.

Objective 3- Model development and description

The objectives formed the basis for describing the model to support nurses to cope in caring for PLWHA. Dickoff et al. (1968:426) was used as a framework. Evaluation and description of the model was done according Chinn & Kramer (1991:101).

7.3 JUSTIFICATION AND ORIGINAL CONTRIBUTION OF THE RESEARCH STUDY TO THE BODY OF KNOWLEDGE

The study is an original contribution to the body of knowledge in nursing with emphasis being on supporting nurses to be able to cope in caring for PLWHA. Participants' experiences of support and care to PLWHA were explored and described. Analysis of the experiences was done using Tesch's eight steps and the findings were supported by relevant literature. Concept analyses was done using Rodgers & Knafl (1993:77), and the result revealed that support is what happens in meetings between human beings, co-created, as opposed to a service given and received and social support could be the umbrella term of choice (Stoltz, Anderson & Wilma, (2007:1482).

Cora & Alwyn (1997:379-379) describe support as an array of social exchanges which involves encountering support, recognizing support and feeling supported.

7.3.1 Importance and characteristic of support

- Support benefits the interpersonal network within the organization.
- A supportive environment reduces stress.
- Supportive environments promote job performance.
- Support enhances the transmission of information, skills and services.
- Support can reduce stress and improve the overall health and well-being.
- Supportive network/relationships helps challenge fears, build clarity of important things.

7.3.2 Benefits of support

Sense of belonging- When individual feels that they belong and are part of the organisation; it enhances a strong interpersonal relationship and self-esteem.

Increased sense of self-worth- Approval and respect that are displayed when people need one's input, when one's presence is felt, when one feels that the organisation values them and are included at work.

Support increases personal identity, how an individual identifies oneself with the organisation, positive identity increases a person's sense of competence, dignity or self worth.

Feelings of security- Support enhances feelings of security, when individuals feel valued, sense of approval, increased self-esteem and experience personal self-worth, when the organisation gives them access to information, advice, guidance and other type of assistance.

The result of concept analysis led to the development of the model of support for nurses to cope in caring for PLWHA, the support model emanated from the three categories of analysed data and conceptualised within Dickoff's element of practice theory. Model evaluation, relational statement derived and the description of the model were described according to Chinn & Kramer (1999:110). The goal of the support intervention is empowerment of nurses/carers who will be able to cope with caring as they will be capacitated on HIV/AIDS care, experience job satisfaction and commitment.

7.4 LIMITATIONS

Nurses/carers interviewed, were not living with HIV and AIDS (NLWHA). Interviews were done in English and Venda, some preferred to mix English with Venda. It is therefore possible that questions and responses were incorrectly interpreted despite the researcher's effort to translate or have someone else translate the responses or questions for the participants.

Empirical data was drawn from one district in Limpopo province, and findings can only be transferable within the district.

7.5 RECOMMENDATIONS

The majority of nurses reiterated that staff be increased to ease the workload, patient ratios be decreased by stepping down patients to local clinics, training of staff to curb skill shortages in HIV/AIDS care and counselling, ensuring educational support and social support through peer support programmes, social support services. The following are recommended.

7.5.1 Physical burden of caring: Managing the human and material resources

- The department should assess reasons for staff attrition and absenteeism to determine the problem, and device strategies for staff retention.
- Monitor the ratio of patient to staff and bed occupancy.
- The promotion of professional practice of rewarding and acknowledging staff.
- Creation of career ladder to empower staff and enhance personal and professional growth.
- Staff allocation/ roster are done with consideration of personal interest, knowledge and skills in a particular field.

7.5.2 A supportive work environment: Psycho-emotional burden of caring

- The workplace environment should be supportive, create environment that are non-discriminatory to enhance the individual's positive self concept, commitment and utilisation of VCT services available or provided by the employer.
- Stigmatisation and discrimination need to be addressed and be included in work-based support programmes and policies.
- Despite these challenges nurses should receive regular debriefing to ease the emotional pain such as anger, grief, death and depression so as to cope with such challenges in the workplace.
- Support groups can also be beneficial as nurses can be able to ventilate their emotions.

7.5.3 Need for educational empowerment

-Bridging the knowledge gap by having an institution based HIV/AIDS education policy document.

-Including HIV/AIDS within curricula for nurse training or health personnel, such inclusion or document will respond to personnel and staff needs to respond positively to PLWHA and members of the staff affected by the disease, and such document should not be restricted to the transmission of the virus and behaviours that reduce the risk of infection, it should be inclusive and comprehensive to deal with issues of human rights, rape, sexual assault and harassment, relating with and supporting PLWHA and occupational safety.

-Extra-curricular sessions with health professionals will improve knowledge and attitude on HIV/AIDS.

-Making HIV/AIDS information available to all personnel such as promoting awareness, disclosure and acceptance of HIV/AIDS through attendance of workshops, seminars and educational sessions by all nursing personnel

-Increasing multi-sectoral involvement in initiatives to combat the pandemic, to support workplace support programmes

-Enforce legislation of employers' obligation to implement workplace support programmes that could reduce or eradicate discrimination and promote individual quality of life.

Nurses are the backbone of the health care system and as providers of care, it is imperative that they be offered staff development programmes that promote quality care, including in-service training, continuing education as well as work-based counselling to cope with the caring challenges related to HIV/AIDS care.

7.6 IMPLICATIONS FOR FUTURE RESEARCH

It would be more relevant to explore the impact of caring by focusing at the sufferers (NLWHA) as a caregiver, to provide more insight into their feelings, reactions and job performance.

7.7 PILOTING AND EVALUATING THE MODEL

The model will be piloted in the hospitals in Limpopo Province with the experimental hospital receiving work based training programmes and control hospital receiving general health promotion activities thereafter evaluation of the model will be done by comparing and assessing the experimental and control sites if interventions were successful or unsuccessful during post doctoral study.

7.8 CONCLUSION

This chapter concludes the study and outlined the purpose, rationale, objectives limitations and recommendations. Nurses/carers experienced caring as challenging and emotionally taxing, the emotional stress was clouded by feelings of hopelessness and helplessness, isolation and dissociation, emotional pain, fear of contracting the disease, lack of confidentiality and discrimination. Nurses also experienced constraints as a result of caregiving role that lead to poor physical health. Lack of knowledge on managing HIV/AIDS was also indicated as one of the challenges in rendering quality care to patients with HIV/AIDS. The findings also revealed that there was no effective support system for nurses; nurses were unable to vent their views and ideas and find productive solutions to their problems, leading to stress and burnout.

The HIV/AIDS pandemic continue to negatively impact the health service; however employers must be able to support their employees to lead productive lives. To reduce the negative influence of HIV/AIDS employers should implement a comprehensive work based programmes in line with HIV/AIDS TAG 2002 and ILO (2001). Legislating the

provision of work based programmes ensures that employers provide a baseline level of support and thus eradicating discrimination and stigmatization and providing practical support by providing resources needed in the care of PLWHA.

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ANNEXURE

North West University (Mafikeng Campus)

P/Bag X2046

Mmabatho

2735

Research Directorate

Limpopo Province

Department of Health

Polokwane

0700

Sir/Madam



RE: Request to conduct research in Limpopo Province

I am a part-time student at North-West University, currently studying for a doctoral degree. One of the requirements for fulfillment of the degree is to undertake a research study. I therefore requesting your permission to conduct research and submit a thesis to fulfil my degree requirements.

The purpose of the study is to develop a model that will support nurses when caring for PLWHA in their respective clinical areas at health institutions. The study will benefit the health institutions in that nurses will be able to cope or find meaning in their workplace, improve HIV and AIDS workplace support programmes that emphasise environmental acceptance within the institution.

The research follows a qualitative approach. Therefore, I intend to interview participants and will make every effort to ensure participant anonymity, undertake to maintain confidentiality, ensure no names or any identifiable characteristics/information of participants are used and written informed consent from all participants will be required prior to interviewing. I am also a professional nurse registered with the South African Nursing Council.

Yours faithfully

A handwritten signature in blue ink, appearing to read 'D. U. Ramathuba', written over a dotted line.

Ramathuba D.U.

ANNEXURE

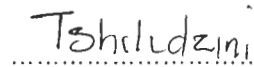
North West University (Mafikeng Campus)

P/Bag X2046

Mmabatho

2735

Nursing Service Manager

 Hospital

Private bag X925

Shayandima

0945

Sir/Madam

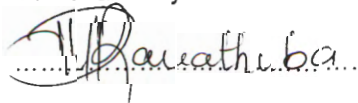
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Yours faithfully



Ramathuba DU



LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH AND SOCIAL DEVELOPMENT

Enquires: Ramalivhana NJ

Ref: 4/2/2

28 June, 2010

Ms Ramathuba Dorah Ursula

University of Limpopo

P/Bag x 5050

Thohoyandou

0950

Dear Ms Ramathuba DU

"An intervention model to support nurses in caring for people living with HIV/AIDS (PLWHA) in Vhembe District: Caring for the carer"

Permission is hereby granted to Ms Ramathuba DU to conduct a study as mentioned above

- The Department of Health and Social Development will expect a copy of the completed research for its own resource centre after completion of the study.
- The researcher is expected to avoid disrupting services in the course of his study
- The Researcher/s should be prepared to assist in interpretation and implementation of the recommendations where possible
- The Institution management where the study is being conducted should be made aware of this.
- A copy of the permission letter can be forwarded to Management of the Institutions concerned



HEAD OF DEPARTMENT
HEALTH AND SOCIAL DEVELOPMENT
LIMPOPO PROVINCE

Private Bag X9302 Polokwane
18 College Str., Polokwane 0700 • Tel: 015 293 6000 • Fax: 015 293 6211 • Website: <http://www.limpopo.gov.za>

The heartland of southern Africa - development is about people

INFORMED CONSENT

TITLE: AN INTERVENTION MODEL TO SUPPORT NURSES IN CARING FOR PEOPLE LIVING WITH HIV/AIDS (PLWHA) IN VHEMBE DISTRICT IN LIMPOPO PROVINCE: CARING FOR THE CARER

Dear Participant

The researcher is a registered doctoral degree student with North-West University, currently busy with this research. The study seeks to develop a model that will support nurses when caring for PLWHA in their respective clinical areas at health institutions. The study will benefit the health institutions in that nurses will be able to cope or find meaning in their workplace, improve HIV and AIDS workplace support programmes that emphasise environmental acceptance within the institution.

Participation in this research is entirely voluntary. You are free not to participate in this study if for any reason you feel uncomfortable to continue as a participant.

Permission to carry out this study was granted by the Department of Health in the Province and region, Higher Education Degrees Committee and Ethics Committee of Research, Nurse Manager of this selected hospital.

No form of experimentation or manipulation shall be done on you. Confidentiality and anonymity will be maintained at all times during data collection. Neither your name nor the name of your institution/hospital will appear anywhere in the study. No unauthorised person will have access to raw data. Only the results of group data will be presented as findings of the study.

A recorder will be used to collect data but information will be treated confidentially. If you agree to participate in this study indicate this by writing your name in the space provided and sign.

I.....have fully understood the purpose of this study and I'm willing to participate on a voluntary basis.

Signature of participant.....

Thank you for agreeing to participate in this study.

Thank you for your time and support.

Ramathuba D.U.

Interview transcript

Researcher: Morning

Participant: Good morning

Researcher: How are you?

Participant: Fine, thanks and you?

Researcher: I'm fine, I am a student doing research. I would like to know about the support that you get from work whilst caring for patients suffering from HIV/AIDS. My first question is " how is it to care for HIV and AIDS patients?

Participant: I don't really know what to say about these patients, it is rather a painful experience knowing that you are sick, but when nursing them is not much of a problem, only when you see the way s/he is suffering is where you really feel that is painful, looking by the way he behaves you realise that that the disease is dreadful

Researcher: How painful is it?

Participant: The pain that you see..... , the pain you observe that the patient is feeling, you really feel for them, especially because the people might have been diagnosed long ago or defaulted treatment, others had denial and now they come being critically ill..... , you can really see that this person is in great pain.

Researcher: So as a nurse what is your experience of care when rendering service to patients suffering from HIV and AIDS?

Participant: We are trying very hard to render care, even though we sometimes fail to satisfy the needs of all patients as they mostly complain that there is nothing that is been done for them, even though you go all out to do best, because we are trying so much, we administer medications, everything that is supposed to be done for them, we do it for them.

Researcher: What challenges do you experience when caring for these patients?'

Participant: We experience many problems, these patients are not receptive at all, and at times it seems they avoid you and they sometimes not answer back when you talk to them, he can even pull up the blanket to make sure that he doesn't want you near him.

Researcher: Is it because they have lost hope?

Participant: Some you can see that they have lost hope, some think that there's nothing done for them, so they want to feel your presence every time which is impossible because the patients are many, we are caring for 53 patients, all waiting to be assisted by you. You will hear them saying "you must be near so that every time we need your help, we can be assisted because it's long that we have been calling" only to find that he never called for help. This is really a challenge.

Researcher: Does this mean that the patients are deprived of the necessary care or is the nurses that are not accessible to patients?

Participant: It's about manpower, we work being five(5), caring for fifty-three(53) patients and we are supposed to be doing everything, from administration of medications, insertion of drips, which they take out after insertion, manpower is very limited.

Researcher: How does the situation affects you?

Participant: The situation affects us negatively, it is extremely painful, especially during the night, and these patients are like psych. You will find him walking and screaming the whole night, some even abscond, so you need to pay attention to this patient, then what about the rest that also need your care.

Researcher: How do you experience support from your seniors or managers from this burden?

Participant: Aaa.....h , is just routine, you report when you encounter a problem, all that is said is "lets just try to work" , there's nothing more.

Researcher: This means that there's no support at all from management?

Participant: We don't have access to the manager, we just talk to the unit manager that we feel the burden and there's nothing done except to say "lets just try and work".

Researcher: So this means you must try to work under such conditions?

Participant: Yes, under such conditions, like this week, when we arrived on duty at 19h00 we found a patient confused and chasing us around and we ran out of the ward, we ended calling security, the policeman came with the security guard as the patient indicated that he don't want to see nurses.

Researcher: So that's it?

Participant: EE.....e (loud) it's best to run for your life, what if he injures you, what will they do? , but if you are not injured nothing is being done.

Researcher: When caring for these patients, has the burden of caring increased or changed in any way?

Participant: There is no much that can be said, you cannot say its better but generally HIV patients need to be cared. The problem is that when they are cared with other patients that are not infected, these patients demand that they be discharged because they are afraid of them as they are wild and dangerous at times they even throw benches around and hit other patients when in denial stage, so they are really afraid of them (low tone).....

Researcher: Mm.....m

Participant: request discharge before they are well

Researcher: As you are say you work being five during the night, do you share the workload?

Participant: We work being two registered nurses, one enrolled nurse and two nursing auxiliaries, and everyone focuses on her task, we only assist one another in instances such as when the patient is aggressive so that he must not assault people, is then that

we support each other....., but concerning the workload everyone does her load....., and the workload is too much.

Researcher: Meaning that on your part the workload is too much?

Participant: Mm...m, as registered nurses there is a too much on our part like inserting IV infusions to almost every patient, and there are many patients on IV treatment, and immediately after insertion some of them are out, you will observe some dangling or being pulled on the floor but.....still you must ensure that they are in situ and functional. Furthermore there are ward problems that need to be attended to, report critical patients and those that have problems, if the patient changes condition, you need to look for the doctor everywhere to come and assist the patient and in the process some patients don't cooperate you'll find them sleeping at the edge of the bed and as you request them to sleep properly, they refuse and end up falling out of bed and still you need to rush and help, the cot beds are insufficient.....

Researcher: Mm.....m.

Participant: some even jump out of the cot beds.

Researcher: Have you ever raised concern that you need extra resources?

Participant: We do raise our concerns....., but we end up making beds on the floor for the patients unlike to be faced with a problem....., knowing that it is not allowed for patients to be sleeping on the floor, but we are pressurized by circumstances because when the patient gets injured you are supposed to write a statement.

Researcher: So how do you cope in such a situation?

Participant: The situation is very hurtful, it's only that that nothing that can be done....., but its painful....., its very painful.

Researcher: In your opinion how do want to be supported in such circumstances, in which way do you need support from your managers?

Participant: I'd like that we be provided with the necessary resources, and enough staff that can be able to take care of patients, not little staff and we should also be supported. I remember one incident when a patient was aggressive and chasing us around, we called the security and policeman to our rescue. He ended up losing his cell phone in the process and we were requested to write a statement about the cell phone we did not see, how you will see the phone when you are running for your life. The relatives were insisting that they will take the matter to their lawyers.

Researcher: So what was your reaction and response to this matter?

Participant: Plainly speaking nurses don't have support in the work place, they only support the community because they are afraid that the community will take legal steps. They don't support nurses to that extent. We don't even know how far is the matter, since it ended with us writing statement (low tone).

Researcher: Mm.....m, so after such circumstances, how is your performance?

Participant: You are not free! (Slight exclamation)..... you won't be free at all. It was suggested that all patients that are admitted during the night the relatives must leave with his cell phones, so we struggle to encourage them to leave with those valuables, but nothing is done during the day, the day staff does nothing about it. They admit them with portable radios, cell phones etc and anybody can take them since he cannot take care of them, many people enters the ward during daytime, visitors or other patients can take them whilst he is asleep. These things can disappear.....

Researcher: Mm.....m

Participant: , and they end up saying is the nurses who take these items, who can take a patient's phone?, what for?

Researcher: Your colleagues who are HIV+, what kind of support do they get from management?

Participant: HIV/AIDS is a secretive disease, you won't know who is infected and who is not, as a people don't disclose, so as people to know.

Researcher: What is the cause of fear of disclosure?

Participant: I think the problem is that they think that the colleagues won't relate well with them, people gossip, and it hurts once it reaches your ears.

Researcher: This means that the environment is not positive for people to disclose, people can't disclose?

Participant: No, they can't disclose.

Researcher: This means management or the nurses don't encourage one another to get tested, so as to support one another?

Participant: Haai....., to be tested, its done privately, ee..e..... maybe when you are sick privately. There is no way..... It was once initiated that people be tested, but now.... , no.

Researcher: So, this means that nurses that are HIV+ are working under pressure?

Participant: Mm.....m

Researcher: From what you have said, that you need resources and staff, is it all the support that you need?

Participant: Mm.....m, that's it, because you find that the patient has been ordered medications, especially antibiotics and they are not available, it hurts, thinking that maybe if he had antibiotics he would be better.

Researcher: Meaning that you also have shortage of medications?

Participant: There are shortages of medications, and the other problem is ARV's because we don't keep stock in the wards, every patient has his own and when they come from home they don't bring their treatments along.....

Researcher: Ok....ay

Participant: they leave the treatment at home.

Researcher: Mm.....m.

Participant: You will find that the patient is on ARV and TB treatment, and left both treatments at home, but with TB is much better as is easily available, ARV is a problem.

Researcher: So you need to ensure that the patient continue treatment?

Participant: Ee...e, sometimes they tell you that they didn't eat..... , and they need food to drink medication at night, and moreover they didn't drink in the morning, meaning that there's a gap in between, the patient did not take treatment the whole day.

Researcher: The problem of medication seems drastic?

Participant: Mm....m

Researcher: Is medications the only problem, other resources?

Participant: Haa.....a, some of the things are available.

Researcher: Meaning that staff and this other resources if increased, all will be well?

Participant: Mm....m, because many patients are ill and staff is minimal, the rate of patients is too much.

Researcher: How are the working relations among colleagues in the unit?

Participant: It's rare not to find attitudes, especially between day and night staff, we are not in good terms, and we are always shifting the blame. Jaa....., that's always the case when you are working (low tone).

Researcher: Mm...m

Participant: But the staff that is allocated with you at that time, there is cooperation and support.

Researcher: Thank you for sharing this information with me, if there's anything further that need to be clarified I will contact you.

Participant: Thank you.