

A model for HIV and AIDS care, research and policy interface

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DECLARATION

I solemnly declare that this thesis, 'A model for HIV and AIDS care, research and policy interface' is my work. As far as I know, it does not contain any material written by another person but not acknowledged by means of references. I declare that all the sources used or quoted in this study are acknowledged in the bibliography. The study has been approved by

- North-West University Ethics committee
- Department of Health – Free State Province
- The relevant permission letters from district level and facility level authorities
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Your Love, O Lord, reaches to the heavens, your faithfulness to the skies.

Psalm 36:5

I am grateful to Almighty God for the ability and perseverance to undertake this task. Without His grace, neither I, nor this study would have been conceived.

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DEDICATION

This thesis is dedicated to my late parents Mr Motsamai Mosenene and Mrs Puseletso Mosenene. My mother passed away during the final preparations for submission of this study.

ABSTRACT

A model for HIV and AIDS care, research and policy interface

Study background

Nursing plays a pivotal role in the care of people living with HIV and AIDS and makes an obvious contribution in influencing HIV and AIDS policy. Studies suggest that despite their knowledge and experience nurses do not systematically inform policy.

Against the background of the research problem above, the following research question was posed: How can a model for HIV and AIDS care, research and policy interface be developed?

Purpose of the study and objectives

The purpose of this study was to develop and describe a model for HIV and AIDS care, research and policy interface. The study objectives were developed in two phases relevant to the methodology of developing a model.

Phase One objectives

Phase 1 objectives – The identification and classification of concepts in relation to HIV and AIDS care, research and policy interface.

- To examine how HIV and AIDS stigma influences nurses' provision of prevention, care and treatment to patients and families.
- To explore and describe how HIV and AIDS affects the workforce.
- To examine the HIV and AIDS policies and interventions

Phase 2 objectives

Phase 2 objectives – Concept definition, description and model development

- To describe a conceptual framework
- To construct the relational statements amongst the identified concepts

Methods

Three different instruments were used in both qualitative and quantitative collection of data. These were the Human Resource Management (HRM) Rapid Assessment Tool, the Clinical Survey and the Interview Guide. Content and construct validity were used to determine rigour of the quantitative instruments; trustworthiness of the qualitative data was established according to Lincoln and Guba (1985) and Krefting's (1991) considerations of trustworthiness

Results

Concluding statements were deduced from the analysed data. These were further deduced into: HIV and AIDS care, research, HIV and AIDS stigma, staff outcomes and policy. These core concepts were used to develop a model for HIV and AIDS care, research and policy interface.

Recommendations

Recommendations for practice, research, education and policy included stakeholder inclusion in HIV and AIDS policy, increasing the research component of clinical nurses and rolling out the use of HIV and AIDS care, research and policy interface model.

Key words

HIV and AIDS stigma, policy, research, interface and model.

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CHAPTER 1: OVERVIEW OF THE RESEARCH

1.1 Introduction

This doctoral study forms part of an international research programme, 'Strengthening nurses' capacity in HIV and AIDS Policy Development in sub-Saharan Africa and the Caribbean' According to Edwards and Roelofs, (2007:34) the research programme brings together researchers and decision makers from the regions with the highest prevalence of HIV in the world, i.e. sub-Saharan Africa (Kenya, South Africa and Uganda) and the Caribbean (Jamaica) in a collaborative effort with Canadian researchers.

This study is conducted in the Free State Province and focuses on the development of a model for HIV and AIDS care, research and policy interface. Health care professionals have an obvious contribution in influencing HIV and AIDS policy. Studies suggest that despite their knowledge and experience, nurses do not systematically inform or take part in the development of policy. Numerous international bodies like 'The Robert Wood Johnson Foundation' and 'The Association of Academic Health Centers' have called for nurses' involvement in policy decisions (Leavitt 2009:74). Edwards and Roelofs (2007:187) confirm that nursing plays a leading role in healthcare delivery for HIV and AIDS sufferers. Such professionals are also at the forefront of HIV and AIDS prevention and care in sub-Saharan Africa and the Caribbean, but have limited involvement in policy decisions. This study is therefore intended to develop a model for HIV and AIDS care research and policy interface.

1.2 Overview of this chapter

This chapter presents the introduction to and overview of the study, background and statement of the problem, the aim and objectives of the study. The researcher's assumptions are discussed, as are the ontological, epistemological and methodological dimensions. The research design and research methods are discussed. At the end of the chapter the research study outline is presented.

1.3 Background to and rationale of the study

'The Institute for Health Care Improvement' developed models of care by engaging nurses as frontline providers in such projects. This was done in order to incorporate the results of such models to public policy. Fyffe (2009:698) confirms that nurses can influence HIV and AIDS policy, though people think that they are poorly prepared to do so. In fact, Leavitt, (2009:74) claims that nurses can lead the way in creating policies, because nursing care contributes to quality outcomes. As such, models which proved to be effective in quality patient care were

developed by nurses. It is therefore imperative to transform existing models of health care to policy as the nursing profession is faced with a lot of changes (Fyffe, 2009:698).

According to Henney and Gonzalez-Block (2014:56) state that engagement in policy development requires commitment from local leaders such as nurses, as international researchers tend to set the agenda themselves when research capacity is lacking. The knowledge of local nurses in the prevention and care of HIV and AIDS should be integrated in policy as this creates ownership of such policies and appropriate implementation thereof. Local knowledge regarding the culture of different people in South Africa, including the Free State, will enable nurses caring for people living with HIV and AIDS to translate the results of the best strategies of care into research and policy. In day-to-day practice the researcher has observed, as a manager that nurses are sometimes unable to fully implement policies, due to the lack of ownership. It is therefore important to appropriately include nurses and other health care professionals in influencing policy.

Nurses can be required to answer research questions regarding factors affecting the care of HIV and AIDS patients which may consequently be translated into policy inputs. According to Holzemer and Uys (2008:165) and Greeff, Uys, Holzemer, Makoe, Dlamini, Kohi, Chirwa, Naidoo and Phetlhu (2009:10) such factors include stigma which is levelled against the patients. Stigma impacts on the care of patients because they refrain from seeking help for fear of stigmatization.

Another factor which impacts on the care of HIV and AIDS patients is workload. Parsadh and Van Dyk (2008:71) confirm this by stating that HIV and AIDS has emerged as a problem that affects the workload of health care personnel. In the case of this study the workforce in the health care system is mostly affected by the disease in terms of its impact, the related policies that need to be adhered to, as well as stigma. Stigma affects the care of HIV and AIDS patients as they refrain from disclosing their status, attending clinics as well as taking antiretroviral drugs for fear of being labelled (Holzemer & Uys, 2008:165; Greeff et al., 2008:10). In spite of this Pawinski and Laloo (2006: 1189) state that Africa has the largest burden of HIV and AIDS worldwide yet human resource constraints are aggravated by the exodus of professionals to countries with more economic resources.

The above factors will be discussed in the subsequent paragraphs as they are issues which affect the prevention and care of HIV and AIDS patients. Research questions will also flow from these concepts which will consequently be utilized to develop a model for HIV and AIDS care, research and policy interface. Below is a discussion on HIV and AIDS care, research and policy.

1.3.1 HIV and AIDS care, research and policy

Policy is defined in various ways by different authors and its fundamental meaning is that, it involves principles set to govern actions needed to reach a defined goal. Policies go hand in hand with the values and beliefs of those who develop them (Leavitt, 2009:73). According to the Pro-Active College module for Policy Development (2007:36) policy is the translation of government's political priorities and principles into programmes and courses of action to deliver desired changes. The Oxford English Dictionary (2011:1110) describes policy as a general plan of action.

Fyffe (2009:699) contends that policy is a 'course of action adopted or proposed by government's ruling party, business or individuals'. Dye (2001) describes policy as simply 'what government can do or not do, action or inaction rather than process'.

Considering the above definitions of policy, the care that nurses provide to patients has proven to be effective in the sense that guidelines for care of patients with different conditions have been developed from evidence-based practice. Therefore it is obvious that the improved nursing care modalities are utilized because of the proof that they are successful. Leavitt (2008:158-159) discusses amongst other guidelines developed by nurses, those for prevention of pressure sores, and emphasizes that such research should be used in informing policy decisions. Furthermore, all nurses engaged in research should consider the policy implications of their work. Those in academia should require that all doctoral theses show the connection between research and policy.

Lomas (2002:236) argues that evidence-based decision-making in the Canadian Health Services Research Foundation became the cornerstone of health care in the 1990's. The idea of better informing practice with research findings has spread from medicine to management and policy decision. This necessitates that those allocating funding and those designing and running health services as well as healthcare providers should use the most up-to-date findings from health services and medical research to inform their decisions. In 1997, federal government sources in Canada set up a foundation to improve the scientific basis for decisions made by those running the health services.

Leavitt and Chaffee (2009:1400) indicate that the nursing literature is critical of the fact that nurses and the nursing profession are not well represented in health policy. This leads to organisations formulating policies that dictate to nurses. Milner, Estabrooks and Humphery (2005:889) assert that in a culture that espouses best practice, policy-makers, researchers and grant agencies search for ways to promote the use of research evidence in health organizations. Best practice is promoted by mentoring others, acting as information sources and

assisting in the development of policies and procedures, based on available evidence. Such best practices are therefore research results that can be utilized in policy. Lomas (2000:237) confirms this by stating that bringing research and researchers into the policy-making process resolves conflict and increases the likelihood of consensus in the areas where research is available. It is therefore the aim of this study to examine the interface between HIV and AIDS care, research and policy.

This endeavour will bring research and researchers into the policy-making process, as Lomas (2000:237) asserts that the synergy of combining research and researchers' analytic abilities, with decision-makers' input reduces uncertainty in interpreting reality regarding healthcare problems. This is confirmed in the Lancet commission's report by Frenk (2010:1925) that knowledge translated into evidence can guide practice and policy. On the other hand Fyffe (2009:698) argues that strategies that support nurses and nursing to influence policy are in place but more needs to be done to promote and increase the participation of nurses in the political process and health policy.

Gilson and McIntyre (2008:749) assert that the knowledge produced by research does not only generate data and findings but also ideas, criticisms as well as policy briefs.

1.3.2 Policy development

According to Roussell, Swansburg & Swansburg (2006:367) policy can be described as both entity and process. As an entity it reflects the beliefs of the administration in power and provides direction for the philosophy and mission of the government. These directives according to Roussell *et al*(2006) can take the form of position statements, goals, programmes, proposals and laws.

Mason, Leavitt and Chaffee (2014: 8) define policy as the principal government action directed towards given ends which are consciously chosen. And a decision is made to meet such ends. Public policy is policy formed by governmental bodies e.g. the tobacco policy. Social policy pertains to the policy decisions that promote the welfare of the public. Health policy includes the decisions made to promote the health of an individual citizen, whilst facility policies are those governing the workplace, what the facility 's goals are and how it will work, and most in particular how the facility will treat its employees.

Gilson and McIntyre (2008:769) state that the process of policy-making is regarded as circular rather than linear. This process according to the authors above involves actions and decisions taken over lengthy periods of time. Policy narratives that flow from research are an important strategy for using research to impact on policy .Roussell, Swansburg & Swansburg (2006:39)

describes the five major stages in decision-making related to government policy translation as agenda setting, legislation and regulation, implementation and evaluation.

Since this study is conducted at the practice level, agenda setting is the stage at which the inputs from nurses have to be considered. However it is argued that nursing is poorly prepared to contribute to the policy agenda. The nursing approach to influence policy is fragmented (Fyffe, 2009:699). On the other hand, Rousell *et al* (2006:369) and Leavitt (2009:73-77) state that this is the stage at which nurses can be involved as they encounter problems related to the populations they serve that require their involvement in policy. These - authors also assert that opportunities for nurses to do so are unlimited. The findings of this study may be utilized to influence policy at the agenda setting level. Rousell *et al* (2006) further indicates that HIV and AIDS is an example that nurses need to be involved in public policy especially at the agenda setting level.

According to Henley (2002:55) public policy refers to policy made for the public, developed and initiated by government and interpreted and implemented by public and private bodies.

In South Africa public policy is developed by means of conducting research on important issues e.g. poverty, unemployment and health issues, in order to determine the needs of the communities (Doyle, 2006:55). Policy is a social process although the major role player in public policy is government; it is a social decision-making process. Public policy represents the collective wishes of society for social goods and services (Rosenthal and Strange, 2004:143-153).

Cloete and de Coning (2011:180) identify the following stages of the policy development process: Problem identification, problem articulation, agenda setting, policy formulation, policy legitimisation, programme design and development, programme implementation, programme evaluation, policy assessment, and policy change.

Agenda setting is preceded by problem identification and the ability to articulate those problems before they reach the agenda setting stage. Not all problems identified or even articulated in public reach the agenda setting phase (Cloete & De Coning: 2011:180).

After identification of a problem, it is refined to a policy issue. Problem, issue definition and mobilization of support are followed by government policy agenda. Doyle (2006:31) in a UNISA study guide for public policy management 1V states that research is conducted in order to determine the extent of the social issues in need of a solution.

Policy implementation consists of planning, programme of action, and evaluation thereof. The policy analysis phase consists of problem structuring, forecasting, recommendations,

monitoring, control and evaluation. It is clear that the issues in HIV and AIDS policy that are elicited from professional nurses during interviews and questionnaire analysis will be utilized in influencing policy. This is done in the agenda setting stage of public policy process.

Political leadership programmes and policy activities were developed in the United Kingdom in nursing so that such programmes could encourage nurses to be more politically active. The nursing profession has been perceived to be slow to respond to this agenda as there are barriers preventing nurses from doing so (Fyffe, 2009:699).

As a means of ensuring engagement in policy, the Canadian Nurses Association (CNA) developed a model that explains processes involved in formulating policies. This model was developed in order to assist nurses in elevating issues up to the public policy arena and move their agenda forward to action. They use this model in explaining processes involved in formulating policies. Figure 1.1 depicts the policy cycle.

Getting to the Policy Agenda

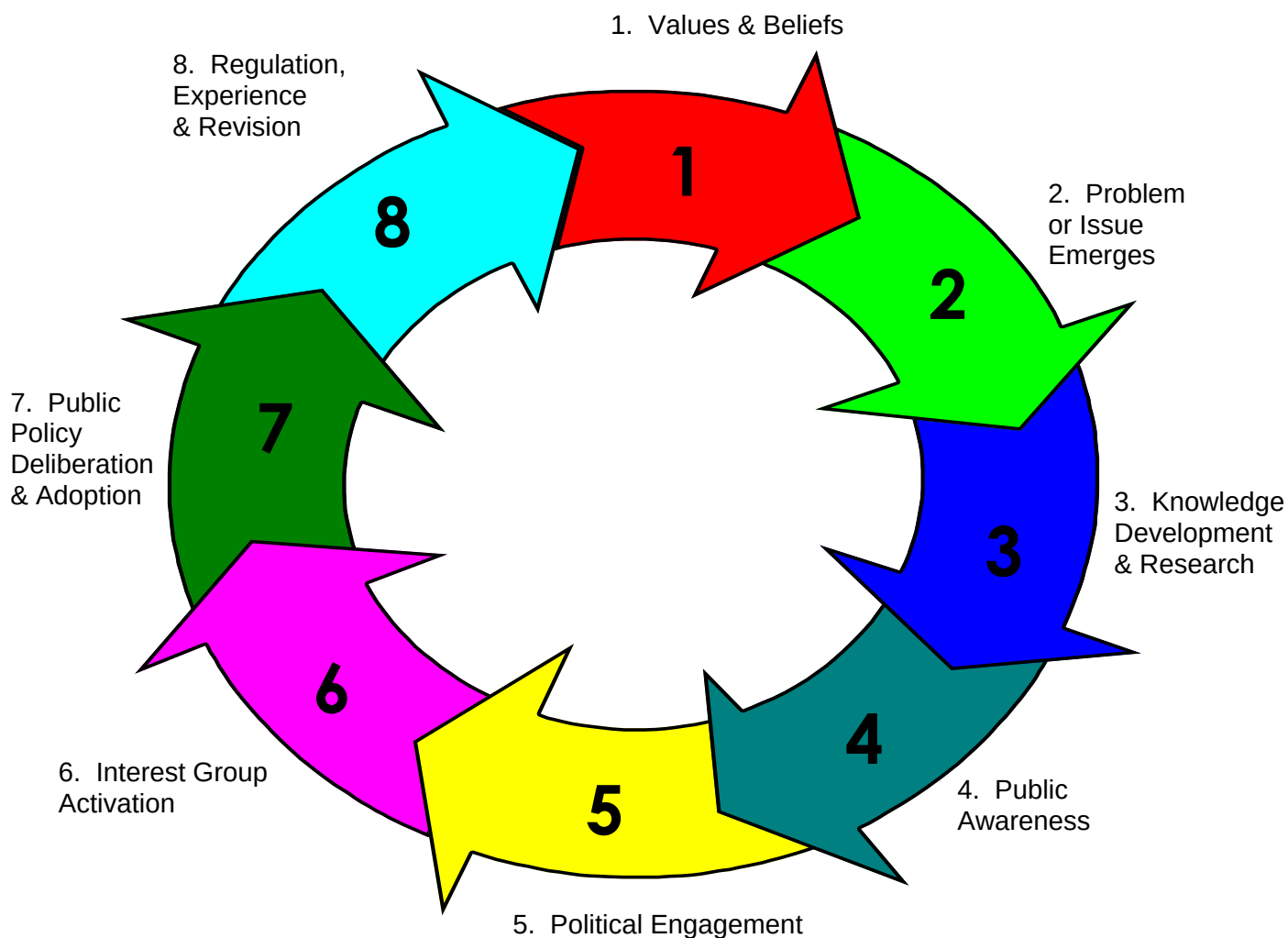


Figure 1-1: The policy cycle (CNA, 2008:1-12)

Moving into Action

The first phase of the policy agenda is embedded in beliefs and values. Issues that are put forward in the policy arena should be those that the community believe in, otherwise such issues will not become a priority in the policy arena.

The steps of the Canadian model are applied in objectives two and three Phase One, as the impact of HIV and AIDS on the workforce is an issue which emerges many times in literature and is perceived as a challenge to be put forth to the policy arena. The national HIV and AIDS strategy and its development necessitate the involvement of stakeholders, and nurses are one group of such stakeholders that could add value to the plan.

In developing the Strategic plan of HIV and AIDS in Southern Africa (2001-2005) there has been no reference to the participation of stakeholders, (refer to Table 1.1). It is therefore

important for the model that enhances HIV and AIDS care, research and policy interface to ensure the participation of nurses in influencing policy.

Table 1.1 displays strategic plans for HIV and AIDS in South Africa and their process of development.

Table 1-1: HIV AND AIDS strategic plans and process of development

COUNTRY	STRATEGIC PLAN	TITLE AND TIME FRAME	PARTICIPATION OF STAKEHOLDERS
Botswana	Yes	Medium-term plan 2 1997-2002	Stakeholders involved. New Strategic Plan being currently developed
Lesotho	Yes	National HIV and AIDS Strategic Plan 2002/03-2004/05	Participative and consultative process
Mozambique	Yes	National Strategic Plan to combat HIV and AIDS 2001-2005	A wide array of stakeholders involved
South Africa	Yes	National Strategic Plan for HIV and AIDS 2000-2005	No reference to participation
Zimbabwe	Yes	Not specified	Stakeholders involved

(Zungu-Ndirwayi et al., 2004).

Having looked at the involvement of stakeholders, the impact of HIV and AIDS on the workforce is examined.

1.3.3 HIV and AIDS impact

HIV and AIDS affect the performance of the health system negatively in terms of demand and supply, because its prevention and care necessitates an increase in material, human and physical resources despite the diminished resources.

Huey (2015:490) explains that, due to the medical and psychological complexities of HIV and AIDS, health and mental health professionals are faced with multiple challenges when working with individuals with HIV and AIDS. This makes them more vulnerable to occupational stress and burnout. The HIV and AIDS pandemic has become a global concern to the extent that all nurses are at the forefront of dealing with this pandemic. Sub-Saharan Africa is no exception

regarding this active involvement pertaining to HIV and AIDS-related matters. The reduction of the workforce due to HIV related sicknesses and death has become a global phenomenon. According to a national survey of health workers conducted in Kenya, it was found that one-third had an immediate family member who was HIV positive. The situation poses a tremendous psychological and social burden as far as personal sickness and family caring responsibilities are concerned (Evans and Ndirangu, 2009: 725-726).

Table 1.2 presents the global statistics for HIV and AIDS. 35 million people were living with HIV and AIDS globally. 23.5 million of the global statistics constitutes sub Saharan African statistics, refer to table 1.3. This is the reason that this study was conducted in sub Saharan Africa. Aid deaths in 2012 were 1.5 million as opposed to 2 million in 2007. This is attributed to the roll out of antiretroviral therapy. On the other hand newly infected people in 2007 were 2.7 million, whilst in 2012 this number was reduced to 2.1 million. This might be an indication that more and more people are taking precautions with regards to HIV and AIDS infection.

Table 1.2 HIV and AIDS estimates.

Table 1-2: Global HIV and AIDS estimates in 2012

	Estimate	Range
People living with HIV and AIDS in 2012	35.3 million	32.2-38.8 million
Adults living with HIV and AIDS in 2012	31.8 million	3.1-33.7 million
Women living with HIV AND AIDS in 2012	16.0 million	15.2-16.9 million
Children living with HIV and AIDS in 2012	3.2 million	29.9-35 million
People newly infected with HIV in 2012	2.1 million	1.9-2.4 million
Adults newly infected with HIV in 2012	1.9 million	1.7-2.1 million
Children newly infected with HIV in 2012	240 000	210 000-280 000
AIDS deaths in 2012	1.5million	1.4-1.7 million
Child AIDS deaths in 2012	190 000	170 000-220 000

(UNAIDSWHO- 2012)

Regional statistics for HIV and AIDS in Table 1.3 show that Sub-Saharan Africa has 23.0 million adults and children living with HIV and AIDS. The impact of this epidemic is high in this region

and this necessitates the contribution of health- care professionals in programme and policy development.

Table 1-3: Regional statistics for HIV and AIDS 2012

Region	Adults & children living with HIV AND AIDS	Adults & children newly infected	Adult prevalence	Deaths of adults & children
Sub-Saharan Africa	23.5 million	1.8 million	4.9%	1.2 million
North Africa & Middle East	300,000	37,000	0.2%	23,000
East Asia	830 000	89 000	0.1%	59,000
Oceania	53,000	2,9,000	0.3%	1,300
Latin America	1.4 million	83,000	0.4%	54,000
Caribbean	230,000	13,000	1.1%	10,000
Eastern Europe & Central Asia	1.4 million	140,000	0.2%	92,000
North America,	1.4 million	51,000	0.6%	21,000
Western & Central Europe	900 000	30 000	0.2%	7 000
Global Total	34 million	2.5 million	0.8%	1.7 million

(Worldwide HIV & AIDS Statistics 2012)

In South Africa a National HIV survey was conducted in 2012. The survey showed the estimated HIV prevalence among South Africans by age. See Table 1.4 for these estimates.

Table 1-4: Estimated HIV prevalence among South Africans by age

Age (years)	Male prevalence%	Female prevalence%
0-14	2.3	2.4
15-19	0.7	5.6
20-24	5.1	17.4
25-29	17.3	28.4
30-34	25.8	36.0

35-39	28.8	31.6
40-44	15.8	28
45-49	13.4	19.7
50-54	15.5	14.8
55-59	5.5	9.7
60+	4.6	2.4

(South African National prevalence, incidence and behaviour Survey, 2012)

As indicated in Table 1.4 above female HIV prevalence is highest between the ages of 35 – 39 years. Whilst the ages of 25-29 the prevalence is 28.4 in females. Males aged 30 to 39 have a high prevalence rate of 28.8. This high prevalence rate in the age groups mentioned above is an indication that the workforce might be affected negatively by the epidemic as this is the age at which people are economically most productive.

The study 'A model for HIV and AIDS care, research and policy interface' conducted in the Free State Province, is necessary as provincial statistics indicate that the impact of the epidemic in the province is high as presented in Table 1.5. The other reason for this is that the Free State has large rural areas which might have a high degree of socially constructed gender roles. This has an influence on decisions that males and females make in terms of protecting themselves against HIV and AIDS. Provincial statistics for HIV and AIDS in South Africa show that the Free State was the third province in terms of HIV and AIDS prevalence in 2008 (see Table 1.5).

Table 1-5: Provincial statistics for HIV AND AIDS in South Africa in 2012

Province	Prevalence %
KwaZulu-Natal	16.9
Mpumalanga	14.1
Free State	14.0
North-West	13.3
Gauteng	12.4
Eastern Cape	11.6
Limpopo	9.2

Province	Prevalence %
Northern Cape	7.4
Western Cape	5.0

(South African National HIV prevalence, incidence and behaviour survey 2012)

Provision of prevention, care and treatment to patients and families with HIV and AIDS might be influenced by many factors, e.g. the impact of the epidemic on the nursing workforce, healthcare workplace policies and programmes, as well as stigma.

It is therefore necessary to explore and describe the nurses' views in this regard in order to develop a model to enhance HIV and AIDS care, research and policy interface.

Stigma poses an added a burden to the healthcare system as HIV and AIDS sufferers seek medical help only when the disease has progressed and complicated, thus adding a greater burden to the system.

1.3.4 HIV and AIDS stigma

Holzemer and Uys (2008:165) state that stigma is 'prejudice, discounting, discrediting and discrimination that are directed to people having HIV and AIDS as well as individuals that are associated with them'. Liamputtong (2013:42-48) defines stigma as a brand, a mark, shame or stain on one's character and entails an act that constitutes severe disapproval from society for behaviour that is considered to be outside the bounds of social norms.

Greeff et al., (2008:10) discuss the three forms of stigma as: Labelling: when people at the advanced stage of the disease are labelled because of the signs with which they present; also referred to as 'brand or mark'. Blaming and shame: when individuals with HIV and AIDS fear the consequences of the disease and they refrain from disclosing it and are ashamed. Silence and secrecy: the stigmatised person becomes silent and isolates him/herself due to fear of being stigmatised. As mentioned by Liamputtong (2013:42-48), both indicate that a person living with HIV and AIDS is discriminated against by others who consider themselves as HIV negative.

The definitions above and labels of stigma pose a threat to care as patients seek medical help late. This hinders adequate care to these individuals. Hence it is necessary to examine the effects of HIV and AIDS stigma in the prevention and care of HIV and AIDS.

1.4 Statement of the problem and research questions

Leavitt (2009:73) asserts that few nurses are actively engaged in developing, redesigning and/or promoting public policies, yet they have the experience and knowledge of caring for the patients. Nurses form the largest group of health care professionals in the prevention and care of HIV and AIDS patients and this offers them opportunities to influence policy in this regard. Contrary to the above, little or no attention has been paid to utilizing nurses' knowledge in care research and policy regarding HIV and AIDS. Despite the constraints discussed above, there are many reasons why nurses should be included in influencing policy. These are:

- Nurses are the frontline workers who have prolonged engagement with the patients.
- The presence of the nurses with the patients and their families form an important ground for clinical research questions.
- Nurses work at various levels of the health system and this has the potential for a high yield of pertinent health services and policy questions (Edwards, Webber, Mill, Kahwa & Roelofs 2009:89).

If nurses could be involved in HIV and AIDS policy development this would yield positive patient care outcomes. Nurses spend a lot of time with patients and their families and their input would assist decision-makers to achieve their goals in improving quality patient care. On 9 March 2009, the president of the African National Congress (ANC) and president of South Africa, stated his speech that academics should influence policy regarding a variety of social issues as their contribution is vital in this regard (SAFM news, March, 2009). This is an indication that politicians realize the need of utilizing expert knowledge in policies. This is also true in as far as the HIV and AIDS care, research and policy interface is concerned as nurses may be able to influence policy in HIV and AIDS care through research.

Against the background of the HIV and AIDS impact on the health system, the workforce as well as resultant stigma, it is crucial to enhance HIV and AIDS care research and policy interface. Based on empirical data that emerged from literature as well as qualitative and quantitative data, a model was developed.

The following research questions were posed in the study:

Table 1-6: Study questions

1	How can a model for HIV and AIDS care, research and policy interface be developed?
2	How does HIV and AIDS stigma influence nurses' provision of prevention, care and treatment to patients and families?
3	What is the impact of HIV and AIDS on the workforce?
4	What policies exist and do they address the national HIV and AIDS strategy?
5	What is the relationship between these concepts and how might these relationships be constructed for designing a model to enhance HIV and AIDS care, research and policy interface?

1.5 Purpose of the study and objectives

The overall purpose of this study is to develop a model for HIV and AIDS care, research and policy interface.

The study objectives are developed in two phases relevant to developing a model. This includes (a) the identification of concepts in relation to HIV and AIDS care, research and policy interface (Phase 1) and (b) development of a model in this regard (Phase 2).

1.5.1 Phase one objectives

The objectives of Phase 1 are formulated to enable the identification of and classification of concepts in relation to HIV and AIDS care, research and policy interface. These objectives are:

- To examine how HIV and AIDS stigma influences nurses' provision of prevention, care and treatment to patients and families.
- To explore and describe the impact of HIV and AIDS on the workforce.
- To examine the HIV and AIDS workplace policies and interventions.

1.5.2 Phase two objectives

In order to develop a model for HIV and AIDS care, research and policy interface, the objectives below were formulated in Phase two of this study.

- To describe a conceptual framework.
- To construct relational statements among the identified concepts.

- Design a model for HIV and AIDS care, research and policy interface

1.6 Researcher's assumptions

The researcher's assumptions in this study are guided by Mouton and Marais's (1996:147) framework and Botes (2006).

1.6.1 Meta-theoretical assumptions

Meta-theoretical assumptions deal with how the researcher views the nature of science and its relationship with the human being and society. These are non-epistemic and not meant to be tested and do not offer pronouncements about the nature of knowledge and knowing (Botes,2006). The views of the researcher regarding the concepts of person, environment, nursing, and health, are discussed:

1.6.1.1 Concepts in the development of this model

- Person: The registered nurse and the person living with HIV and AIDS are bio-psycho-social beings, in interaction with each other. Their encounter contributes a pragmatic social milieu necessary to influence HIV and AIDS policy.
- Environment: The environment where HIV and AIDS care takes place is ambiguous, not pre-programmed; hence exposure of registered nurses to it forms a fertile ground for bridging the practice-theory gap in caring for HIV and AIDS patients. Nurses learn the experiences and behaviours of patients and may be able to transform those into policy.
- Nursing: A science constituting a relationship between the nurse, patient/individual/family and community. It consists of quality care, research, competent practice, as well as maintenance and promotion health, in the prevention and treatment of illness, and rehabilitation. Such care activities are carried out throughout a person's lifespan.
- Health: Is a dynamic phenomenon, constantly changing according to environmental and societal changes. It is a composite of emotional, social, physical and psychological well-being. The components mentioned above are unified wholes and are more than the sum of their parts.

1.7 Philosophical perspective of this study

The philosophical perspective regarded as most suitable for this study is post- modernism.

- **Postmodernism**

Postmodernism is widely used because it represents a new understanding or interpretation of the world (Rossouw, 1995: preface). It can be used in different ways to contribute to our understanding of science. It rejects unified explanations of the nature of science. There is no one definition that is applicable to all sciences. This is the reason that scientists have to reach a consensus on the definition of their discipline or on the aims of their projects (Lincoln & Guba 1985:44).

It is a deconstruction of reality in order to gain access to its nature but does not necessarily destroy what is already known. In this study multiple realities are taken into consideration by using both quantitative and qualitative research in collecting data, previous research on the phenomenon under study, as well as analysis of existing policy. This approach represents multiple views in dealing with reality. The field of study is approached with openness which is the true nature of postmodernism. The arguments of the above authors are an indication that there is consensus that postmodernism is congruent to multiple human narratives, and multiple interpretations of reality. It rejects the notion of viewing reality from the positivist perspective only. The world should be seen as a social construction of ideas. And so should science also be seen.

Postmodernism is not a panacea for all philosophical versions of science, it may work in one area of science and fail to work in another. The fact of the matter remains that knowledge construction is fluid; it is always becoming and never an end in itself. It is therefore necessary to evaluate the application of any philosophy to research. This is confirmed by Lincoln & Guba (1985:45) by saying that there is still a lot of controversy about the exact definitions of modernity and post modernity. This is true in the sense that in postmodernism both positivism and naturalistic inquiry may be used in combination as no single explanation of truth is accepted. As mentioned earlier, this is a notion central to the development of a model in this thesis.

1.7.1 Theoretical assumptions

The theoretical assumptions are discussed with regard to theories, models, central theoretical statements and definitions. Theoretical-conceptual commitment represents commitment to the accuracy or the truth of the theories and laws of the particular paradigm (Mouton & Marais, 1996:147). They assert that theoretical assumptions offer epistemic pronouncements about the research field and form part of existing theory of the discipline. Unlike meta-theoretical assumptions, theoretical assumptions can be empirically tested. In order to be of use in the research field, theoretical assumptions are expressed as statements, which in turn help to shape the conceptual framework of the study (Bruce & Klopper, 2010:2-3).

1.7.1.1 Theories and models

The theories used in this study are, the cognitive psychosocial and behaviour change in HIV and AIDS care, the HIV and AIDS conceptual framework and the Canadian cycle for policy development.

1.7.1.2 Central theoretical statement

The examination of how HIV and AIDS stigma influences the provision of prevention, care and treatment to patients and families, the exploration and description of the effects of HIV and AIDS on the workforce and implementation of workplace policies, consequently provide the framework to develop a model for HIV and AIDS care, research and policy interface.

1.7.1.3 Conceptual framework

A conceptual framework for this study is developed based on the identification of concepts from the empirical research and is described in Chapter 5. The researcher does not depart from a pre-determined conceptual framework.

Woods and Catanzaro (2010: 80) point out that the conceptual phase of a study gives guidance about the dimensions of knowledge related to the phenomenon of study and the researcher's image of how that phenomenon appears in the real world. The logical development of the framework for study must be clear. Assumptions upon which relationships are based must be made explicit. The investigator may choose to diagram the hypothesized relationships among the concepts and include this diagram on the written report. Schneider, Elliot, Lo-Biondo-Wood and Haber (2006:133) state that the importance of a conceptual framework is in linking the proposed or current study to the previous knowledge based on the concept of interest either by examining relationships between concepts or building on known and established theories or models. This is the reason that HIV and AIDS stigma, impact of HIV and AIDS on the workforce, and HIV and AIDS policies were explored using old and recent literature in this thesis.

1.7.2 Methodological assumptions

Methodological assumptions pertain to the criteria regarded as scientific and to the methods and instrumentation by means of which a given view of what is scientifically valid may be realised (Mouton & Marais, 1996:147). In this study it is assumed that:

- Knowledge is constructed through subjective and multiple, co-existing and contextual truth as perceived and created by the scientific. The research field was approached with no pre-conceived ideas. This allows for discourse, debate and dialogue. The experiences of nurses

were taken into consideration in exploring concepts relevant to HIV and AIDS care, research and policy interface. This suggests a post-modern view towards knowledge construction.

- The use of both qualitative and quantitative research methods is a confirmation that in a postmodernist perspective acceptance of multiple views in knowledge construction should be considered.

The nurses' views were taken into account in the development of this model. Multiple sources of data were used in this study (both recent and old literature) in order to investigate the phenomenon under study in its entirety. The use of both the quantitative and qualitative methods of data collection also demonstrates openness to multiple realities.

1.7.3 Assumptions pertaining to ontological commitments

According to Mouton and Marais (1996:147), the ontological dimension of research examines the nature of the research object, and tackles the 'what is' of the phenomenon. In this study ontological assumptions are regarded as those assumptions describing the nature of good science. In Denzin and Lincoln's (2011:15) view ontology refers to the study of being, reality or existence together with its basic categories and relationships. It refers to the researcher's beliefs about the nature of the phenomena and the reality which is investigated (Denzin & Lincoln's 2011:15; Mouton & Marais, 1996:147).

1.7.3.1 The nature of good science

Chinn and Kramer (2011:44) assert that 'A distinguishing feature of scientific observation is that the observer knows what is being sought, and to a certain extent what is likely to be found.' In this study, the investigator knows what is being sought, i.e. 'A model for HIV and AIDS care, research and policy interface.' To put this more clearly, the study sought to identify the relational statements that could be used in the development of a model for HIV and AIDS care, research and policy interface. The investigator did not know what was likely to be found. This answered a question about 'what' because as Chinn and Kramer (2011:74) indicate, science is both an approach to the generation of knowledge and how that knowledge could be utilized. In this study both qualitative and quantitative approaches were followed in order to generate knowledge about the phenomenon under study. Having examined the nature of good science it is necessary to discuss the ontological dimension of this study as it relates to the researcher's beliefs.

1.7.4 Concept clarification

According to Mouton and Marais (1996:147), the ontological dimension of research examines the nature of the research object, and tackles the “what is” of the phenomenon. The definitions of key terms in this study are as follows:

- **Policy:** According to the Pro-Active College module for Policy Development (2007:36) policy is the translation of Government's political priorities and principles into programmes and courses of action to deliver desired changes. The Oxford English Dictionary (2011:466) describes policy as a general plan of action.
- **Research:** It is an orderly process of inquiry that involves purposeful and systemic collection, analysis and interpretation of data in order to gain new knowledge or to verify already existing knowledge (Dempsey & Dempsey, 2000:4). This is a process that contributes to scientific knowledge development. Burns and Grove (2010) describe research as a systematic inquiry, investigation done to validate or refine existing knowledge and generate new understanding. According to (Rossouw, 1995) it is a systematic methodological search for information.
- **Interface:** Where interaction occurs between two systems or processes (Oxford English Dictionary, 2011:740). It means binding together intricately.
- **HIV/AIDS stigma:** Holzemer and Uys (2008:165) definition that stigma means prejudice, discounting, discrediting and discrimination that are directed to people that are having HIV/AIDS as well as individuals that are associated with them. Greeff, Uys, Holzemer, Makoe, Dlamini, Kohi, Chirwa, Naidoo and Phethlu (2008:10) discuss the three forms of stigma as: Labelling, blaming and shame. Liamputtong (2013:20) defines stigma as a brand, a mark or shame or stain on one's character and entails an act that constitute severe disapproval from society for behaviour that is considered to be outside the bounds of social norms. The Oxford English Dictionary (2010:602) defines stigma as a mark of shame.
- **Researcher's definition:** HIV/AIDS is a characteristic that is negated by others, which leads to discrimination. Such discrimination is directed both to the person regarded as impure as well as his/her family.
- **HIV human Immunodeficiency Virus:** One or two viruses that progressively destroy the called lymphocytes causing acquired immunodeficiency syndrome and other diseases resulting from impaired immunity (Berkow, 1997)
- **Acquired Immunodeficiency syndrome:** A syndrome caused by impaired immunity leading.

- **Model:** Any device used to represent something other than itself. It is also a representation of a theory (Walker & Avant, 2005:28). Chin and Kramer (2011:184) refer to a model as a symbolic experience in the form of words, pictorial or graphic diagrams, mathematic notations or physical material. Mouton and Marais (1996:31) states that it is frequently used synonymously with theory, but a theory has an explanatory function.

1.8 Research design

Klopper (2008:68) defines a research design as a 'set of guidelines and instructions to be followed in addressing the research problem'. It is the blueprint of the study. This design, which is theory generative, exploratory, descriptive as well as contextual, allows the researcher to investigate the phenomenon in detail using both quantitative and qualitative approaches.

1.8.1 Theory generative

The design in this study is theory generative in the sense that it is based on the process of theory development as well as the cyclical relationship between research, theory and practice (Chinn & Kramer, 2011; Walker & Avant, 2005).

The defined concepts are examined for existence statements and relational statements to present descriptions, patterns, and hypothesized relationships as extracted from a body of empirical data. This will lead to emergence of a theory, represented in the form of a model.

HIV and AIDS care, research and policy interface is compatible with middle range theory generation because it is broad and does not focus on a specific aspect of nursing, but guides nursing in general on HIV and AIDS care, research and policy interface.

1.8.2 Explorative and descriptive

The researcher explored the phenomenon under study to gain rich qualitative data through focus group interviews. Literature was reviewed to embed the qualitative and quantitative data finding. The phenomenon of interest i.e. HIV and AIDS care, research and policy interface was accurately described by collection of both qualitative and quantitative data. Themes and categories emerged from the interviews and clusters of attributes were extracted from the quantitative data by using the SPSS Version 1.8 (2010) statistical package. Descriptive research according to Burns and Grove, (2010:44) is the exploration and description of phenomena in real life situations. This approach is used to generate knowledge about topics on which little or no research has been conducted. In this study this approach was used because little research has been conducted in HIV and AIDS care, research and policy interface. The two data sets complemented each other to give an accurate description of the concepts in a model.

1.8.3 Contextual

The study is context-bound in the sense that it is conducted in the Free State. Clinics hospitals and community health centres, in which HIV and AIDS patients are assessed and treated for HIV and AIDS, were selected. See Table 2.4 for a map of the context of this study.

1.8.4 Quantitative

In this study numerical data was used to obtain information regarding HIV and AIDS care, research and policy interface. This research approach is used to describe variables, examine relationships among them and determine cause and effect interactions between them (Burns & Grove, 2010:23).

1.8.5 Qualitative

Rich descriptive data was collected using the qualitative approach. The phenomenon under study was explored in its entirety. Individual and focus group interviews were conducted to elicit verbal responses from the informants. Data was analysed in the form of verbatim narratives and stories. This approach allowed the researcher to probe and clear any misunderstandings from the informants. Data collection was done until data saturation was reached.

1.9 Research methods

Klopper (2008:69) describes the research method as the steps of population and sample, data collection and data analysis, and ensuring rigour. Each of these steps are discussed in detail in Chapter 2.

Table 1.7 provides a summary of the research methods followed.

Table 1-7: Schematic representations of the research methods in different phases

RESEARCH OBJECTIVE	DATA COLLECTION	DATA ANALYSIS	SAMPLE AND SAMPLING	RIGOUR
Phase One: Concept identification and classification				
(a) To examine how HIV and AIDS stigma influence nurses' provision of prevention, care and treatment to patients and families	Clinical survey	SPSS – descriptive statistics.	Professional nurses	Criterion-Related Validity Construct Validity (Burns & Grove, 2010:377-378)
(b) To explore and describe the impact of HIV and AIDS on the workforce	Clinical survey	SPSS package –descriptive	Professional nurses	Criterion-Related Validity Construct Validity (Burns & Grove, 2010:377-378)
(c) To examine the HIV and AIDS work-place policies and determine if they address the national HIV and AIDS strategy	Interview guide Clinical survey HRM tool	Themes and sub- themes	Professional nurses	Lincoln and Guba (1985) Credibility Dependability Confirm ability
Phase Two: Concept definition, description and model development				
(a) Describe a conceptual framework	Results from Phase 1 (a, b, c)			Construct validity (Burns and Grove, 2010:377-378)
(b) To construct the relational statements amongst the identified concepts	Results from phases (a, b and c)			
(c) To evaluate the model for HIV AND AIDS care, research and policy	Self-evaluation of the model against the guidelines: Chinn and Kramer(2011) and Walker and Avant (2005)			

[Type text]

1.10 Ethical considerations

- The following ethical considerations were adhered to (I) Ethical approval (II) Informed consent and participant authorization (III) Provision of information for the study (IV) Freedom from harm and (V) Scientific honesty. These will be discussed in detail in chapter two.

1.11 The layout of the thesis

Chapter 1: Overview to the study

Chapter 2: Research design and -methods

Chapter 3: Results of quantitative data analysis

Chapter 4: Results of qualitative data analysis

Chapter 5: Conceptual framework

Chapter 6: A Model for HIV and AIDS care, research and policy interface

Chapter 7: Evaluation of the study, limitations of the study and recommendations for education, practice, research and policy

1.12 Summary

From the content discussed in the overview and orientation to the study in this chapter, a clear understanding of the reasons for conducting this study was established. These reasons are supported by literature which describes the extent of the problem both nationally and internationally. HIV and AIDS is a worldwide epidemic that warrants inclusion of nurses in policies that are designed for its prevention and care. The impact of this epidemic puts a burden on the health system because it necessitates added interventions in nursing care. Stigma also poses a problem as it prevents early disclosure of the condition which could otherwise lead to curbing of the disease progress.

The chapter discussed the research problem as experienced nationally and internationally, formulated the research questions regarding the main concepts in the study i.e. HIV/AIDS stigma, its impact on the workforce (staff outcomes) as well as HIV and AIDS policies. The purpose, objectives and key terms in the study were also formulated and described, namely HIV and AIDS stigma, impact on the workforce (staff outcomes) as well as HIV and AIDS policies. This ensured rigour in the study as these concepts are used as constructs in the study instrument. In this way construct validity and consistency was ensured.

The research design was discussed and is appropriate for the study. A summary of the research methods of the study was presented in Table 1.7. The ethical considerations discussed ensured protection of the rights of the professional nurses. No coercion was used for them to participate in the study. In fact, no coercion was used for anyone to participate in the study. All other relevant ethical considerations were also observed in this study. The next chapter focuses on the detailed description of the research design and methods.

CHAPTER 2: RESEARCH DESIGN AND – METHODS

2.1 Introduction

Chapter one dealt with the orientation to the study. In this chapter, the research design and research methods will be discussed in detail. These are discussed in accordance with the objectives of the study. The design is divided into two phases. Phase One (1), the empirical phase, comprises literature supporting the background of the study and the argument for conducting it. In this phase identification and classification of the concepts took place. Phase Two comprises model development. Rigour is discussed with regard to the quantitative and qualitative approaches. Lastly the chapter addresses the ethical considerations as related to this study.

2.2 Research design

The purpose of the research design is to provide a plan for answering research questions. It involves a structure and strategy used in research (Lo-Biondo-Wood & Haber, 2006: 202). This follows logically from the research problem, and the problem directs the choice of the design (Klopper, 2008:68). “Design implies the organization of research elements into a masterful work of art and represents the major distinctive research approach that has been chosen for the purpose of answering a specific question’ The research question: the aim and objectives influence the design methods to be used by the researcher” (Schneider, Elliot, Lo-Biondo-Wood & Harber, 2006).

The authors mentioned in the paragraph above agree in principle that the design guides the researcher in answering the research problem. However, Klopper,(2008:68) clarifies this by claiming that its main function is to enable the researcher to anticipate the appropriate research decisions that would contribute to the authenticity of the research findings. Thus, Burns and Grove (2010:211) confirm Klopper’s (2008:68) argument that the design is a blueprint that the researcher will use in conducting the research. In addition, Burns and Grove (2010:211) indicate that it is a broad pattern or guide that can be applied to many studies but tailor-made to fit a specific study.

Coetzee (2010:97) also states that the research methodology includes the research design, the research strategy, the methods for data collection and analysis, the target population, sampling methods and rigour of the study.

As mentioned in chapter one, this study is theory generative, explorative descriptive, contextual, quantitative and qualitative, in nature. In theory development, words and sentences that

represent perceptual experiences of objects have been organised systematically. The numerical and narrative data was organised and displayed in tables and graphs. This empirical evidence was then used to develop a model for HIV and AIDS research and policy interface in Chapter 6. Theory generation is discussed in Paragraph 2.2.1.1.

2.2.1.1 Theory generative

According to Chinn and Kramer (2011:20-21) the term theory is complex. Its definition ranges from an idea or feeling, to an explanation of something. In this study, the definitions that have been chosen give a clear understanding of theory in relation to development of nursing knowledge and how such knowledge could be utilized in policy.

Theory is a systematic abstraction of reality and implies an organisation of words that represent perceptual experiences of objects (Chinn and Kramer, 2011:1). It may also take many forms but the process of its development is always systematic and the form is always patterned (Chinn and Kramer (2011:1). In this study, numerical and narrative data were organised and presented graphically in the form of a model. This is clarified by Meleis (2001: 12) in that in theory development is an organised, coherent and systematic articulation of related statements which is done and presented in a discipline. Empirical evidence in this study was represented in the form of a model for HIV and AIDS care, research and policy interface.

A rigorous process of logical thinking strategies was used to arrive at the model that shows the relationship amongst HIV and AIDS care research and policy. Chinn and Kramer (2011:219) assert that theory projects a systemic view of a phenomenon. In theory development the theory may be discovered, verified and utilized in knowledge development. In this regard scientific knowledge is accumulated in a systematic and orderly fashion in order to reach the goal that the researcher is aiming at (Corbin & Strauss , 2014:24; Chinn & Kramer, 2011:69). Though the purpose of a theory might not be explicitly stated, but it should be identifiable in order to find its purpose (Chinn and Kramer, 2011:219).

Furthermore, Chinn and Kramer (2011:91) state that if a theory represents the structuring of ideas, the ideas will be in the form of concepts that are expressed in language. In this study, concepts that are used in the objectives and questions in the instrument are HIV and AIDS stigma, impact of HIV and AIDS to the workforce (staff outcomes) and HIV and AIDS policies. These concepts were identified generate a graphic illustration that depicts a model. Other significant issues considered in this study were the assumptions stated in Chapter one (1. 6), which formed the underlying truths on which this model is built.

A theory may describe, explain or predict and control phenomena. Description means that abstractions of reality are systematized to account for something. Explanation implies that theory interrelates things to account for how they function. It can also predict how something will occur. These processes are described by Dickoff, James and Wiedenbach (1968) to theory as a conceptual system or framework bearing a purpose in mind. Therefore nursing has to generate theory that will serve to achieve its goals and purposes.

2.2.1.2 Levels of theory

Chinn and Kramer (2011:69) refer to four levels of theory: factor-isolation, factor-relating or situation-depicting, situation-relating, and situation-producing. Level 1, factor-isolating, involves naming or classifying phenomena. Level 2, factor-relating, requires correlating or associating factors in such a way that they become part of larger units that meaningfully depict a situation. Level 3, situation-relating, explains and predicts how situations are related. Level 4, situation-producing. Walker and Avant (2005:15) discuss the theory levels above under practice and refer to four levels of theorizing in nursing practice. They also argue that developing a theory for practice needs a well-developed body of knowledge on effective nursing interventions. In the case of this study, the relational statements are derived from questions related to issues known to professional nurses regarding HIV and AIDS. Walker and Avant (2005) argue that conducting and utilizing research in a nursing project, research-based knowledge was transferred into protocols for nursing practice. HIV and AIDS care, research and policy interface is consistent with middle-range theory because it is broad and does not focus on a specific discipline in nursing. HIV and AIDS is a cross-cutting problem in all aspects of nursing. The study therefore guides nursing in general on HIV and AIDS care, research and policy interface.

Bruce & Klopper (2010:2) discusses the levels of theory in respect to the theory's relative power, and refers to the scope of phenomena to which the theory applies. Whether its function is to describe or not, the higher the level of a theory, the wider the scope of the phenomenon under study. The level of abstraction of the theoretical concept is integral to its scope (Chinn & Kramer, 2011:132). It can therefore be said that the relative power of theory is determined by its function and its level of abstraction; level four being the most powerful (control function) with a high level of abstraction and level one, least powerful (descriptive function) and less abstract. Walker and Avant (2005) and Chinn and Kramer (2011) generally agree on the following classification of theories:

- **Meta-theories**

Meta-theory focuses on broad issues related to theory in nursing; it does not generally produce any grand- and middle-range or practice theories (Walker & Avant, 2005:6). This theory's

central focus is the philosophical and methodological aspects that are related to theory development in a discipline. Chinn and Kramer (2011) state that meta-theory entails the nature of theory and the process for generating or developing theory. Issues debated at this level of theory include (1) analysing the purpose and kind of theory needed in nursing; (2) proposing and critiquing sources and methods of theory development in nursing; and (3) proposing the criteria most suited for evaluating theory in nursing. It involves the meaning of nursing as a practice discipline (Walker and Avant, 2005:6) and it is informed by the theoretical nature of the discipline (from grand theory), for the purpose of clarifying and developing grand theory

- **Grand theory**

Grand theory focuses on broad areas of concern, and other issues within a particular discipline. Walker and Avant (2005:10) suggest that grand theories are abstract and give 'conceptual clarity' about the practice of nursing. Bruce (2003:24) states that although constructs are abstract, their power of explanation is increased. Hence, grand theories have made a significant contribution to distinguish nursing practice from medical practice.

Grand theories in turn, link with middle-range theories by 'serving as guides and heuristics' for the phenomena in middle-range theory (Walker and Avant, 2005:12). Grand theories are abstract and give a broad perspective to the structure of nursing practice. Their role is to explicate a worldview useful in understanding key concepts and principles within a nursing perspective. They explicate perspectives for nursing practice, education and research but yet they may not be tested, hence middle-range theory was developed as a layer between grand theories and their empirical dimension, the practice theory. This according to (Walker & Avant, 2005:12) is central to postmodernism thinking which discounts grand theory as a suitable level of discourse for nursing. Figure 2.1 is an illustration of the linkages amongst the levels of theory.

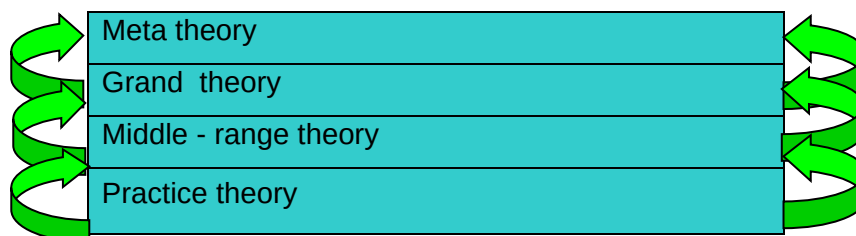


Figure 2-1: Linkages amongst levels of theory (Walker and Avant 2005:18)

Having investigated the linkages amongst the levels of theory, a presentation of the application of levels of theory follows in Table 2.1.

Table 2-1: Schematic representations of the research methods in different phases

Level of theory	Application	Characteristics	Reference
Meta-theory	• Person • Environment • Health • Nursing • Refer to Paragraph 1.6.1	• Focus on philosophical and methodological questions	• Walker & Avant (2005:6-9) • Chinn & Kramer (2011)
Grand Theory	Not applicable to this study	Untestable	Walker & Avant (2005:12-14)
Middle range	A model for HIV AND AIDS care, research and policy interface is consisted with this level of theory	• Testable • Directs nursing practice • Describes	Walker & Avant (2005)
Practice Theory	Not applicable to this study	• Testable • Discipline specific	Walker & Avant (2005:14-16)

In a professional discipline such as nursing, the knowledge that is generated through research must eventually benefit the practice. It is therefore **NECESSARY** to ensure that there is congruency between all levels of theory and the discipline. From the above description, the interrelationships between the different levels are a clear indication of the fact that theory can be developed at any level. This study in particular is consistent with the middle-range theory

- **Middle-range theory**

Walker & Avant (2005:12) propose a more workable level of theory development since there are difficulties inherent in testing grand theories. These theories contain a limited number of variables and are limited in scope. They are therefore testable. Bruce (2003) asserts that this level of theory represents the middle ground between grand and practice theories. Unlike grand theory, middle-range theory is more specific and as such, does not cover the full range of phenomena within the discipline (Chinn & Kramer, 2011). It is however, informed and guided by the grand theory of the discipline. Mid-range theory can also be tested in practice, for example by employing clinical research methods. This study is consistent with middle- range theory. It is therefore important for the researcher to discuss this level of theory and explain how it fits to the study.

This type of theory serves as a reference point for further refining grand theories to which they are connected. They also direct the prescriptions of practice theories which are aimed at direct goal attainment (Walker & Avant, 2005:16). It is a theory that defines general parameters on which the nursing function is based. It can form practice and lead to new practice approaches as well as investigate factors that lead to outcomes desired in nursing practice (Chinn &

Kramer, 2008:60-61; Chinn & Kramer, 2008:36-37). A middle-range theory is a conceptual structure that synthesizes practice research into ideas central to the discipline and it lies between the everyday working hypothesis and all inclusive grand theories (Lo-Biondo-Wood & Haber, 2006:119). The applies to the study of HIV and AIDS care, research and policy interface as the overall aim of this study is to develop a model to achieve the interface regarding the above concepts.

The day-to-day experiences of professional nurses in caring for HIV and AIDS patients generate ideas for the formation of a model to guide nursing in general with regards to HIV and AIDS care, research pertinent to HIV and AIDS, and how this could be utilized in informing policy. This can lead to new practice approaches in HIV and AIDS care. As a consequence, the model developed in this research is not specific to a particular discipline in nursing.

The middle-range theory is limited to a particular phenomenon of concern in a discipline. For example in the case of this study the theory is intended to guide nursing regarding the interface among HIV and AIDS care, research and theory development, not other aspects of nursing. Because they are lower in level of abstraction than grand theories they offer a more direct application to research and practice (Lo-Biondo-Wood & Haber, 2006:119).

This it is not as broad as a theory that would focus on high-level wellness which would include a full range of phenomena. This is confirmed by Dempsey and Dempsey (2000) who argue that middle theories are more precise than grand theories and do not deal with the entire range of phenomena.

- **Practice theory**

This is a form of theory that is causal in nature and has variables that can be modified by nurses. Theory is aimed at achieving the desired goal and prescribes actions to achieve the goal (Walker and Avant, 2008:14) Practice theory receives its directives from middle-range theory for concrete goal attainment in practice. Its main purpose is to provide prescriptions for the achievement of practice goals. Considering Chinn and Kramer's (2011) relative classification of theories, practice theory can be described as narrow in scope with low levels of abstraction. Walker and Avant (2005:16) discuss the four phases of theorizing in practice theory and these appear in Table 2.2.

Table 2-2: Phases of theorizing in nursing (as revised in Walker and Avant [2005:16] in reference to Dickoff, James & Wiedebach [1968])

Levels of theory	Parallel Acts	What the theory does
• Factor isolating	Description	Classifies and names phenomena
• Factor relating	Explanation	Associates or correlates factors to depict a situation
• Situation relating	Prediction	Explains and predicts how situations are related
• Situation producing/prescriptive	Control	Prescribes how a desired situation could be reached

Having examined the phases of theorizing in nursing practice, we will discuss the elements of theory and how they are used in theory development in 2.3.

2.3 Elements of theory and how they are used in theory development

It is necessary to understand the elements of theory and how they are used for theory development. Walker and Avant (2005:26) mention three basic approaches for working with these elements. These elements include:

- **Concepts**

Concepts in this study were identified through interviews, quantitative data collection and conceptual and operational definitions. In qualitative research concepts are meaningful words that can be analysed in order to gain a greater depth of understanding. In quantitative research concepts chosen or created do not have more than one meaning. That is why the quantitative researcher from the start provides an explicit operational meaning of the word, to get rid of ambiguity. Meanings of concepts in quantitative research are completely denotative, precisely identified and not open to many interpretations (Mouton & Marais, 1996:160).

- **Statements**

Statements are important in building a scientific body of knowledge. Statements can either be relational non-relational. Relational statements declare a relationship of some kind between two or more concepts. Non- relational statements may either be existence statements or a definition, either theoretical or operational (Walker and Avant, 2005:27). They may exist near each other to help in the formation of a theory without being in relation to each other. A theory therefore is a representation of a set of relational statements that are internally coherent but as Walker and Avant (2005) declare, these might not necessarily be relational but may form new insights into the phenomenon under study.

According to Chinn and Kramer (2011:16) concepts and statements are integral to theories and as such theory development often begins with these basic elements. Furthermore, Chinn and Kramer (2011) are of the opinion that the process of theory development requires creative and rigorous structuring of concepts, which in turn are conveyed as relationship statements. In this study concepts to be included in were already identified and analysed in the instruments that were tested before, i.e. HIV and AIDS stigma, HIV and AIDS impact on the workforce, as well as HIV and AIDS policies. The relationship between and among such concepts was then determined (Walker and Avant, 2008:39).

- **Models**

A model is a symbolic representation of an empirical experience (Chinn and Kramer, 2011:75). It is a graphic representation of a theory or any device used to represent an object (Walker & Avant, 2005:28). It also describes the relationships among concepts that may exist in a theory and it therefore represents something that cannot be directly observed or about which little is known (Nicoll, 2003:355). In these study relationships among HIV and AIDS stigma, HIV and AIDS impact and HIV and AIDS policies were described.

Chinn and Kramer (2011:184) describe a model as a symbolic representation of an empirical experience in the form of words, pictorial or graphic diagrams, mathematic notations or physical material. A model is therefore useful during the conceptual phase of a study because it provides an understanding of basic conceptual issues and suggests instrumental rules and methodological approaches (Woods & Catanzaro, 2010:75) Table 2.3 depicts conceptual frameworks and their functions.

Table 2-3: Conceptual frameworks and their functions (Mouton & Marais, 1996:144)

	TYPOLGY	MODEL	THEORY
Function(s)	Classifying categorizing	Classifying categorizing	Classifying categorizing
		Heuristic discovering	Heuristic discovering
			Explanatory

Having discussed the theory generative nature of this study, its explorative and descriptive nature will be discussed.

2.3.1 Explorative and descriptive

Due to the **explorative and descriptive** nature of the study the phenomenon under study was investigated fully, by using questionnaires and interviews, to gain better insight into the phenomenon. A clinical survey was done to survey the experiences of the professional nurses with regard to the phenomenon under study. This was followed by the human resource analysis questionnaire to analyse the experience of professional nurses regarding the phenomenon under study. Literature was used to support the data collected from the questionnaires and interviews. The nature of the phenomenon under study was therefore explored fully (Mouton & Marais, 1996:43; Polit & Hungler, 2010:20).

As the study is descriptive the identification and comprehension of the nature of the real life experiences and their relationship were described and new knowledge and meaning about the phenomenon was generated (Burns & Grove, 2010:44). Existing knowledge regarding how HIV and AIDS stigma influences the prevention and care of HIV and AIDS patient, the HIV and AIDS impact on the workforce as well as HIV and AIDS policies was described in order to develop a model for HIV and AIDS care, research and policy interface (Coetzee, 2010:100).

An exploratory study begins with the phenomenon of interest with the aim of exploring the dimensions of the phenomenon, about which little information has been found. Exploratory research focuses on the 'what' and everything about the phenomenon is important. Facts related to the phenomenon are identified (Brink, Van der Walt, Van Rensburg 2010:12; Polit & Hungler, 2010:11).

The researcher explored the literature throughout the study to gain information about policy development in general, HIV and AIDS policies, impact of HIV and AIDS on the workforce as well as HIV and AIDS stigma. Although the researcher is a nurse, she approached the study with an open mind, without preconceived ideas and with the aim of increasing knowledge and

providing new data about the phenomenon of interest, namely HIV and AIDS care, research and policy interface (Mofokeng, 2003:50).

In this design accurate information was collected through the use of interviews which described the phenomenon to enable the researcher to understand it better. The purpose of the description was to portray the effects of HIV and AIDS on the workforce. In this study a description of what exists at the work environment as a result of HIV and AIDS (staff outcomes) or the impact of HIV and AIDS on the workforce was elicited from the interviewees. The frequency with which something happens is determined and categorized in descriptive studies.

Exploratory research investigates the full nature of the a relatively unknown phenomenon and its related factors (Polit & Hungler 2010:20) New insights into the phenomena are gained in order to explain concepts and constructs (Mouton & Marais, 1996:43). This was done by a survey of people who have experience with the phenomenon under study.

The study context is contextual and the characteristics of the population under study within a context-bound view. This type of research does not aim to generalize the findings, but rather analyses and describes a particular research context (Mouton & Marais, 1996:49-50; Botes 2006:9). The context of this study was the Free State and it is discussed in 2.3.4.

2.3.2 The contextual nature of this study

The context is of great significance in qualitative research as this method captures the phenomenon in its entirety without trying to control the context. The researcher conducted interviews in the Free State without controlling the study context (Mofokeng, 2003:49; Brink *et al.*, 2010:15). Klopper (2008:68) emphasizes the importance of maximising trustworthiness in a qualitative study by not manipulating the context. As explained in Chapter One of this thesis, this study forms part of an international research project. The context of the study will therefore be presented as an overview at three levels as indicated by (Bester, 2010:40) i.e. the macro level, meso level and micro level.

Contextual research describes differences and distinguishing characteristics of a single case, group or subculture of interest. In this case, research is done in the immediate, unique, and time-space context (Mouton and Marais 1996: 49-50). This type of research does not aim to generalize findings of the research, but rather aims to analyse or describe the reality of a particular research setting in detail, in such a way that transferability of the research findings will be possible in a similar context (Botes 2006:9). The context in this case is HIV and AIDS care environments, therefore clinics, primary health care centres, and all hospital types.

2.3.3 The macro level

The study is conducted internationally in sub-Saharan Africa (Kenya, South Africa and Uganda) and the Caribbean (Jamaica). The impact of HIV and AIDS in sub-Saharan Africa is so huge that it prompted researchers to initiate the project 'Strengthening the nurses' capacity HIV and AIDS policy development in Saharan Africa. The global estimate of HIV and AIDS in 2007 was 33 million (WHO/UNAIDS, 2008) (see Chapter One, Table 1.2). Sub-Saharan Africa had 22 million people living with this pandemic (see Table1.3 in Chapter One). Below is a map of the world depicting the areas for the study globally.

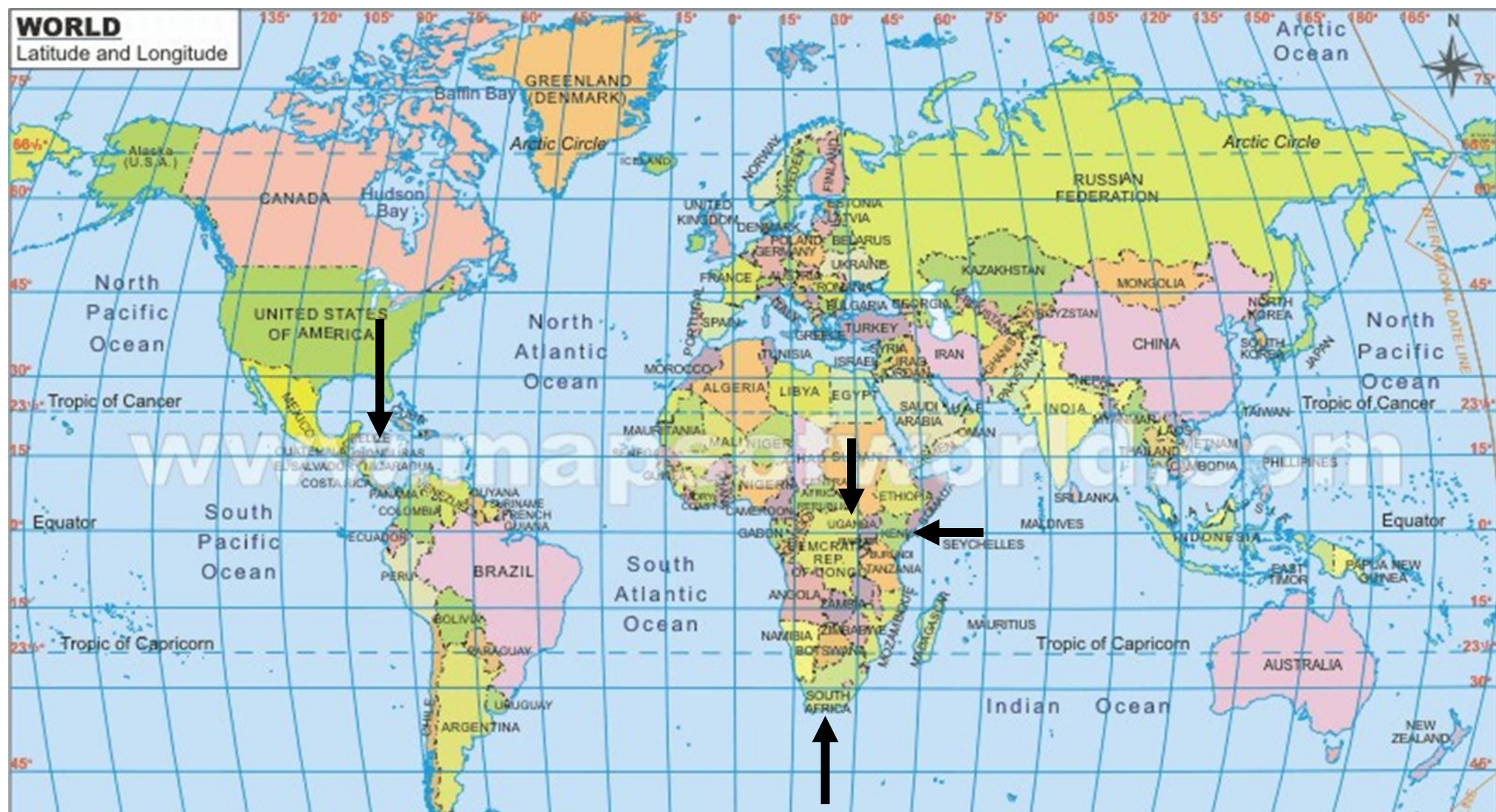


Figure 2-2: The World map

A model for HIV/AIDS care, research and policy interface

- **Meso level**

South Africa is a country hard hit by the HIV and AIDS pandemic. The survey conducted in 2008 in South Africa as indicated in Table 1.4 in Chapter one of this thesis shows that female HIV prevalence is highest between the ages of 25 and 29. Males aged 30-39 also have a high prevalence rate. This high prevalence rate in the age groups mentioned above is an indication that the workforce might be affected negatively by the epidemic as this is the age at which people are economically productive. Pretorius (2012:65) alludes to the prevalence rate of HIV and AIDS in South Africa as having increased from 4.1 million in to 5.2 million in the year 2000.



Figure 2-3: Map of nine provinces in South Africa
(www.google.co.za/images)



Figure 2-4: Free State Province map indicating the districts in which the study was conducted

2.3.4 The micro level

The Free State province ranked third-highest HIV and AIDS-impacted province in South Africa as indicated by WHO (2008) (see Table 1.5, Chapter 1). The districts used for the study were three and these are Thabo Mofutsanyane, (Motheo) Mangaung Metro as well as Fezile Dabi (refer to Table 2.3). However Interviews were conducted only in Thabo Mofutsanyane.

2.3.5 The quantitative nature of this research

The study design is also quantitative in nature. This refers to the fact that, it uses a general set of orderly systematic and disciplined procedures to acquire empirical evidence (Coetzee, 2010:97) and it is embedded in objective reality rather the personal beliefs of the researcher. Evidence is gathered in a logical manner using defined steps according to a pre-designed

specific plan (Polit & Hungler, 2010: 14). A clinical survey and a human resource analysis questionnaire were used to collect quantitative data.

The quantitative approach emanates from logical positivism, which is founded on the belief that 'the world could be viewed as a machine, the task of science being to discover the laws by which the machine is operated'. Therefore the quantitative researcher views the means of understanding the world as emphasising measurement and quantification of observable data (Cormack, 2000:165). In HIV and AIDS care, research and policy interface tools for quantitative data were viewed as measurements for collecting data. Numerical data collected using the clinical practice survey questionnaire for managers and nurse managers and the Human resource management (HRM) Rapid Assessment questionnaire in HIV and AIDS environments.

2.3.5.1 The characteristics of the quantitative method as applied to this study

The characteristics of this method are also consistent with the design chosen, i.e. the use of both methods (quantitative and qualitative) as quantification facilitate the description of both humans and the universe in order to quantify properties that generate numerical data (Cormack, 2000:166). In this study data was presented in the form of descriptive and inferential statistics. The second characteristic consistent with this particular study is randomisation, which was used to randomly select the facilities used in each district for data collection. This was also done in order to ensure representativity, which maximises validity (Schneider, Elliot, Lo-Biondo-Wood and Haber, 2006:262).

Thirdly, reductionism was used to gain insight into the respondents' views about HIV and AIDS care, research and policy interface. Three aspects were explored in this regard, i.e HIV and AIDS care including stigma, impact on the workforce (staff outcomes) and policies (Cormack, 2000:167). The discussion on the qualitative nature of this research will follow.

2.3.6 The qualitative nature of this research

Burns and Grove (2010:23) describe qualitative approach as a systematic, interactive and subjective approach used to describe life experiences. Whilst Schneider et al. (2005:140) state that using qualitative methods of research enables the researcher to study everyday life experiences of the subjects and focuses on human experience. This is consistent with this study of HIV and AIDS care, research and policy interface as in exploring the views of professional nurses regarding the impact of HIV and AIDS (HRM Rapid Assessment Tool), a qualitative research method of data collection was used. While the focus of the quantitative method was on statistics, the focus of the qualitative method was on words and sentences in the form of speech (Cormack, 2000:141).

Mofokeng (2003:141) asserts that qualitative research methods and qualitative analysis aspire to capture what people and their lives are about. Preconceived ideas are put aside and research methods are consistent with the philosophy of nursing in which subjectivity and shared experience are important. This is true in the case of this study as the researcher is a professional nurse and has some knowledge of the phenomenon under study, but this was put aside in order not to influence the study findings.

Streubert, Speziale and Carpenter (2011:16-17) contend that the fundamental belief of qualitative research is that, to create meaning for individuals studied, multiple realities exist. Instead of searching for one reality, the researcher in qualitative research believes that informants of the study actively participate in social actions and thus understand the phenomena under study in different ways. The researcher supports the notion of multiple realities and this study is aimed at describing HIV and AIDS care, research and policy interface. The qualitative nature of the study, denotes that rich descriptive data was collected using the qualitative approach. The phenomenon under study was explored in entirety. Individual and focus group interviews were conducted to elicit rich verbal responses from the informants. Data was analysed in the form of narratives and stories, verbatim.

A semi-structured tool was used for collecting qualitative data. This was done in order to obtain rich descriptive data from the participants regarding the impact of HIV and AIDS on the workforce. The participants were allowed to talk about their views and experiences regarding how HIV and AIDS affects them. In this manner, qualitative descriptions of the life worlds of the participants with respect to the interpretation of their meaning were achieved (Kvale, 2009:126).

This method allowed the researcher to probe, and follow up any information that needed clarity. All questions were open-ended and their sequence in this regard was not adhered to. If the respondent answered a question that was still to follow, the researcher did not stop her from talking. In this case flexibility was used in collecting data (Pretorius, 2012:42).

Individual and focus group interviews were scheduled according to the availability of the participants. For each individual interview and focus group, the following documents were provided: the interview guide, the demographic information, the coding document and the consent form. The information document which included the purpose of the study, the objective to respond to, as well as ethical considerations (as explained in chapter one). Each interviewee had to speak English as the interviews were conducted in English.

Research methods of Phase I objectives of the study are discussed in relation to the instruments used. A clinical survey and a human resource rapid analysis tool were used to

collect quantitative data. The instruments used for data collection were already tested in a study conducted in the North West Province. This ensured the validity of the instruments. To further ensure that the data collection method is consistent with the larger project, the field-workers were inducted on how to use the instruments. The project manager for the study in South Africa trained all fieldworkers who assisted with data collection in the Free State.

Each fieldworker had to familiarise themselves with the instrument after a formal training session was held. Fieldworkers were given a package of documents to be used during data collection for each facility. Each one received an information sheet and a consent form according to the objective that the participants had to respond to, an identification (ID) code document. The identification code of the researcher, country, district, facility, tool number, as well as type of tool used to collect data. The organizational permission letter regarding the research was also given to each fieldworker. Each fieldworker was also provided with the permission letter from the Head of Free State Department of Health to conduct the study.

2.4 The empirical phase

A discussion of the research method of the empirical phase (Phase One of this study) was organised in relation to the aim and objectives of the study as well as the research design.

2.4.1 Research method

In this section data collection is discussed with regard to the research instrument, the research instrument, the population under study, the sampling method, as well as data collection and analysis for each of the phases and steps are discussed. An overview was provided in chapter 1 (see table 1.7) and is discussed in detail here.

2.4.2 Data collection

Hereunder the research instrument is discussed

2.4.2.1 The research instrument

The clinical survey for nurses and nurse managers, the human resource rapid assessment tool and the interview guide were used to collect objective one data. Objective Two (2) data was obtained by using the human resource rapid assessment tool. Objective 3 was answered by using both the human resource rapid assessment tool and the interview guide.

Burns and Grove (2010:395) assert that questionnaires are sets of questions and statements which determine facts or attributes about the participant under study. These might be the

participants' actions, events or situations known by them. Their beliefs and attitudes, opinions and intentions might also be determined using questionnaires. Questionnaires vary according to structure i.e. open and open forms of questionnaires. Structured questionnaires are easy to fill and are quick to complete. Unstructured questionnaires take a long time to complete as participants are not restricted in their answers. They are free to describe the variable or phenomenon in detail as they do not have to choose between preconceived answers (Coetzee, 2010:102; Brink *et al.*, 2010:149).

The questionnaires used in this study were initially prepared and tested, as this study forms part of the international collaborative study (refer to Chapter 1, Paragraph 1.1).

2.4.2.2 Objective One – Phase 1:

To examine how HIV and AIDS stigma influences nurses' provision of prevention, care and treatment to patients and families

To answer this objective the clinical survey was used.

- **The clinical survey**

The clinical survey questionnaire (managers and nurse managers) was used to collect data for Phase One- Objectives One, two and three.

- **Structure of the clinical survey**

The clinical survey consisted of yes/no questions, a Likert scale of four (4) and five (5) items respectively, three items containing possible answers of 'Yes', 'No' and 'Unsure'. The last part of the questionnaire was narrative in which participants were free to suggest interventions regarding the phenomenon under study. The sections of the clinical survey consisted of section A (the demographic profile), section B the- assessment and clinical management of (HIV and AIDS in the participants' own practice), section C, the -assessment and clinical management of HIV and AIDS by other nurses and midwives in the participants' own units, section D (-organisational structure: HIV and AIDS – this part contained questions about HIV and AIDS workplace policies and quality assurance on HIV and AIDS initiatives at the workplace and section E (-policies and procedures). These contained questions on procedures about implementation HIV and AIDS policies, and monitoring and evaluation of such policies. Section F referred to the-HIV and AIDS stigma; this section contained observation action by participants suggestive of inherent stigma.

The format of the questionnaire was consistent with the following criteria as described by Coetzee (2010: 106) and Ary, Jacobs & Razavieh (2010:430).

- The questionnaires should be laid out in an attractive way.
- Logic is important in questions as this would keep the participant moving towards completion.
- The questionnaire item and pages should be numbered.
- Brief, clear and bold-type print instructions for answering, and keys for ranking the items should be provided in section and
- The questionnaire should not be too long.

Objective One Phase One objectives were also achieved by using the Human Resource Rapid Assessment tool.

2.4.2.3 Objective Two – Phase 1

To explore and describe how HIV and AIDS affect the workforce. The Human Resource Management (HRM) Rapid Assessment tool was used together with the clinical survey to answer the above objective.

- **The HRM Rapid Assessment Tool for HIV and AIDS Environments**

The HRM rapid assessment tool for HIV and AIDS Environments contained sections A to.

Section A - (The HRM staff): This part contained questions regarding the existence of HRM staff, their training in basic HRM functions and HIV and AIDS related to HIV and AIDS, and human resource planning capacity and remuneration level of staff at entry level.

Section B - (Personnel policy and practice): This section of the questionnaire contained question relating to the compensation system, which determined the presence of formal salary system for each job category whether this exist and is understood by all employees, salary upgrades and means of attracting and retaining staff within the system. Staff retention recruitment, hiring, transfer, and promotion, were also explored and described in this section. This section also contained questions regarding the presence of a policy of non-description based on HIV and AIDS status. The existence or non-existence of an employee manual and its usage, relationship of the organisation with the unions, labour law compliance including HIV and AIDS related issues.

Section C - (Performance Management): This component contained questions regarding job descriptions, organisational strategies for HIV and AIDS infection prevention, care and or /treatment of clients, staff supervision and training of supervisors with regard to HIV and AIDS. The last part of this component contained questions regarding work planning and performance review.

Section D - (Training): Questions related to staff training, staff training on HIV and AIDS protocols, management and leadership programmes as well as links that the organisation has with pre-service training facility i.e. hospital nursing schools, colleges, and universities.

Section E - (HRM data): In this component, the employee tracking system e.g. data on the number of staff position, location, gender, age, year of commencement of work salary level and projected HIV and AIDS prevalence rate of attrition and absenteeism by staff,

In this questionnaire, HRM Rapid Assessment Tool, the current stage of the organisation with regard to the constructs contained in the questionnaire had to be circled had to written in the space provided for such a purpose. Other comments were to be written next to the evidence column.

2.4.2.4 Objective 3 – Phase One:

To examine the HIV and AIDS workplace policies national HIV AND AIDS strategy, programmes as well as nursing interventions executed in practise

To answer the above objective, both the HRM Rapid Assessment Tool and the interview guide were used. The guide was used to explore the professional nurses' views regarding HIV and AIDS policies.

2.5 Population and sample

A population (N) consists of all the cases that meet the designated criteria (De Vos, 2011:190; Thomas, 1997:227).The sample population (comprises persons, organisations, objects or study elements to represent the population under study (Coetzee, 2010: 108; Mouton & Marais, 199: 135). In this study, the population under study consisted of all the professional nurses, nurses and nurse managers. The nurse manager population consisted of operational managers in charge of clusters of units, as well as unit operational managers.

The sampling method used in the quantitative design was convenient and inclusive of professional nurses, who are involved in one way or another with HIV and AIDS patients. All professional nurses and operational managers that could be available at the time of the

administration of the questionnaire were included. Table 2.4 presents the sample of the districts and facilities in which the study was conducted.

Table 2-4: Sampled facilities according to districts

District	Facility	Type of facility
Thabo mofutsanyane 4	Bakenpak	Clinic
	Bethlehem	Clinic
	Bohlokong	Clinic
	Mphohadi	Clinic
	Paul Roux	Clinic
	Lesedi	Clinic
	Boiketlo	Clinic
	Namahadi	Clinic
	Phuthadithjaba	Clinic
	Thebehospital	District hospital level 1
	Phekolonghospital	District hospital level 1
	Elizabethrosshospital	District hospital level 1
	Mofomahadimanapomopeliregionalhospital	Regional hospital level 2
	Dihlabenghospital	Regional hospital level 2
Fezile dabi 5	Boitumelo	Regional hospital level 2
	Metsimaholo	District hospital level 1
	Pax	CHC
	Seisoville	Clinic
	Lesedi	CHC
	Thusanong	Clinic
Motheo 6	Thaba-nchu	Clinic
	Gaongalelwe	Clinic
	Mafani	Clinic

	Botshabelo	District hospital level 1
	Dr. J.s moroka	District hospital level 1
	National hospital	District hospital level 1

The number of facilities sampled in each district are presented in figure 2.5:

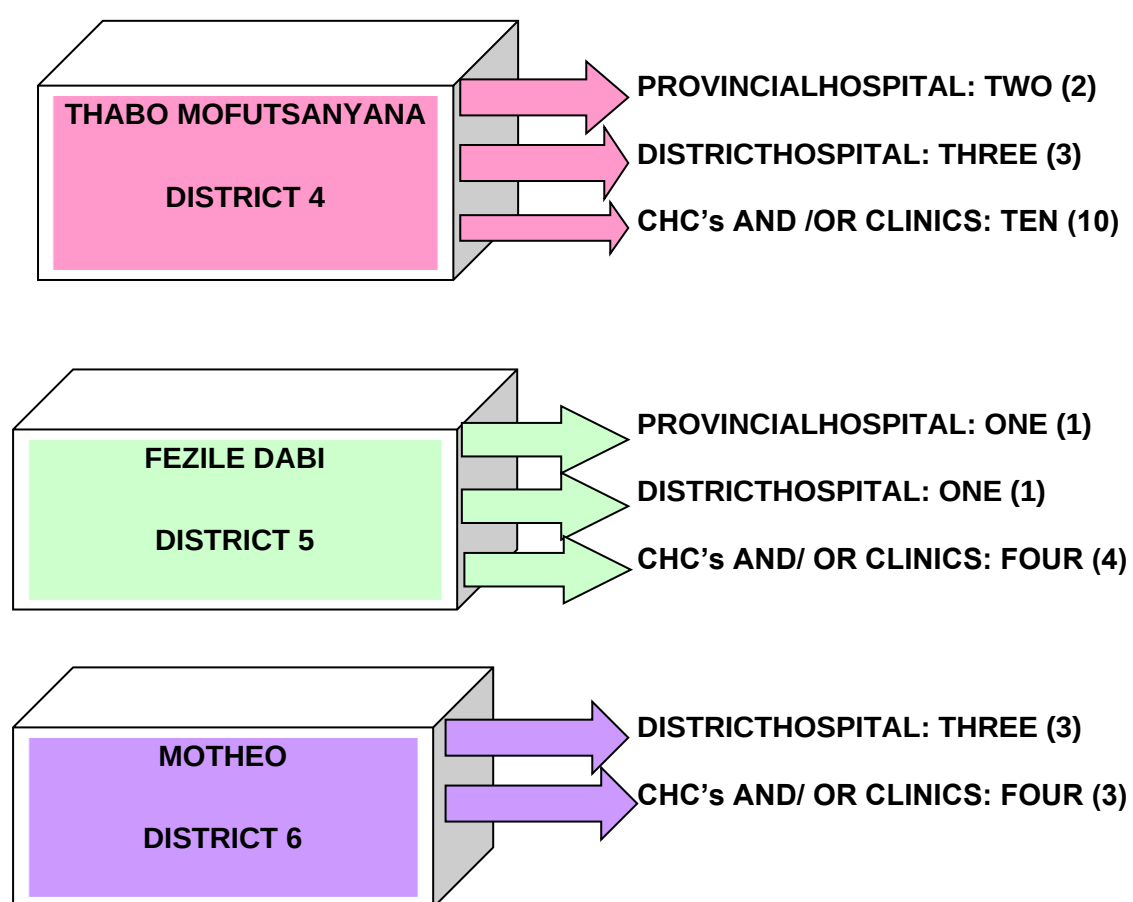


Figure 2-5: Sample size

- **The eligibility criteria**

The eligibility criteria included professional nurses working in the Free State at the time when the research was conducted. These could either be full time, part time or working on contractual basis. This population included community health professional nurses.

Interviews conducted comprised four focus (4) groups and eight (8) individual interviews. The reason for conducting focus groups and individual interviews was for the researcher to complement the two sets of data.

2.6 Data collection

To collect data on a large scale, researchers use questionnaires as these can be distributed to large numbers of participants. These were delivered in person. Questionnaires can be hand delivered, mailed by post or internet-mediate method as confirmed by Coetzee (2010: 102).

Appointments were made to visit each of the 26 hospitals sampled (n=26). Upon each visit the study information was explained to the management of the facilities . Then a permission letter was either given to the CEO/Acting CEO and the Head of Nursing Services to sign. At the clinics the local area managers/operational managers were informed first, and permission to conduct the study was sought, then the individual facilities were visited prior conducting the study.

- **The information to the participants**

The information contained in the information package explained the purpose, the objectives of the study and the benefits of the study. The study risk, ethical considerations, expectations for participation in the study and researcher information was provided (Burns & Grove, 2010:181).

After signing the facility al permission letter, each facility set an appropriate date for the researcher to introduce the study to the participants and let them fill in the consent forms.

After reading and handing the information over to participants, the questionnaires were handed over to every participants i.e. the clinical survey questionnaire, whilst the HRM Rapid Assessment Tool was filled in the presence of the researcher in order for her to follow up every circled response with questions for further clarification. Probes were undertaken in this study in order that the evidence of what was given as a response could be provided.

Interviews were conducted using an interview guide. In this case also, appointments were made for the information sessions, and then interviews were conducted in six facilities at Dihlabeng Local Area.

- **The researcher as a human instrument**

During the interviews, the researcher used her expertise as a psychiatric nurse, a nurse educator and a nurse manager to conduct interviews in a diligent manner. Questions were

asked and respondents' answers were followed up (Kvale, 2009:125; Lincoln & Guba,1985:236).

2.7 Ethical considerations

Research involving human subjects should not put participants at a risk of violation of their rights. Therefore researchers have to avoid, and control any predicted harm to the human subjects. The role of the nurse is to advocate, promote health and prevent suffering, whether functioning as a researcher, caregiver or consumer of research (Polit & Beck 2012:171; Lo-Biondo-Wood & Haber 2006:294-295; Mkhize 2010:40).

This is why this study considered the pertinent issues regarding protection of human rights in research. Ethical issues were taken into consideration to protect the rights of the participants of the study. The following ethical considerations were utilised in order that the informant's rights were not violated (Polit & Hungler, 1995:134-135).

2.7.1 Ethical approval

The research protocol was submitted to the North-West University Ethical Committee for Research on Human Subjects to ensure ethical compliance. The ethical approval certificate number is NWU-00044-07-S2 (see Appendix A).

Approval to conduct the study at the Free State was obtained from the Head of the Health Department, Free State Province. In each study facility, the permission to conduct the study was granted by the operational managers and the local area managers respectively (see Appendices B and C).

2.7.2 Informed consent and participant authorization

The participants gave consent to participate in the study on condition that their rights were protected. They were not coerced to do so and ethical principles such as freedom of choice, to withdraw from the study at any time, the principle of respect were adhered to by observing their self-determination. Participants' names were withheld from the study findings by means of identification codes. The information presented in the study could not be linked to any participant. In this way confidentiality and anonymity were adhered to.

Participants were not chosen for the sake of their vulnerability, but because they met the criteria for inclusion in the study. This ensured the principle of justice (Lo Biondo-Wood & Haber 2006:297-300; Polit & Beck, 2012: 176-179; Polit & Hungler, 2010:124).

Their right to privacy was ensured by collection of information that is relevant to the study and not prying into the participants' private lives.

2.7.3 Provision of information for the study

It was imperative for the researcher to communicate the necessary information concerning the study to the prospective participants for them to understand clearly what the study entails. This information included study goals, type of data collected, procedures used, the nature of commitment, participant selection, potential risks and benefits, compensation, confidentiality pledge, voluntary consent, right to withdraw and withhold information as well as the researcher's contact information (Polit & Hungler, 2010:124).

To adhere to the facility al permission form provided the information regarding the study. This was also given to the study participants. The information included the purpose of the study, study objectives, expectations from the participants.

2.7.4 Freedom from harm

This was ensured by making sure that no study participant was asked to reveal her/his HIV status. If any of the participants felt emotional with regard to any issue, they could indicate to the fieldworkers or the researcher and be referred to a counsellor. The names of the HIV counsellors and their contact numbers were provided.

2.7.5 Scientific honesty

This was adhered to by means of acknowledging all sources used in the thesis. Data was not manipulated in any way and bias was avoided in reporting the findings. Bracketing was adhered to in the qualitative section of the study as the researcher brought into the research field some information regarding the phenomenon under study. Recording, transcribing and analysing data was done without bias as discussed in data analysis. The statistician of North-West University acted as consultant, and ensured the correctness of the quantitative data.

2.8 Data analysis

Qualitative data was analysed in the form of descriptive statistics. The SPSS Package Version 1.8 (2010) was used in analysis of the data. Data capturing was done, thereafter, data was coded and analysed. The project manager co-checked the captured data and verified it against each tool before analysis. Qualitative data was analysed according to themes and sub themes (see Chapter four of this thesis)

2.9 Rigour

In this study rigour was ensured by means of content validity, construct validity and trustworthiness of the qualitative data and triangulation. Trustworthiness included credibility, conformability and transferability as described in Lincoln and Guba (1985).

Every study has to be valid, and validity is an important concern right through the study (Burns & Grove, 2010:214). Validity refers to the capacity of an instrument used in a study to do what it purports to do (Cormack, 2000:26). As validity of an instrument is a cumulative process and not established through a single study, the instruments used in this study were tested before in order to establish validity (Young, Taylor & Renpenning, 2001:31).

- **Validity of the instruments**

Two types of validity were determined. Content validity was established as the instruments were checked by experts in the field of nursing research as the promoter of this study in particular is a professor and an expert in nursing research. In addition a statistician was contacted to analyse the tools which were formally checked and analysed and tested at the North-West Province as well as in Jamaica where the study was already conducted. Young, Taylor and Renpenning (2001:31) indicate that the study experts evaluate the instrument items to establish content validity.

Content validity concerns the extent to which the measure adequately covers the various dimensions of the phenomenon under study. Since it was evident that the instruments used contained concepts pertinent to the phenomenon under study e.g concepts like HIV and AIDS stigma and. HIV and AIDS policies and procedures, the instruments used met the principles of content validity. Cormack (2000:31) agrees to this by indicating that the rigour of the research approach can be also be enhanced by searching literature for information against which to compare the content of the instruments.

The second type of validity established in this study is construct validity. The questions asked contained constructs which appeared to be congruent with the study. This type of validity relates to the fit between the conceptual definitions and the operational definitions of the study e.g. impact of HIV and AIDS on the workforce can be measured by staff retention rates. This construct is contained in the HRM Rapid Assessment Tool of this study.

- **Reliability**

The extent to which the instrument measures the concepts repeatedly in a study indicates reliability. Internal consistency was used in order to check whether the items that were used to measure one conceptual domain yielded consistent responses. The Cronbach Alpha measure was used to test the reliability of both the Clinical survey and the HRM Rapid Assessment Tool. The Cronbach Alpha was 0.7. In the case of this study the Cronbach Alpha ranging from 0.7 to 0.8 is considered reliable.

- **Validity of clinical survey**

As mentioned in chapter two this tool was tested in the Teasdale Corti project, it was necessary to test its validity before data was analysed in this study. This tool actually measured what it is supposed to measure, as the population to which it has been administered is professional nurses involved in the prevention and care of HIV and AIDS patients (Burns and Grove, 2010:215).

- **Reliability of the clinical survey**

The statistical consultation department of the North West University (Potchefstroom campus) analysed the data. The first step followed, was to determine the consistency of this questionnaire, that is, the clinical survey (clinical survey questionnaire for nurses and nurse managers). This questionnaire consisted of seven factors. A Cronbach Alpha score of 0,7 to 0,9 in different factors was regarded as reliable. Field (2005:668) argues that a Cronbach alpha coefficient of 0,6 is appropriate and if the number of items added in each factor are low, a Cronbach Alpha score will be low. In the case of this study, the numbers of items were many hence there is a high Cronbach coefficient. As this tool was administered to nurses (professional nurses) and nurse managers (operational managers) who differed in their experiences in as far as the factors in the questionnaire were concerned, the Cronbach Alpha test also varied in each factor. Table 2.5 presents the Cronbach Alphas in this study.

Table 2-5: Cronbach Alpha test in the clinical survey

Factors	Cronbach Alphas	Cronbach's standardized items	No of items
Factor B (Assessment and clinical management)	0.925	0.926	12

Factors	Cronbach Alphas	Cronbach's standardized items	No of items
of HIV and AIDS (participant)			
Factor C Assessment and clinical management of HIV and AIDS by the colleagues	0.948	.949	12
Factor E Policies and procedures.	0.815	.800	10
Factor D Organizational structure: HIV and AIDS	0.805	.799	10
Factor F (HIV and AIDS stigma)	0.913	.924	19

The Cronbach Alpha test in each factor is reliable, because no statistical difference is indicated. Babbie (2010:150) asserts that the reliability of the tool determines its repeatability in different situations and its consequent yielding of the same results in such situations. This is true in case of this tool, as this tool was used in other instances i.e. in different countries involved in the study.

The items in each factor in the clinical survey tool which were subjected to analysis were 10 to 15. The factors or constructs were:

- Assessment and clinical management of HIV and AIDS in own practice
- Assessment and clinical management of HIV and AIDS by the participant's colleagues
- Organizational structure : HIV and AIDS
- Policies and procedures

- HIV and AIDS stigma
- Support for improving HIV and AIDS nursing care.

As explained earlier, this tool consisted of seven constructs or factors which were analysed. A total number of 71 items was analysed. The number of questionnaires administered was 256 out of which 179 were captured on the Excel data sheet. The data from the sheet was entered in the Statistical Package for the Social Sciences (SPSS, Version 18.00) Institute Inc. software package. As in the case of Objective One (1) the reliability and validity of a questionnaire was determined as this is the same questionnaire used in Objective 1.

A total of 26 facilities participated, out of which 179 questionnaires were usable. During analysis, missing data equalled to 3 and 176 tools were analysed.

Below is a table of means in this study and discussion of such means. Babbie (2010:409) states that the mean is the average of the sum of the items falling under each construct, divided by the number of items in the same construct. It is used as a measure of central tendency and is 'associated with the term average'. Babbie (2010) in this paragraph agree in principle that the mean is the most stable measure of central tendency. Lo-Biondo-Wood and Haber (2006:380) and Burns and Grove (2010: 474) confirm that the mean is used in most tests of significance. Table 2.6 indicates the means in this study.

Table 2-6: Summary of factors in clinical survey

Factor	N	Mean	SD	Interpretation
Factor B (Assessment and clinical management of HIV and AIDS (participant))	173	3.7	0.9	Holistic assessment of clients regarding prevention of infections and adherence to anti-retroviral is done though most nurses are not involved in HIV and AIDS research
Factor C Assessment and clinical management of HIV and AIDS by the colleagues	173	3.9	0.9	Most of the time other nurses and midwives asses clients and families re: prevention of infections and adherence to anti-retroviral is done though most nurse are not involved in HIV and AIDS research. (SD = inconsistent)
Factor D	176	0.8	0.2	Quality assurance committees are available, but not all nurses participate in them. (SD =

Factor	N	Mean	SD	Interpretation
Organizational structure: HIV and AIDS				consistent)
Factor E (Policies and procedures)	176	0.8	0.2	Policies are available
Factor F (HIV and AIDS stigma)	174	1.3	0.4	Nurses and nurse managers do not necessarily discriminate patients on the basis of HIV and AIDS but they (nurses) may be discriminated against by the community as they care for such patients

Factor B (Assessment and clinical management of HIV and AIDS by the participant) has a higher mean of 3.7 but the dispersion of data as shown by the standard deviation is less (0.9). This indicates individual differences of the members of the population. It gives an indication of how scores are dispersed around the mean. In this way data that is not available from the measures of central tendency, in this case the mean, are provided. The deviation of scores indicates the degree of error that would be made if the mean alone would be used. In the case of this study, the degree of error would not be too high as indicated by the lower standard deviation. Even if a mean was used independently of the standard deviation, the data in this case is more dispersed, close to the mean. The standard deviation is 0.9.

Factor C (Assessment and clinical management of HIV and AIDS by the colleagues) the mean of 3.9 is acceptable. This also shows that data dispersion is acceptable for differences in the population but the assumed error is less. Brink et al., (2010) argues that two sets of results with the same mean may differ considerably in distribution, but the standard deviation quantifies the difference. This is the case in this study as factor B and C have a higher standard deviation whilst the rest, i.e. D, E and F, have a lower standard deviation. The lower deviations mean data is more consistent (Babbie, 2010: 432). See the table on the summary of all factors with regard to the results.

Factor D (Organizational structure: HIV and AIDS): the mean in this factor is 0.8 and the standard deviation is 0.2. Though the mean is low, the standard deviation shows an acceptable distribution of data as differences in responses showed that some professional nurses may have differing views regarding quality assurance or quality improvement initiatives at the

workplace. As mentioned above, the low standard deviation indicates that data are more consistent.

Factor E (Policies and procedures). In this factor the mean is 0.8 and the standard deviation is 0.2, as in factor D above. See Table 2.6 for the summary of results and their significance in this study.

Factor F (HIV and AIDS stigma). The mean is 1.3 whilst the standard deviation is 0.46. This factor shows that nurses and nurse managers do not necessarily discriminate against patients on the basis of HIV and AIDS but they (nurses) may be discriminated against as they care for such patients. This item has a high standard deviation. There might be some inconsistency in the data.

Factor B (Assessment and clinical management of HIV and AIDS by the participant) has a higher mean of 3.7 but the dispersion of data as shown by the standard deviation is less i.e. 0.9. This indicates individual differences of the members of the population. It gives an indication of how scores are dispersed around the mean. The deviation of scores indicates the degree of error that would be made if the mean alone would be used. In the case of this study, the degree of error would not be too high as indicated by the lower standard deviation. The standard deviation is 0.9.

Factor C (Assessment and clinical management of HIV and AIDS by the colleagues). The mean in this case is 3.9 and is acceptable. This also shows that data dispersion is acceptable for differences in the population but the assumed error is less. Brink *et al.*, (2010) argues that the two sets of results with the same mean may differ considerably in distribution, but the standard deviation quantifies the difference. This is the case in this study as factors B and C have a higher standard deviation whilst the rest have a lower standard deviation i.e. D, E and F. The lower deviations are more which means data is more consistent (Babbie, 2010: 432). See the table on the summary of all factors with regard to the results.

Factor D (Organizational structure: HIV and AIDS) the mean in this factor is 0.8 and the standard deviation is 0.2. Though the mean is low, the standard deviation shows an acceptable distribution of data as differences in responses showed that some professional nurses may have differing views regarding quality assurance or quality improvement initiatives at the workplace. As mentioned above, the low standard deviation indicates that data is more consistent.

Factor E (Policies and procedures). In this factor the mean is 0.8 and the standard deviation is 0.2, as in factor D above. See Table 3.2 for the summary of results and their significance in this study.

Factor F (HIV and AIDS stigma). The mean here is 1.3 whilst the standard deviation is 0.46. This factor shows that nurses and nurse managers do not necessarily discriminate patients on the basis of HIV and AIDS but they (nurses) may be discriminated as they care for such patients. This item has a high standard deviation. There might be some inconsistency in the data.

- The reliability of the HRM-questionnaire (HIV and AIDS environments)

The HRM-questionnaire consists of five constructs, namely HRM Capacity, Personnel Policy Practice, Performance Management, Training and HRM-data. The population of this study consisted of professional nurses and nurse managers. Their experiences will be different with regard to each item of the constructs. A rating of 1 to 4 was allocated so that participants may choose the situation that they deemed most suitable to their circumstances. Table 2.7 depicts the reliability of the HRM tool according to each construct.

Since this study was part of the international project, "Strengthening nurses' capacity in HIV and AIDS policy development". This questionnaire was tested earlier in the Teasdale Corti project. In discussing objective one results, the reliability of this tool was included. This was supported by literature. The Cronbach Alpha Coefficient was calculated. Table 2.7 shows the reliability of the HRM HRM tool.

Table 2-7: Reliability coefficient of HRM-questionnaire on the study population

Construct	Number Of Participants (n)	Cronbach Alpha Coefficient	Number of Items
HRM Capacity	68-22 =44	0.603	3
Personnel Policy and Practice	68-22 =44	0.920	12
Performance Management	68-22 =44	0.850	5
Training	68-22 =44	0.668	3
HRM data	68-22 =44	0.566	2

Personnel policy and practice has a Cronbach Alpha of 0.920 and performance management has a Cronbach Alpha of 0.850. These items are reliable.

The validity of the Human Resource Management Assessment questionnaire within the context of the study refers to the extent to which the instrument measures what it is supposed to measure. Tests of construct validity revealed a weight of evidence that the HRM questionnaire used in this study measures the quality that was expected (Babbie, 2010:153; Burns & Grove, 2010:775; Brink *et al.*, 2010). The number of items in each construct varied from two (2) to twelve (12).

In this tool, (as in the Clinical Survey) a Cronbach alpha coefficient of 0.7 to 0.9 is an acceptable level of reliability. As Muller (2010) asserts, the number of items under a certain construct determines the Cronbach alpha coefficient of that of that construct or factor. Since the number of items in HRM data is 2 (lower than that of policy practice, and performance management) this construct has a low Cronbach alpha. HRM data and training have 2 (two) and 3 (three) items respectively giving rise to a low Cronbach alpha. Training has a Cronbach alpha coefficient of 0.668 which could be rounded up to 7. This is the reason that this is acceptable. Therefore the HRM tool is reliable.

- **Trustworthiness**

The truth value of the findings of the study according to Lincoln and Guba (1985) and Krefting (1991) is determined by credibility, **reflexivity**, transferability, dependability as well as confirmability. Brink (2010:124) states that trustworthiness has to do with the consistency, stability and repeatability of the informants' accounts as well as the investigator's ability to collect and record information.

- **Credibility**

Marshall and Rossman (2011:39) define credibility as 'an act of conducting inquiry in such a manner as to ensure that participants were identified and described for the study to show that the inquiry is credible to the constructors of the original multiple realities'. The researcher ensured credibility by choosing registered nurses as the study population. This ensured that the responses to the questions asked are credible and as a consequence registered nurses' experiences were taken into consideration. Throughout the interviews bracketing was employed as the researcher put in abeyance all that she knows regarding the phenomenon under study. The participants were also allowed to see the drafted versions of the data collected from them, because credibility is demonstrated when participants confirm that the reported research findings are their own experiences (Streubert & Carpenter, 1995:314).

- **Reflexivity**

As a professional nurse, the researcher acknowledges that she brings some knowledge regarding the phenomenon under study into the research field. She therefore had to put in abeyance all that she knows about the subject of HIV AND AIDS care in order as not to influence the study findings. This objectivity helped the researcher to avoid bias when analysing the study findings.

The researcher was reflective in order to monitor the process of data collection and analysis. The researcher was aware of her assumptions and values throughout the research process. She remained objective during the research process and could analyse the data collected without bias.

- **The researcher's authority and referential adequacy**

The researcher's competence, training background and experience contributed to the credibility of the research. As a facilitator, a psychiatric nurse and a nurse educator, the researcher was able to conduct focus group interviews. The researcher is competent in transcribing and analysing conversations because of her experience as a psychiatric nurse (Mofokeng, 2003:59).

- **Structural coherence**

Consistency of data collected and its interpretation was ensured by seeking the help of a professional data capturer and an interpreter. This ensured structural coherence, and the concepts used to develop a model were a true reflection of the professional nurses' views.

- **Confirmability**

As structural coherence and reflexivity were ensured, this contributed to confirmability as the data collected and analysed was credible (Holloway & Wheeler, 2010:304-305). The researcher used the following auditing criteria:

- The raw data of the narrative conversations and the audiotapes was collected.
- The raw data was analysed at an early stage of data collection and at the analysis phase.
- The researcher made sure that the conclusions of the study's findings were supported by the analysed data.

Table 2-8: Trustworthiness strategies

STRATEGY	CRITERIA	APPLICATION BY RESEARCHER
Credibility	Reflexivity	Bracketing and intuiting in each phase of the research process. This was achieved by putting in abeyance the information known about the phenomenon under study.
	Authority of the researcher and referential adequacy	As a nurse educator and manager well equipped with interview skills. Probing was done to understand the phenomenon under study in entirety.
	Interview technique	- Interview guide used was tested as this study was conducted in four countries. - As a psychiatric nurse. The researcher is well acquainted with group interviews and group facilitation. No leading questions were asked and a non-judgemental attitude was maintained throughout the interview
	Structural coherence	- The interviews were transcribed by a professional. This ensured coherency of data collected with the study purpose and objectives. - The research programme manager checked all data that was captured. Editing was done by a professional editor.

STRATEGY	CRITERIA	APPLICATION BY RESEARCHER
Triangulation	Stepwise replication	• Triangulation was ensured by using three instruments for data collection. Both the qualitative and quantitative approaches were used to compliment the two data sets. • Collating data in HRM Rapid Assessment Tool (HRM policies) with that of the focus group interviews. Lastly all analysed data was supported by literature.
Confirmability	Confirmability occurs with: • credibility • triangulation	• The research project proved confirmable through credibility and triangulation. • Conclusions and interpretations were derived directly from the data.

• Triangulation

Schneider, Elliot, Lo-Biondo-Wood & Haber (2005:31) state that triangulation is the expansion of the research methods in a single study or multiple studies to enhance diversity and increase understanding of the phenomenon under study. It also helps to achieve specific goals. Triangulation is the use of multiple sources or referents to draw conclusions about the truth. In quantitative studies this might mean having multiple operational definitions, whereas in qualitative study, triangulation might involve trying to understand the full complexity of poorly understood phenomenon by using multiple means of data collection to converge on the truth (Polit & Beck, 2012:196). Cormack (2000:165) confirms this by stating that using different approaches in a study can provide a much richer and deeper understanding of what is being investigated than would otherwise be the case.

According to (Burns & Grove, 2010: 25), a single method is inadequate; triangulation is used to ensure that the most comprehensive approach is taken to solve a research problem. The problem investigated in this study is complex, involving for example HIV and AIDS care, research and policy interface. The approach is also complex as quantitative data was

complemented by qualitative data. The philosophical basis of both quantitative and qualitative research was maintained when these methodologies were used. Since the research question in this study was answered by using the above mentioned designs and supporting the results thereof in literature, triangulation was evident in this study.

Both methods were used specifically by the utilization of the HRM Rapid Assessment tool (quantitative and qualitative) and the interview guide (qualitative). This facilitated a greater understanding of the impact of HIV and AIDS on the workforce. Phaladze (2003:22) alludes to the reliability and validity of a study in using triangulation. Creswell (2013:191) and Lincoln and Guba (1985) agree on this method as increasing rigour in research.

- **Principles in methodological triangulation**

Burns and Grove (2010: 25-26) discuss the principles of triangulation, emphasising the fact that the research question must be clearly focused, strengths and weaknesses of the chosen method must complement each other, methods must be selected according to their relevance to the phenomenon being studied and the methodological approach must be monitored throughout the study to make sure the first three principles are followed.

In the case of this study, the first principle of making sure that the research question is clearly focused, was achieved by using the same research question in both methods. The same objective was used in both methods (see tools 3, 4 and 5 of this study in Annexure E). In the case of the second principle the strengths and weaknesses of the methods complemented each other as in HRM Rapid Assessment Tool follow-up questions were asked for clarification using the same participants. If a participant could not elaborate on the question asked in the quantitative data collection method, probing was done in the second instance during interviews for greater clarity. Thirdly, methods were chosen according to their relevance to the phenomenon being studied. Interviews and questionnaires are relevant for collecting data on HIV and AIDS stigma, quantitative clinical surveys, HIV and AIDS impact on the workforce, HRM Rapid Assessment Tool – quantitative and interview guide as well as tool 4 – HIV and AIDS policies.

In the case of this study, it was anticipated that the use of both the quantitative and qualitative research data collection methods would be suitable, as one set of data would complement the other, leading to maximisation of the validity of the research findings. This design also corresponds to the view that the researcher, as explained in Chapter One subscribes to the postmodern philosophy, which comprises a belief in multiple realities in knowledge construction.

Having discussed the research design, it should be noted that the research design will influence one's decisions about the research methods (Klopper, 2008:69).

2.10 Summary

On embarking on this chapter of the research methodology it became evident that the problem of the study, its purpose and objectives determine the type of the design chosen. This in turn determines the method/s of data collection and how the data will be analysed and findings presented. Adherence to validity and reliability is also important as the instrument used has to be valid and reliable. For these reasons a clear discussion of measures to ensure validity and reliability was presented. In the qualitative data collection method, trustworthiness was also ensured.

A detailed discussion of both qualitative and quantitative approaches was undertaken as they fit into the study of HIV and AIDS care, research and policy interface. The chapter ended with ethical considerations as these form the cornerstone of every research study. In the next chapter quantitative data results are discussed.

CHAPTER 3: RESULTS OF QUANTITATIVE DATA ANALYSIS

3.1 Introduction

Chapter Two dealt with the research design and research methods used in this study. In this chapter, the results based on the quantitative data will be discussed. Before discussing the results, it is imperative to relate to the reader once more how the data was collected and analysed. Therefore realization of data collection, preparing data for analysis, and statistical analysis according to each data collection instrument will be presented.

Burns and Grove (2010:44) state that data analysis reduces, organizes and gives meaning to data. This is mainly determined by the research objectives, questions or hypotheses, the research design and the level of measurement achieved by the research instrument (Burns & Grove, 2010:44). In this chapter the analysis is provided, and the findings of the study with regard to participants' demographics, and description of the variables shown in percentages. The means and standard deviations are used to present the results of the HRM Rapid Assessment Tool.

This chapter presents the planning and implementation of statistical analysis.

3.2 Realization of data collection

Quantitative data was collected using both the clinical survey and the HRM Rapid Assessment Tool. The clinical surveys delivered were 256 (N=256) and 179 were collected. The response rate was 70%. One hundred-and-seventy-six 176 (n=176) clinical surveys were analysed as three (3) were discarded due to too much missing data upon capturing in the EpiData.

Data was collected in twenty-six (26) health facilities in the Free State. These included hospitals, clinics and community health care centres. Refer to Figure 2.3 and Table 2.4. Prior to data collection, telephonic and physical appointments were made with the management of the sampled health care facilities. A visit to conduct the study was set on a date suitable for the facility concerned, as the permission to conduct the study clearly indicated that there should be no disruption to patient care during data collection.

The information to the participants was read by the researcher to both the participants and management. This ensured thorough understanding of the purpose of the study and the objectives thereof. The benefits of the study, risks, and ethical considerations, expectations for participation in the study and researcher information were provided

The facility al permission letter was then signed and each participant signed the consent form after thorough understanding of its contents. The questionnaires were handed out to the participants, in an endeavour to achieve a higher response rate. Since there is a tendency for the response rate to be poor when questionnaires are posted, the researcher found it necessary to personally deliver and collect the questionnaires. This idea resulted in a higher response rate, namely 70%.

3.2.1 Preparing the clinical survey data for analysis

Responses from 179 participants in the clinical survey were entered into a prepared data sheet which contained the particulars of the participants. This information was kept confidential and the data sheets were marked “confidential” across each page. Later, data capturing was done on the excel data spread sheet (EpiData), which contained the codes of the interviewer, the country, the district, facility , the questionnaire code, and the questionnaire type. The age was coded 1 to 4 according to age ranges. Gender was coded 1 and 2, male (1) and female (2). The questions were captured according to corresponding coding values. The coding manual was based on the sequence and wording of questions in the final version of the survey. Missing data for all numerical fields was coded 999, whilst missing data for all qualitative fields was coded NR. The questionnaire variables above were coded to facilitate capturing in the Statistical Package for the Social Sciences (SPSS) Version 18.00.

3.2.2 Statistical analysis

Data was analysed using SPSS Version 18.0 (SPSS Inc., 2010). Descriptive statistics, for instance means, percentages, standard deviations and Cronbach's Alpha coefficient were computed.

The mean is used as indicator for central tendency and is statistically known as an arithmetic average of all scores in a distribution (Polit & Hungler, 2010:41). Burns and Grove (2010:472) describe the mean as the sum of the scores divided by the number of the scores being summed. It is used to indicate the average score of the study population on a questionnaire.

The standard deviation is the distance of all individual scores from the mean. The larger the standard deviation, the more spread out the score about the mean of the distribution (Brink et al., 2010:178). Burns and Grove (2010:474) describe the standard deviation as the ‘average’ difference of the score from the mean in a certain sample. It indicates the degree of error if the mean alone was used to interpret the data.

3.2.2.1 Statistical analysis of the clinical survey

Section A of the questionnaire was the demographic part. This contained questions in which the relevant response had to be circled and the codes used ranged from 1 to 8, depending on the question asked. Yes/no questions were also contained in this section, where yes was numerically coded 1 and no, numerically coded 0. Sections B (Assessment and clinical management of HIV and AIDS) and C (Assessment and clinical management by other nurses) contained a Likert scale of 5 items, namely never (1), rarely (2), sometimes (3), most of the time (4), and always (5). Furthermore, Sections D (Organisational structure HIV and AIDS) and E (HIV and AIDS policies and procedures) consisted of three-point scale item questions, containing yes, no and unsure which were coded as: yes (1), no (2) and unsure (3). Section F (HIV and AIDS stigma) contained a four- point Likert-type scale, namely never (1), once or twice (2) and several times (3).

Items on the questionnaire were then coded according to themes using colour codes. The corresponding responses were also coded according to the themes identified. Seven (7) themes were identified and coded in different colours, thereafter numerical values were assigned according to each colour coded theme. Table 3.1 presents the identified themes.

Table 3-1: Identified themes in the clinical survey

Nursing care	1
Capacity building	2
Research	3
Workload/shortage of resources	4
Policies	5
Stigma	6
Family involvement	7

Analysis of the clinical survey commenced with the analysis of the demographic data including the statistics of HIV and AIDS patients cared for by each participant according to the different units in which they work, for instance Section A. The second section, Section B, covered the assessment and clinical management of HIV and AIDS, including involvement of nurses in HIV and AIDS research. The third part of the questionnaire covered quality assurance initiatives in the organisational structure and HIV and AIDS policies (Sections D and E). The fourth section, Section F, covered questions on HIV and AIDS stigma.

3.2.2.2 Phase one objective One: To examine how HIV and AIDS stigma influences nurses' prevention, care and treatment of patients and families

To cover the objective above, questions on the assessment and clinical management of HIV and AIDS were asked in Section B. Table 3.6 presents the data collected in this regard, whilst Table 3.7 presents the views of participants with regard to their colleagues' assessment and clinical management of HIV and AIDS (Section C).

As mentioned in the preceding paragraphs, data was coded in order to facilitate data entry into the SPSS Version 18.00 programme. The results that were analysed quantitatively were those of the clinical survey questionnaire and the Rapid Human Resource Assessment questionnaire. The clinical survey questionnaire contained qualitative fields which were analysed qualitatively in Chapter 4. Each questionnaire contained the biographical data section.

Table 3-2: Age of the participants in study

Not reported	21-30 Years	31-40 years	41-50 years	Older than 50 years	Total
1.70%	8.60%	12.60%	49.0%	28.10%	100%

Figure 3.1 presents the age of the participants.

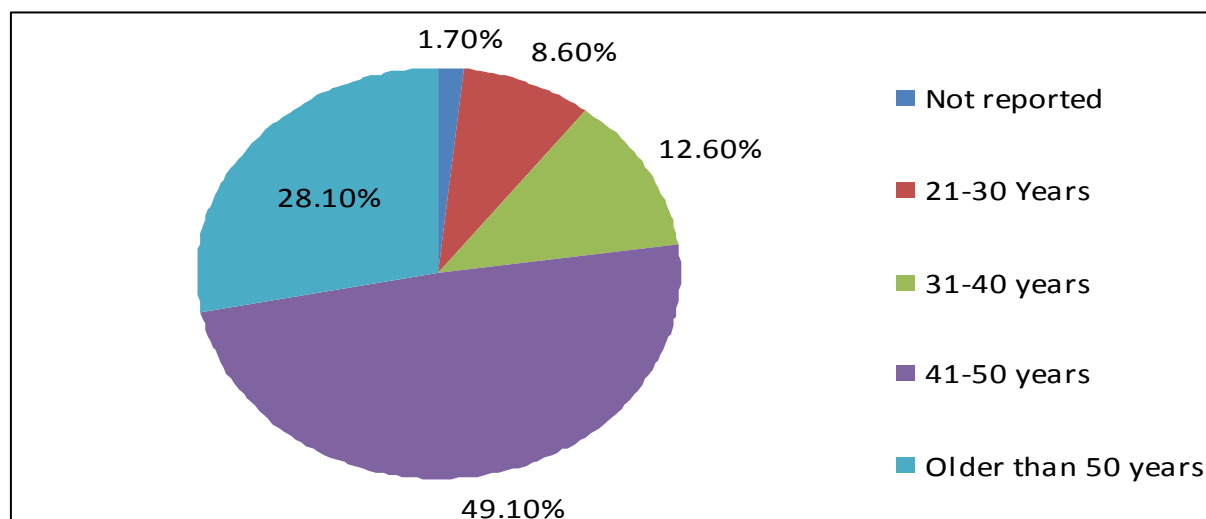


Figure 3-1: Age of the participants

Description of the variables in the clinical survey

The age distribution of the respondents was divided into four groups and statistical analysis carried out.

- **Biographical data**

Age of the participants

The age of the participants was analysed according to intervals of 21-30 years old, 31-40 years old, and 41-50 years old and older than 50 years. Data in Table 3.2 shows that 49% of the participants were between the ages of 41 and 50. This shows that nurses who took part in this study are an aging population.

Gender

Table 3.3 presents the gender of the sample of the study.

Table 3-3: Gender

Female	Male	Not reported	Total
85%	11%	4%	100. %

Figure 3.2 represents the gender of the participants.

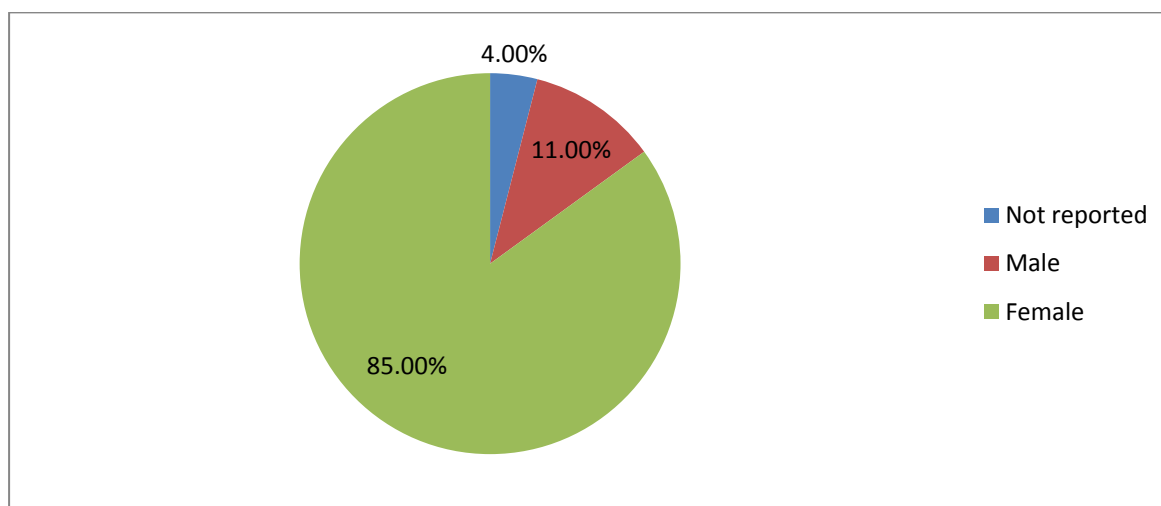


Figure 3-2: Gender of the participants

The significance of gender in this study is not only directly related to this study but to nursing in general, as nursing has always been a female dominated profession. Unsurprisingly, 85% of the participants were females, whilst 11% were males.

Having discussed and presented the biographical data, we will move on to discuss the results according to the objectives of the study.

3.2.2.3 Discussion of results from phase one, objective One, to examine how HIV and AIDS influence nurses prevention care and treatment to patients and families

The results from Phase One, Objective One comprise data obtained by means of the clinical survey. Table 3.4 presents the clinical survey results, taking into consideration those below 50% as this indicates deficiency or lack in the item concerned. The items above 60% are reported as this shows above average function. The percentages are then presented graphically in Figure 3.3.

Table 3-4: Assessment and clinical management of HIV AND AIDS

Variable	Not answered	Never	Rarely	Sometimes	Most of the time and always
B1. I assess my patients'/clients' physical, social, emotional, psychological, and spiritual needs related to HIV AND AIDS	4%	2.9%	6.2%	16.%	70.68%

Figure 3.3 presents assessment of the family to provide HIV and AIDS care, physically, emotionally, spiritual and socially.

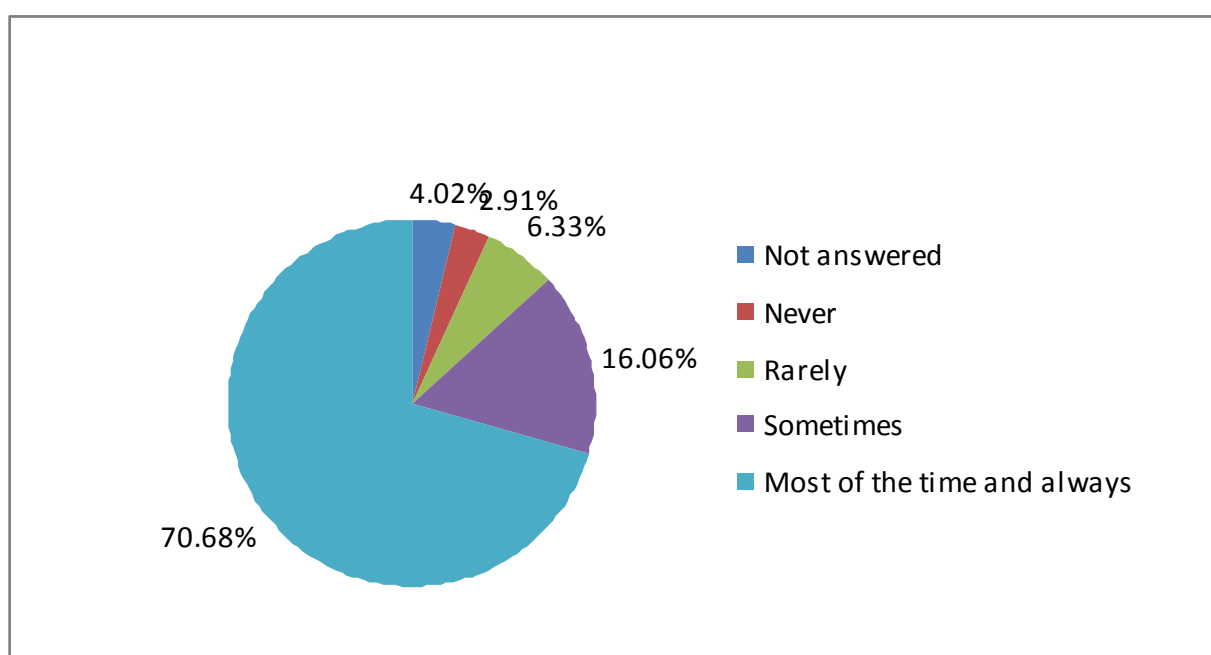


Figure 3-3: Assessment of the family to provide HIV and AIDS care, physically, emotionally, spiritual and socially

The United Nations General Assembly special session on HIV and AIDS on 25 and 26 June 2001 announced in this regard that individuals, households, families and communities affected by HIV and AIDS should be supported psychologically, and this should be included in the national strategic plans for HIV and AIDS. That is why the physical, social and emotional care of

the patients is assessed. Figure 3.3 presents the results of the assessment and clinical management of HIV and AIDS. 70.68% of the participants indicated that most of the time and always they assess clients/ patients' physical, psychological, spiritual and social needs related to HIV and AIDS. This percentage shows that patients are cared for according to components of health as the WHO definition of health denotes includes all of the above aspects.

Table 3-5: Assessment of patients'/clients' comfort in disclosing their status

Variable	Not answered	Never	Rarely	Sometimes	Most of the time and always
B2. I assess my patients'/clients' comfort in disclosing his/her HIV status to family members	2.3%	8.61%	9.11%	18.92%	61.06%

Figure 3.4 presents assessment of patients'/clients' comfort in disclosing their status.

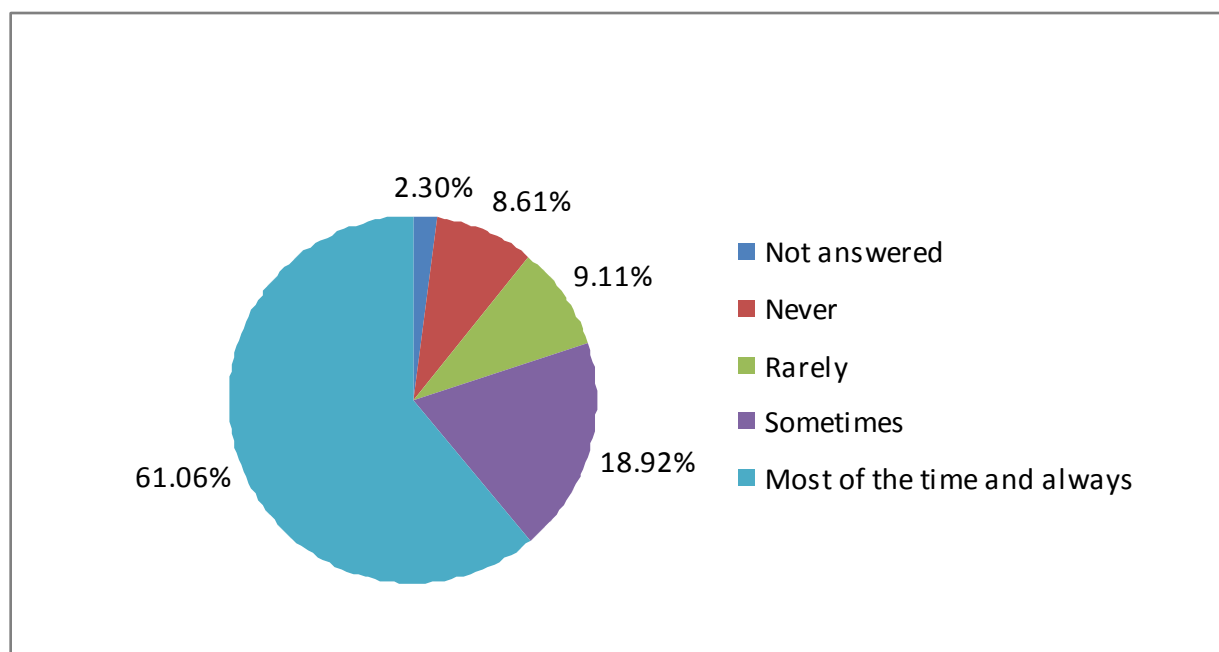


Figure 3-4: Assessment of patients'/clients' comfort in disclosing of their HIV status

The results of the assessment of patients' comfort are reflected in Table 3.5. Thereafter these will also be represented graphically thereafter in Figure 3.4.

In this figure a graphic representation of the results of B2: Assessment of patients in disclosing their HIV and AIDS status: 61.06% of the participants reported that they assess the patients comfort in disclosing their HIV and AIDS status most of the time and always. In this case, confidentiality in disclosing of the HIV and AIDS status was reported in the qualitative fields of the clinical survey as a deterrent to the care of individuals with HIV and AIDS these people seek medical help very late when symptoms have progressed.

Table 3.6 presents assessment of family ability to provide care.

Table 3-6: Assessment of family ability to provide care

Variable	Not answered	Never	Rarely	Sometimes	Most of the time and always
B3. I assess the family's ability to provide care (physical, social, emotional, psychological and spiritual) for the family member with HIV or AIDS	2.33%	6.99%	12.16%	26.34%	52.18%

Figure 3.5 presents the assessment of the family to provide psychological, social, spiritual and physical care.

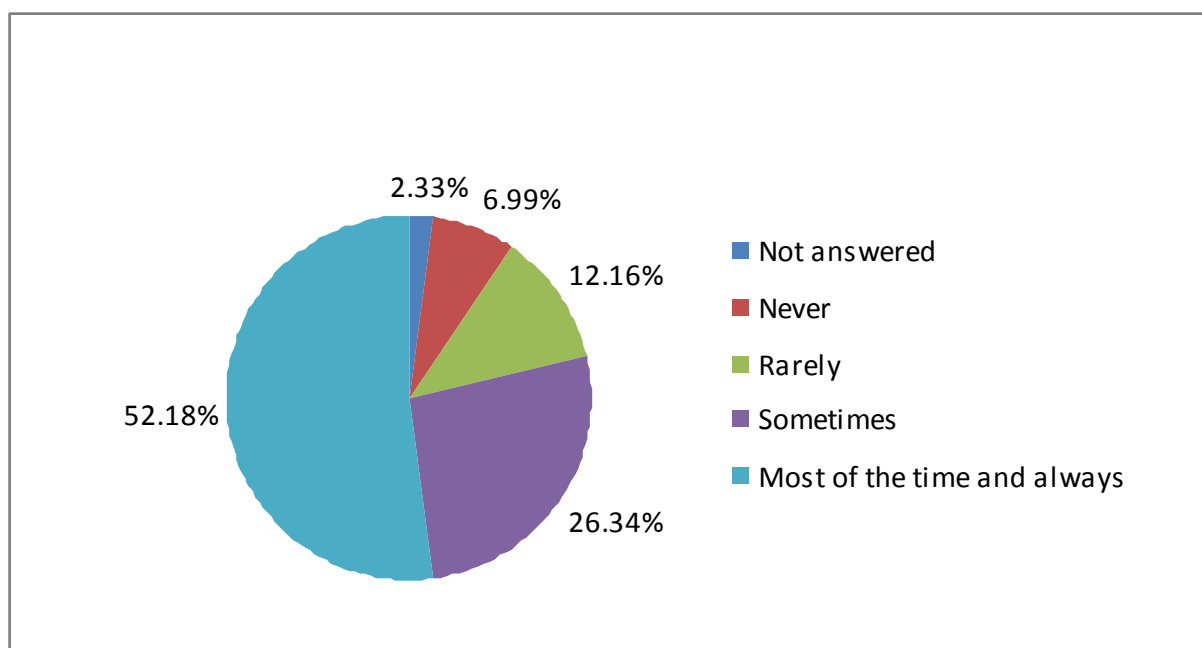


Figure 3-5: Assessment of the family's ability to provide psychological, social, spiritual and physical care

The next item to be discussed is item B3: The ability of the family to provide psychological, social, spiritual and physical HIV and AIDS care. In Figure 3.5, the results on the ability of the family to provide psychological, social, spiritual and physical HIV and AIDS care was depicted.

The majority of the participants, 52.18%, reported that family members provide psychological, social, spiritual and physical HIV and AIDS care to the patients' family is the most significant component in the care of HIV and AIDS patients. Nurses recognised the importance of building their capacity in this regard as evidenced in one of the themes which emerged both in the clinical survey and the interviews conducted. Family involvement came up in this study as professional nurses claimed that if families understood the dimensions of this pandemic, they would be able to assist the patients in their care.

Table 3-7: Standard/universal precautions to prevent transmission of HIV

Variable	Not answered	Never	Rarely	Sometimes	Most of the time and always
B4. I consistently use standard/universal	2%	1%	4%	3%	90%

precautions to prevent transmission of HIV with patients/clients					

Figure 3.6 presents the use of standard/universal precautions to prevent transmission of HIV.

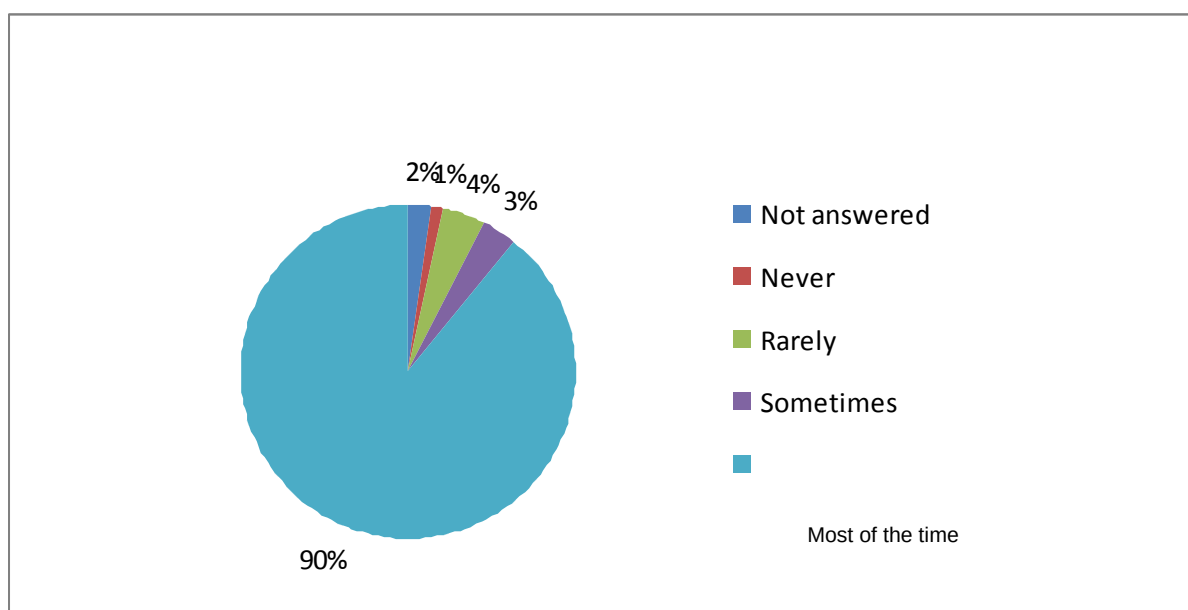


Figure 3-6: Ability to use standard/universal precautions to prevent transmission of HIV and AIDS

Let us now proceed to Figure 3.6, assessment of the ability to use standard/universal precautions to prevent transmission of HIV and AIDS.

An overwhelming majority (90%) of the participants reported they always or most of the time take precautions to use standard precautionary measures to prevent HIV and AIDS transmission, Du Toit, Schutte and de Wet (2003: 65) argue that since all employees in the health sector run the risk of being infected or are living with HIV and AIDS it is important that they should protect themselves and in this case this would mean taking universal precautions in the prevention of transmission of HIV and AIDS. In this regard Dijkstra, Kangazwa, Boer & Kasker (2007:636) indicated that their study participants knew the policies for their own protection.

Table 3-8: Assessment of knowledge of family members to prevent HIV transmission

Variable	Not answered	Never	Rarely	Sometimes	Most of the time and always
B5. I assess knowledge of family members to prevent HIV transmission (from the infected person to other family members) in the home setting	1.72%	7.5%	7.5%	26.04%	57.24%

Figure 3.7 presents the assessment of knowledge of family members to prevent HIV transmission.

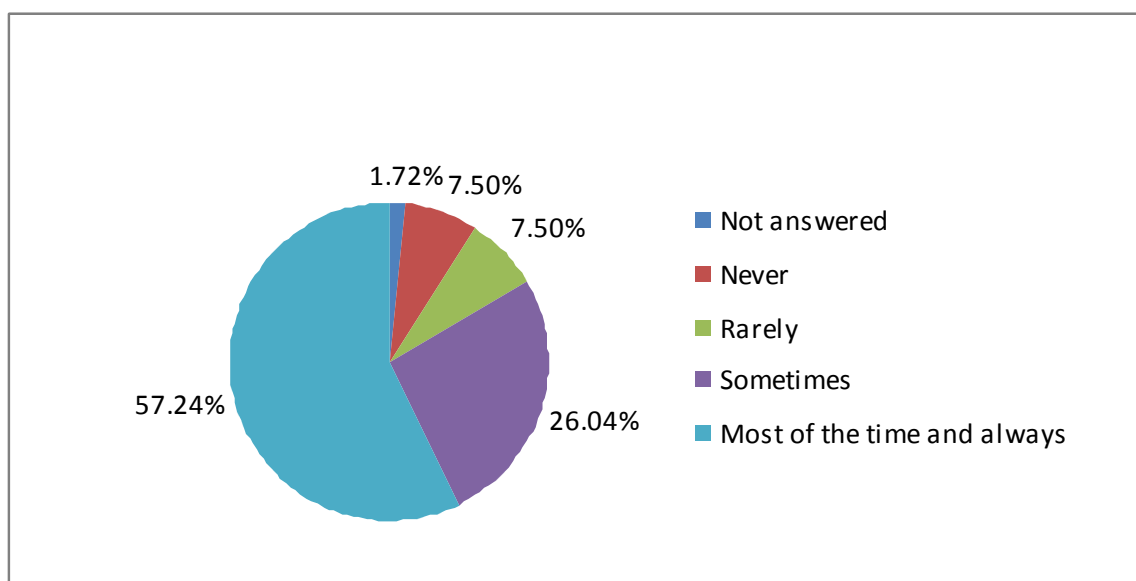


Figure 3-7: Knowledge of family members to prevent HIV and AIDS transmission

A discussion of the knowledge of family members to prevent HIV transmission (from the infected person to other family members) in the home setting will now follow. Figure 3.7 presents a graphic representation from the results of Table 3.8. Gibney, Rabanal, Skalicky, Wand & Dutton (1999:190) focus on four cornerstones of the theory, namely (i) enhancing knowledge of risk prevention (ii) promoting acquisition and proficiency in HIV preventive skills (iii) enhancing self-efficacy, and (iv) fostering protective peer norms. Some of the above constructs were applied to this theory as it relates to risk prevention behaviour.

Risk prevention knowledge in this study will be applied to the evaluation of policies and programmes in HIV and AIDS and a clear understanding of whether or not such policies enhance risk prevention knowledge as expected in general and indicated in the cognitive psychosocial and health behaviour change theory. The example cited by Gibney et al., (1999:190) is that of condom use. In promoting acquisition and proficiency in HIV preventive skills Gibney et al., (1999) state that one of the goals of health promotion intervention is to bring the performance of health behaviours under the control of the individual.

The South African strategic plan focuses primarily on reducing the number of new infections, especially among youth. The strategic plan is built around four care areas, namely (i) prevention; (ii) treatment care and support; (iii) human and legal rights; and (iv) monitoring, research and surveillance. It lays emphasis on effective and culturally appropriate information, education and counselling; increasing access and acceptability of voluntary counselling and testing (VCT); HIV and AIDS care treatment and counselling (HTC), improving the management

of sexually transmitted diseases (STDs) and promoting condom use to reduce STD transmission; and improving the care and treatment of people living with HIV and AIDS (Van Rensburg, 2004:6).

Gibney et al., (1999) also assert that many HIV and AIDS prevention programmes target social competency skills including sexual negotiation, sexual refusal and proper condom use, skills acquisition and proficiency. Reduction of the rate of new infections has been cited in many strategic plans of the Department of Health in South Africa.

One of the goals of health promotion intervention is to bring the performance of health behaviours under the control of the individual. We therefore know that control of the individual goes hand in hand with family involvement. Gibney et al., (1999) also asserts that many HIV and AIDS prevention programmes target social competency skills including sexual negotiation, sexual refusal and proper condom use, skills acquisition and proficiency. Significant others are important in determining sexual behaviour in some families. The use or non-use of condoms, exclusive feeding choices for lactating mothers and other general preventive behaviours are largely dependent on beliefs and practices of the family and folklore. Socially constructed behaviours have a lot to do with HIV and AIDS prevention.

Table 3-9: Assessment of patients/clients with AIDS for opportunistic infections

Variable	Not answered	Never	Rarely	Sometimes	Most of the time and always
B6. I assess patients/clients with AIDS for opportunistic infections	1.7%	4.6%	5.7%	10.9%	76.96%

Figure 3.8 presents the assessment of patients with AIDS for opportunistic infections.

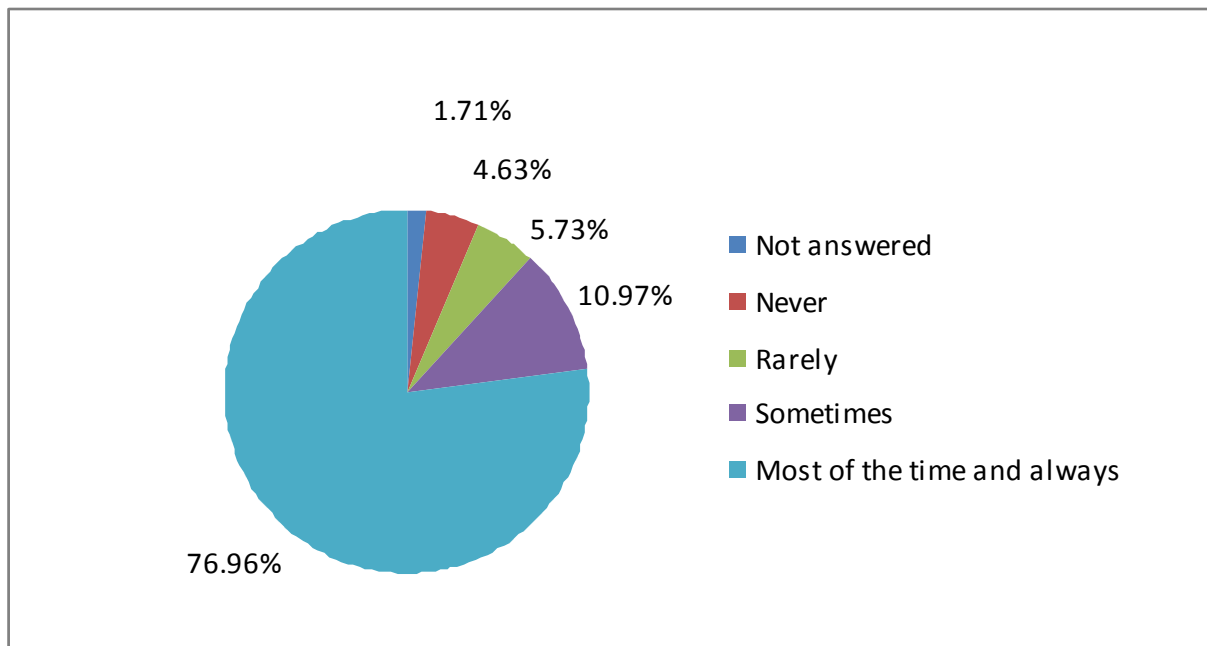


Figure 3-8: Assessment of patients/clients with AIDS for opportunistic infection

We will now proceed to discuss the assessment of patients/clients with HIV opportunistic infections. Assessment of clients for opportunistic infections forms part of a very important aspect of quality care of HIV and AIDS patients. This forms part of the comprehensive care of these patients. The treatment of sexually transmitted infections is done concurrently with assessment of HIV and AIDS and is continued in the routine care of such patients. Pulmonary Carini pneumonia assessment is also done in every paediatric HIV and AIDS care. This is the reason that every professional nurse should be able to perform such assessment. The Health care counselling and treatment HCT campaign also includes the assessment of opportunistic diseases.

More than three-quarters (76.96% of the participants) reported that they always or most of the time assess patients for opportunistic infections. This is an area that needs improvement in spite of the response referred to. Proper assessment of all aspects in HIV and AIDS also contributes to quality of life. Prevention and treatment of opportunistic diseases is another important component for management of HIV-related illnesses. If these conditions are not treated, they can lead to morbidity and mortality of people living with HIV and AIDS. Assessment of patients does not only include assessment of opportunistic infections, but includes other conditions as this is regarded as standard for HIV and AIDS care. Leavitt (2008:159) argues that standard

practice, clinical guidelines and position statements direct the practice of nurses. This simply means that though there are policies, programmes and guidelines for HIV and AIDS care, research should still be conducted to support these.

We will now discuss family needs related to HIV and AIDS. Thereafter we will present the results thereof graphically.

Table 3-10: Assessment of the family needs related to AIDS care

Variable	Not answered	Never	Rarely	Sometimes	Most of the time and always
B7. I assess the family health needs related to AIDS care	2.3%	10.89%	8.59%	26.27%	51.95%

Figure 3.9 presents a graph on assessment of family needs related to AIDS care.

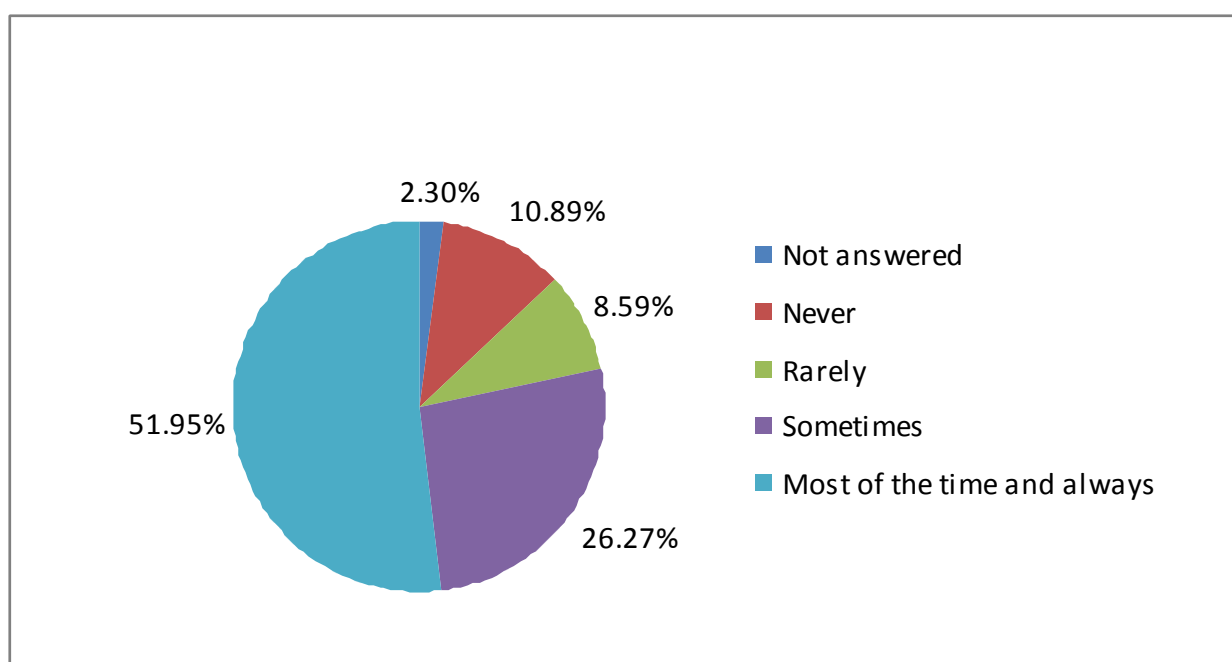


Figure 3-9: Assessment of the family needs related to AIDS care

More than half (51.95%) of the participants affirmed that they most of the time and always assess family health-related needs. The issue of the importance of family involvement has been

discussed in item B3 and item B5 and responses to these items are represented graphically in Figures 3.3 and 3.7 respectively.

Table 3-11: Appropriate referral of undiagnosed patients for voluntary HIV testing

Variable	Not answered	Never	Rarely	Sometimes	Most of the time and always
B8. I appropriately refer undiagnosed patients for voluntary HIV testing and counselling	2.3%	7.41%	8.02%	13.13%	69.14%

Figure 3.10 presents referring of undiagnosed patients for voluntary HIV testing and counselling and is a graphic representation of the results in table 3.11.

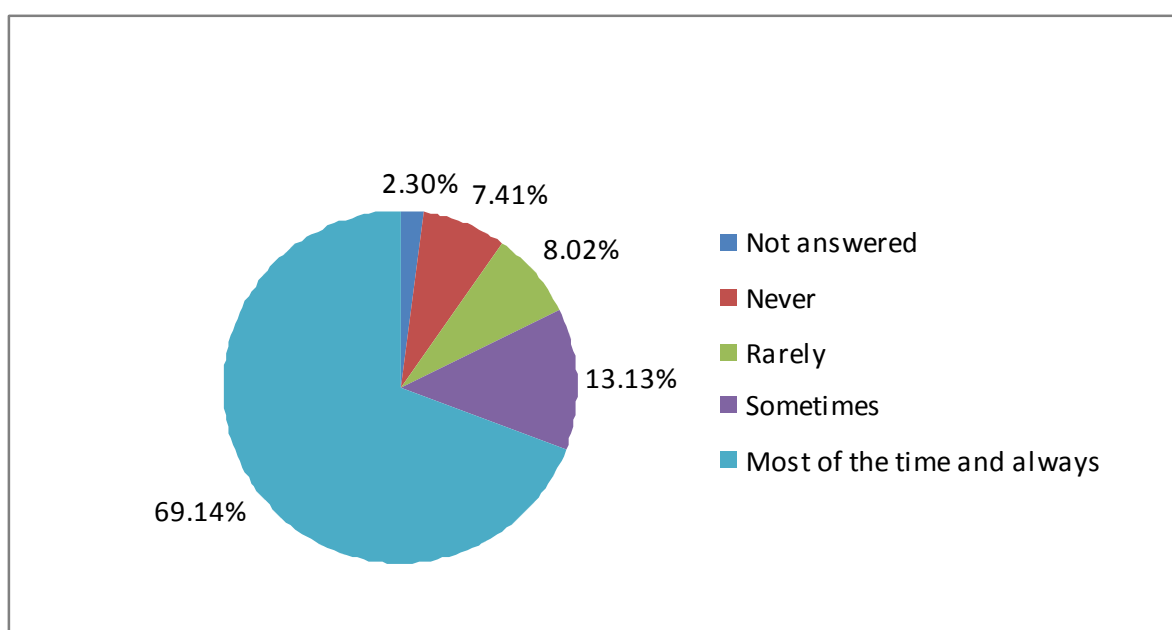


Figure 3-10: Referring undiagnosed patients for voluntary testing and counselling

As mentioned in Chapters One and Five, voluntary counselling is now done only with clients requesting this service as HTC replaced this. In terms of the HTC every person who presents herself to the health care service for any other service is counselled and assessed for HIV. Campaigns are also carried out in this regard.

Almost three-quarters (69.14%) of the participants always and most of the time refer clients/patients for voluntary counselling. This percentage is above average as indicated in the introduction to the discussion of the results and therefore confirms that professional nurses' function in this regard is appropriate.

Table 3.12 presents appropriate referral of AIDS patients for additional services.

Table 3-12: Appropriate referral of AIDS patients for additional services

Variable	Not answered	Never	Rarely	Sometimes	Most of the time and always
B9. I appropriately refer AIDS patients for additional services (e.g. nutritional, social) within my health care organization	2.3%	8.59%	9.69%	18.88%	60.54%

Figure 3.11 displays referring of patients for additional services within the organisation.

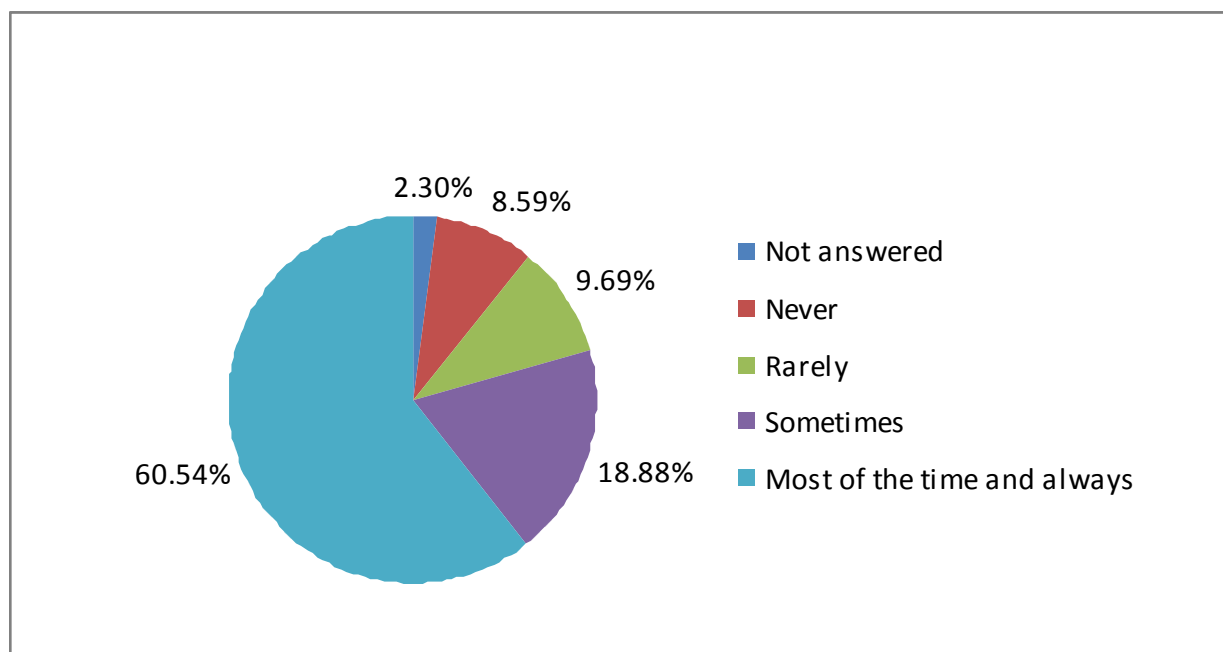


Figure 3-11: Referring patients for additional services within the organisation

Almost two-thirds (60.54%) of participants always and most of the time refer patients within the healthcare system for appropriate care. This item is almost similar to the pattern in Figure 3.10, referring undiagnosed patients for voluntary counselling. In the case of Figure 3.11 the item indicates referral for diagnosis, and as mentioned in the results of item Figure 3.11, the South African health care system has now changed to the notion of HIV and AIDS care treatment and counselling (HTC). Testing of clients is done in each facility as they come for treatment other than HIV and AIDS. This now facilitates treating clients without referral to other centres. It is encouraging that 69.14% of participants referred patients appropriately and later took part in HTC campaigns.

Table 3-13: Referring of patients for additional services within the organisation

Variable	Not answered	Never	Rarely	Some-times	Most of the time and always
B10. Do you refer patients for additional services within your organisation?	3.4%	16.62%	13.71%	25.7%	40.54%

Figure 3.12 is about appropriate referral AIDS patients for additional services e.g. nutritional and social service.

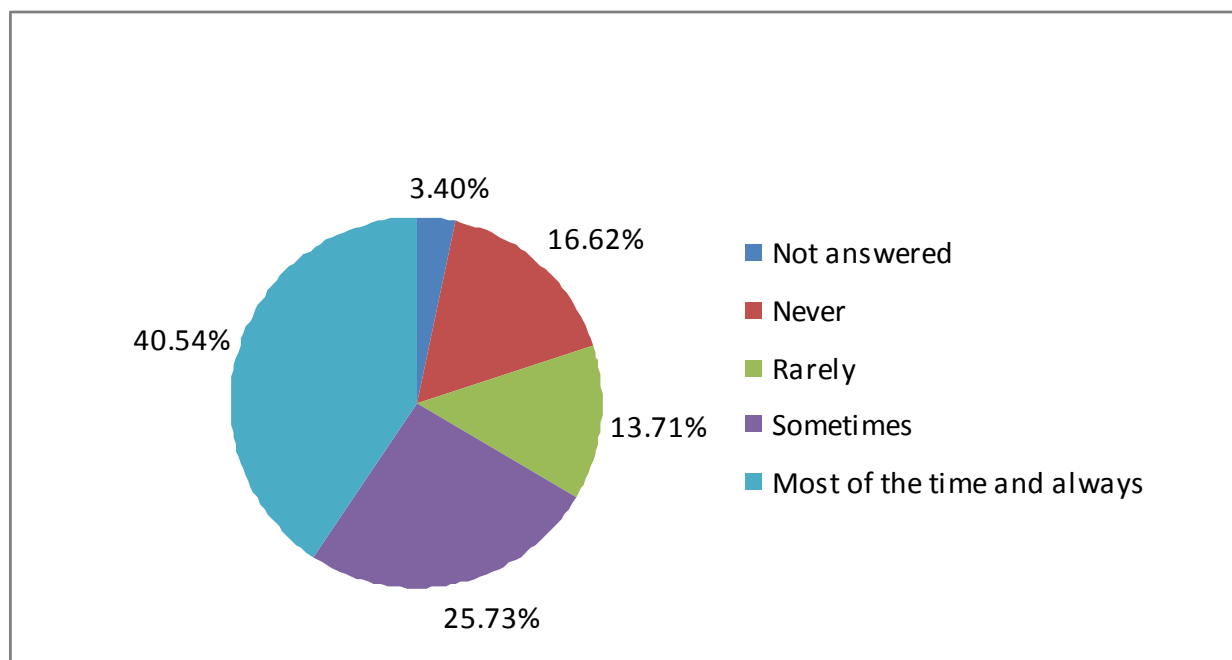


Figure 3-12: Appropriate referral of AIDS patients for additional services

More than a third (40.54%) of participants refer patients for additional services. This percentage is very low as the questionnaire stated that these services are outside the health sector. Therefore this might have caused some confusion in this regard as these services in South Africa are within the health sector.

Table 3-14: Appropriate referral of family members of patients for voluntary testing

Variable	Not answered	Never	Rarely	Sometimes	Most of the time and always
B11. I appropriately refer family members of patients for voluntary HIV testing and counselling	2.3%	13.71%	9.11%	29.13%	45.75%

Figure 3.13 presents appropriate referral of family members of patients for voluntary testing.

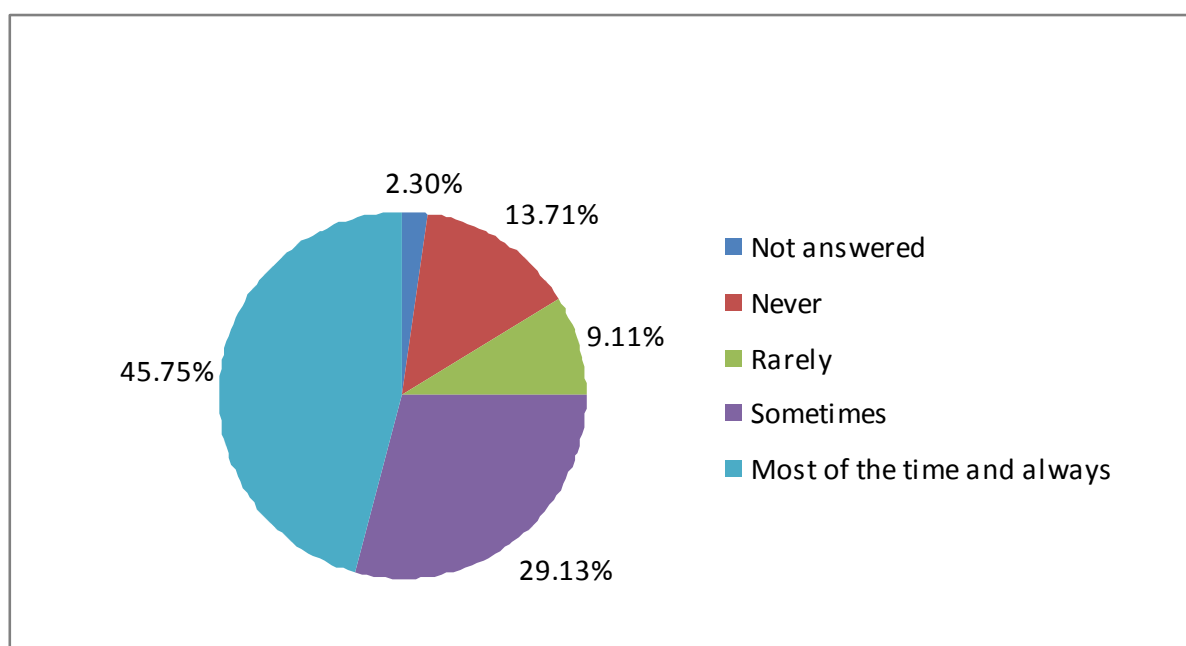


Figure 3-13: Referral of family members for voluntary HIV counselling

As explained under Figure 3.11 VCT has been replaced by HTC. But at the time when this was still done, during data collection in this study, 47.75% of the participants referred patients for voluntary counselling. This percentage is low because at the time of data collection, there was a transition towards HTC.

Table 3-15: Monitoring side effects and assessing ARV treatment in patients

Variable	Not answered	Never	Rarely	Sometimes	Most of the time and always
B12. I monitor (e.g. watch for side effects, assess adherence) anti-retroviral treatment in my patients with AIDS	2.9%	8.6%	8%	18.7%	42.9%

Figure 3.14 presents results on monitoring of adherence and watch for side effects of antiretroviral treatment.

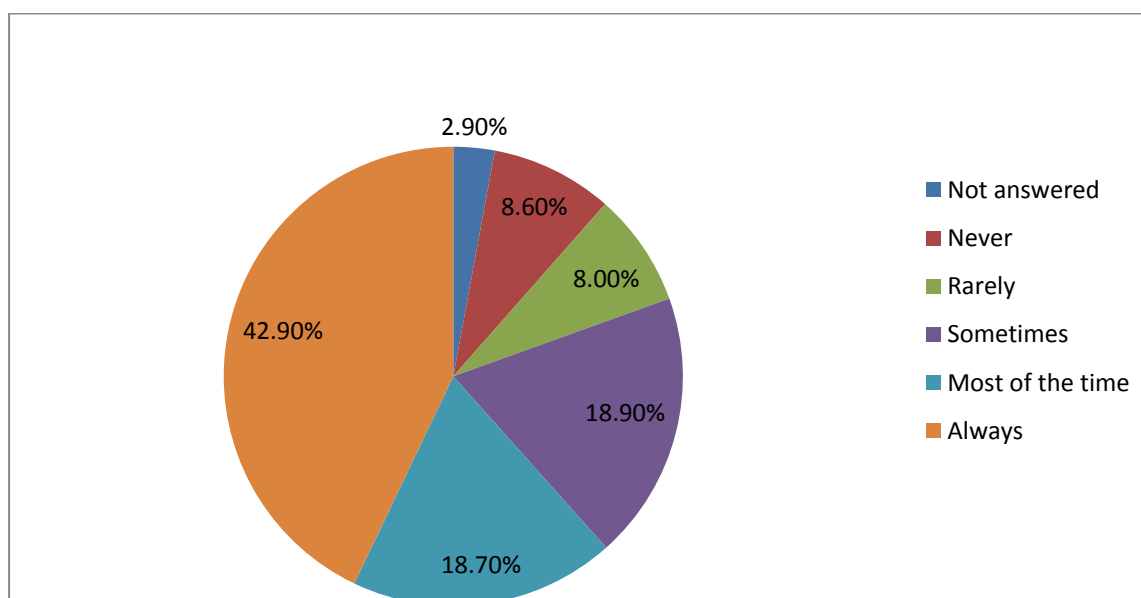


Figure 3-14: Monitoring of adherence and watching for side effects of antiretroviral treatment

42.9% of participants always assess side effects of antiretroviral treatment appropriately. This also confirms that the care given to such patients is appropriate. Assessment of patients for side effects of any medication which they take, whether prescribed not prescribed, is one of the important nursing care interventions in their scope of function.

Table 3-16: Participation in research related to HIV AND AIDS or ARV's

Variable	Not answered	Never	Rarely	Sometimes	Most of the time and always
B13. I actively participate in research related to HIV, AIDS, and/or antiretroviral treatment	3.4%	43.3%	13.1%	20%	13.10%

Figure 3.15 presents participation in research in related to HIV and AIDS or ARV Treatment.

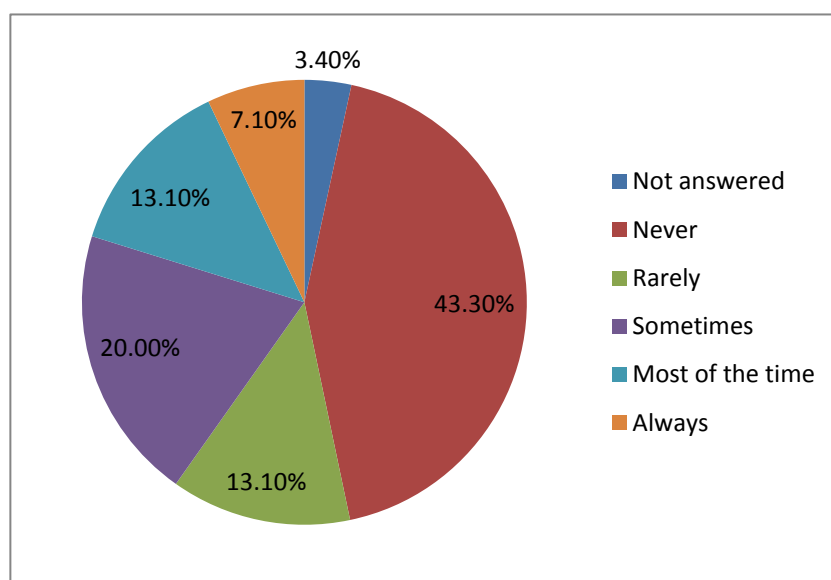


Figure 3-15: Participation in research related to HIV and AIDS or ARV treatment

Less than a quarter (20%) of participants reported that they participated in research related to HIV and AIDS and antiretroviral therapy, however, research is lacking as 43.3% never or rarely participate in research related to HIV and AIDS. In this regard Milner, Estabrook and Humphrey (2005:899) confirmed that there is a lack of research as far as clinical nurses are concerned. This according to the above authors constitutes a theory- practice gap which in their opinion is a social construction rather than a reality as nurses think that practical knowledge and research knowledge follow their own logic. There is an argument in the Canadian Nurse Newsletter (2006, vol. 102 (18) that conducting research in the profession is important in order to understand what creates inequities especially in policy and other social constructs.

Section B of the clinical survey has been dealt with and as it was explained in Paragraph 3.3 of this chapter, Section C of the clinical survey contains the same items as Section B, but in this section, participants have to report about their colleagues.

Table 3.17 presents the results of Section C of the clinical survey: Assessment and clinical management of HIV and AIDS (other nurses).

Table 3-17: Assessment and clinical management of HIV and AIDS (other nurses)

Variable	Not reported	Never	Rarely	Sometimes	Most of the time and always
C1. Nurses and midwives assess patients'/clients' physical, social, emotional, psychological, and spiritual needs in relation to HIV AND AIDS	3%	4%	6%	11%	76%

Figure 3.16 displays the results in the form of a graph.

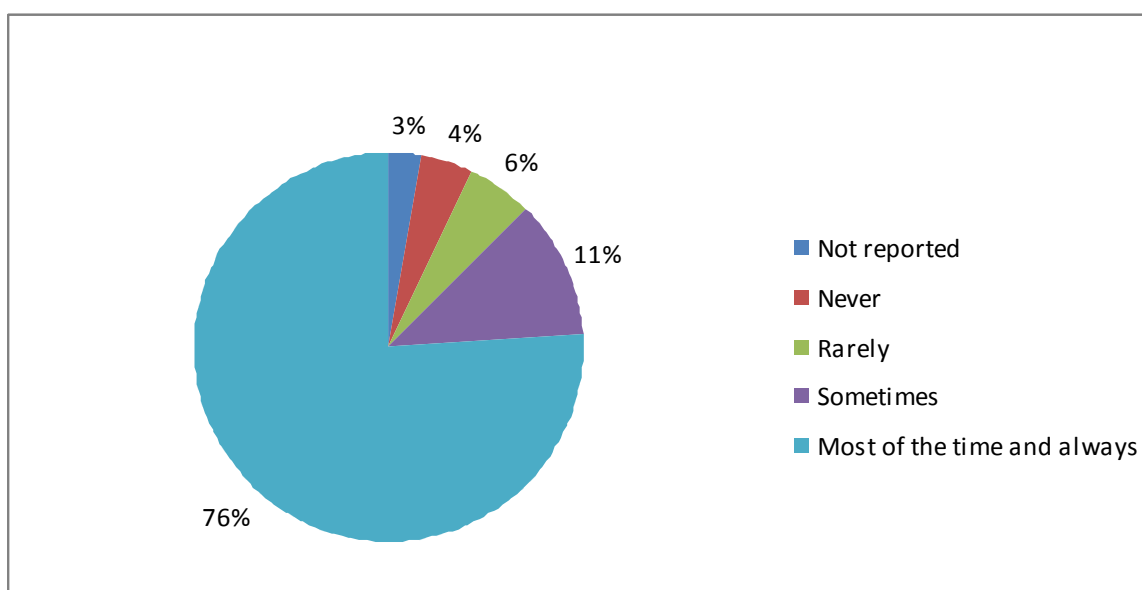


Figure 3-16: Assessment of clients' physical; emotional social psychological and spiritual needs by other nurses

More than three-quarters (76%) of participants reported that their colleagues assess clients' physical, emotional, social psychological and spiritual needs. This is important as the emotional, social and spiritual aspects affect the physical health of a person.

Table 3-18: Assessment of patients' comfort in disclosing their status (other nurses)

Variable	Not reported	Never	Rarely	Sometimes	Most of the time and always
C2. Nurses and midwives assess their patients'/clients' comfort in disclosing his/her HIV status to family members	3%	4%	10%	18%	65%

Figure 3.17 displays the results of assessments of patients' comfort in disclosing their HIV status by other nurses.

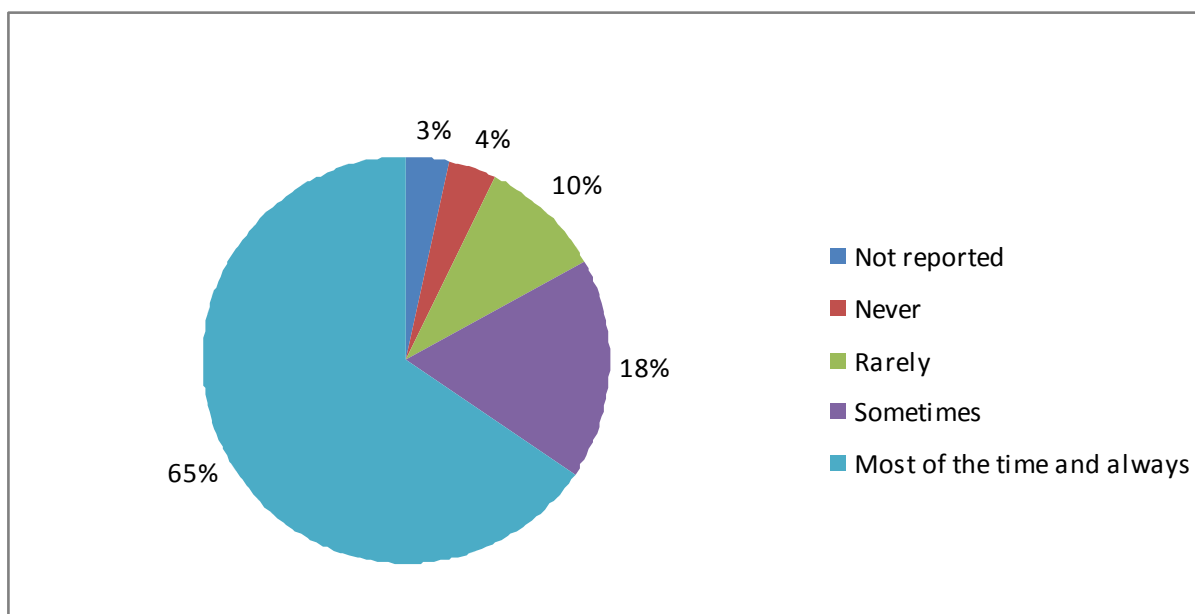


Figure 3-17: Assessments of patients' comfort in disclosing their HIV status by other nurses

Almost two-thirds (65%) of participants reported that their colleagues assess patients' comfort in disclosing their HIV status. This according to participants in the results discussed in Chapter Four of this thesis is very important as it may contribute to reduction of the disease.

Table 3-19: Assessment of the family's ability to provide care (other nurses)

Variable	Not reported	Never	Rarely	Sometimes	Most of the time and always
C3. Nurses and midwives assess the family's ability to provide care (physical, social, emotional, psychological and spiritual) for the family member with HIV or AIDS	2%	5%	7%	21%	65%

Figure 3.18 presents assessment of family's ability to provide physical, emotional, social and spiritual care.

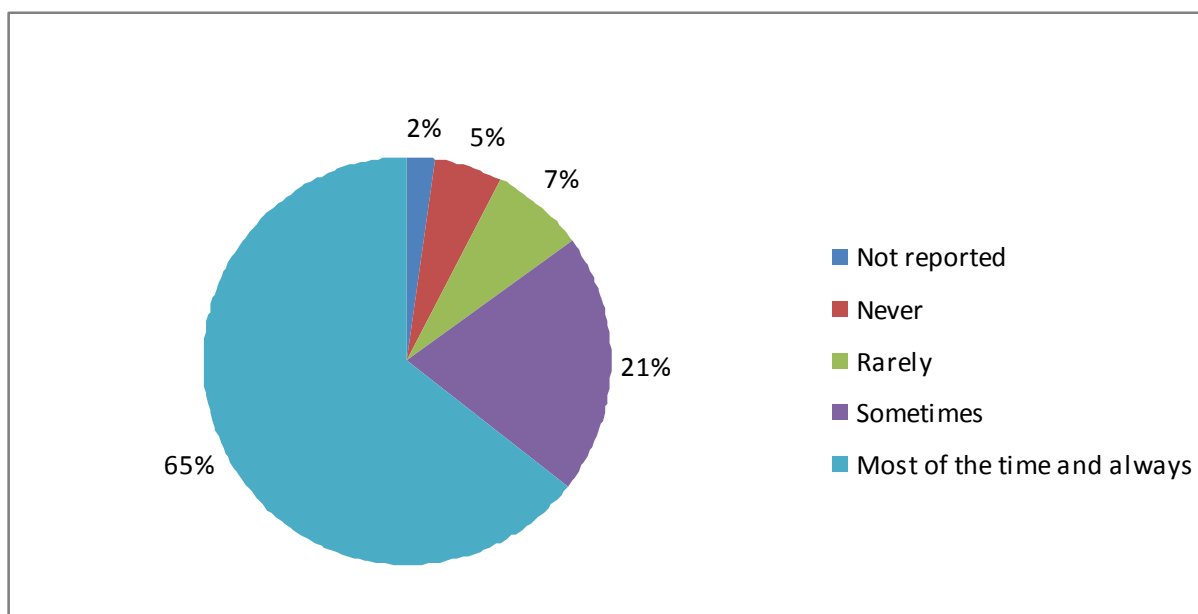


Figure 3-18: Assessment of family's ability to provide physical, emotional, social and spiritual care by other nurses

Almost two-thirds (65%) of the participants reported that their colleagues sometimes and always assess the family's ability to provide care whilst 5% never assess families in this regard. This is a high percentage which shows involvement of families in the care of HIV and AIDS patients. The United Nations declaration on HIV and AIDS (2006) affirmed that involvement of families in HIV and AIDS care is important.

Table 3-20: Use of standard/universal precautions to prevent transmission of HIV (other nurses)

Variable	Not reported	Never	Rarely	Sometimes	Most of the time and always
C4. Nurses and midwives consistently use standard/universal precautions to prevent transmission of HIV with patients/clients	2%	2%	3%	8%	85%

Figure 3.19 presents the results on consisted use of universal standards to prevent transmission by other nurses.

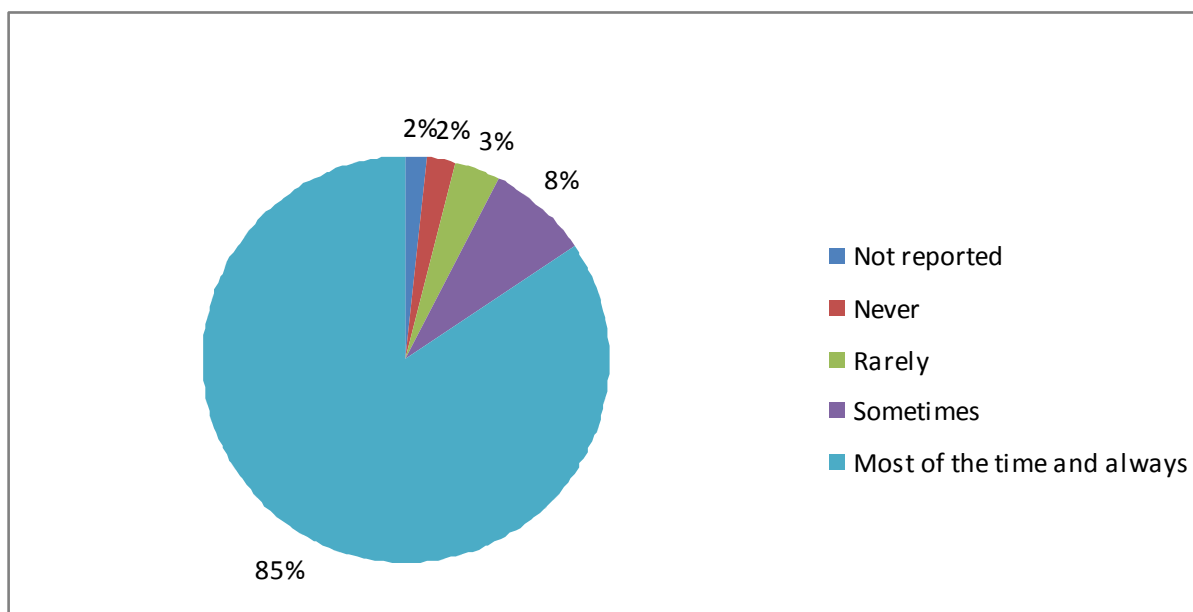


Figure 3-19: Universal standards to prevent transmission of HIV other nurses

An overwhelming majority (85%) of the participants reported that their colleagues use universal precautions to prevent transmission of HIV. This is a positive response as it shows adherence to universal precautions.

Table 3-21: Prevention of the transmission from the infected person to other family members

Variable	Not reported	Never	Rarely	Sometimes	Most of the time and always
C5. Nurses and midwives assess knowledge of family members to prevent HIV transmission (from the infected person to other family members) in the home setting	1%	6%	9%	15%	69%

Figure 3.20 presents results on assessment of knowledge of family members to prevent transmission of HIV from one family member to another.

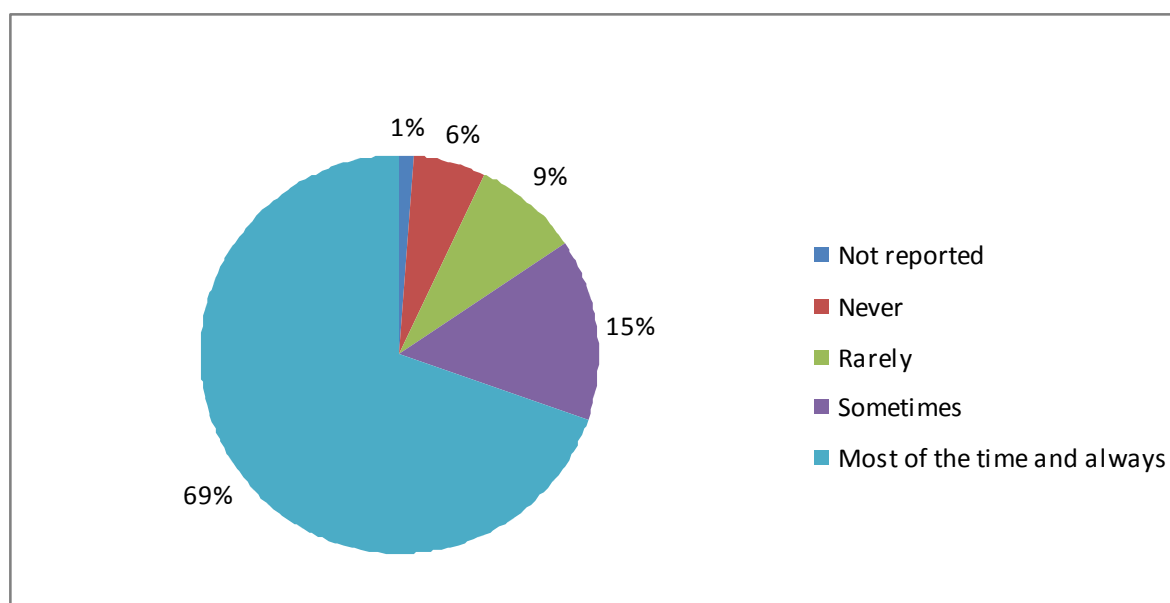


Figure 3-20: Assessment of knowledge of family members to prevent transmission of HIV from one family member to another

More than two-thirds (69%) of participants reported that their colleagues assess the knowledge of family members to prevent transmission of HIV from one family member to another. A positive response to this item shows that reduction of new infections is adhered to.

Table 3-22: Assessment of opportunistic infections

Variable	Not reported	Never	Rarely	Sometimes	Most of the time and always
C6. Nurses and midwives assess patients/clients with AIDS for opportunistic infections	3%	3%	5%	11%	78%

Figure 3.21 presents the results of assessment of opportunistic infections by nurses/midwives.

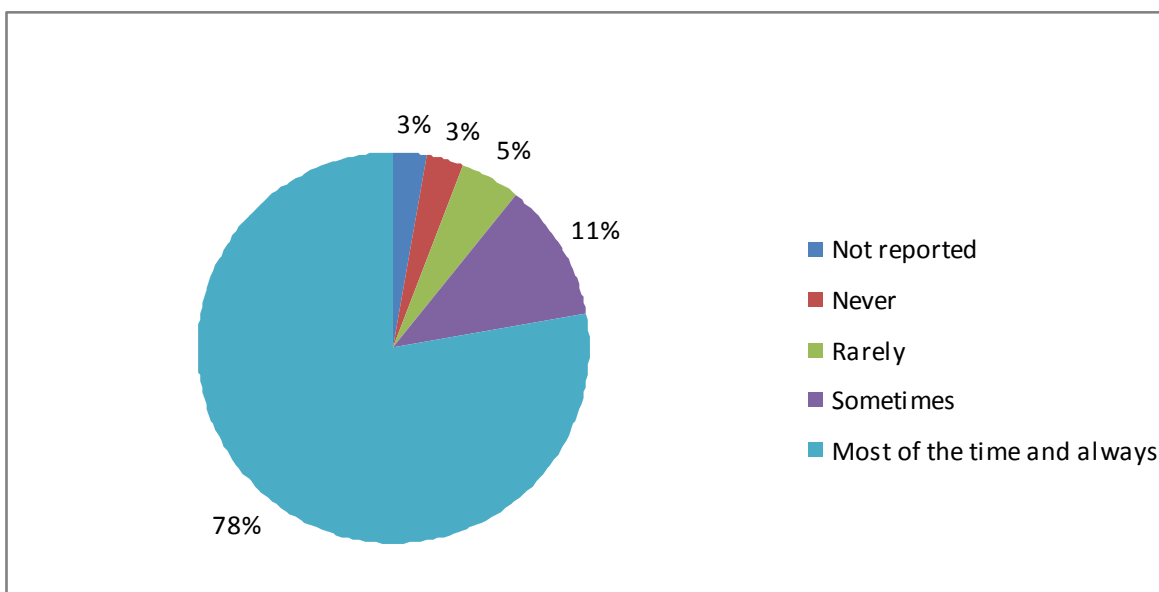


Figure 3-21: Assessment of opportunistic infections by nurses/midwives

The majority (78%) of the participants reported that their colleagues assess opportunistic diseases and this indicates a positive response to this variable. This is congruent with holistic care of the patients and prevention of HIV and AIDS complications. Refer to table 3.23 for the assessment of the family health needs related to AIDS care.

Table 3-23: Assessment of the family health needs related to AIDS care

Variable	Not reported	Never	Rarely	Sometimes	Most of the time and always
C7. Nurses and midwives assess the family health needs related to AIDS care	2%	7%	13%	22%	56%

Figure 3.22 presents assessment of the family health needs related to AIDS care.

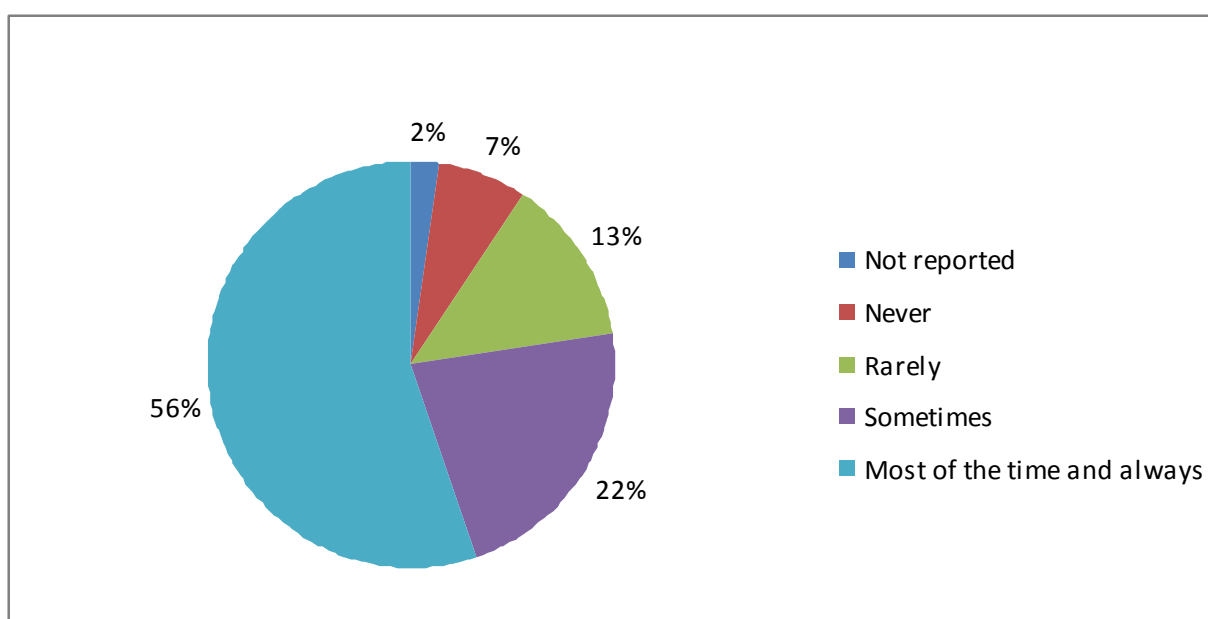


Figure 3-22: Assessment of the family health needs related to AIDS care

More than half (56%) of the participants reported that their colleagues sometimes and always assess the family health needs related to AIDS care. This percentage is average and probably increased at the time of reporting these results as there are many improvements in HIV programmes.

Table 3-24: Appropriate referral of undiagnosed patients for voluntary testing and counselling (other nurses)

Variable	Not reported	Never	Rarely	Sometimes	Most of the time and always
C8. Nurses and midwives appropriately refer undiagnosed patients for voluntary HIV testing and counselling	4%	4%	7%	22%	63%

Figure 3.23 presents appropriate referral of undiagnosed patients for voluntary HIV testing and counselling by nurses and midwives.

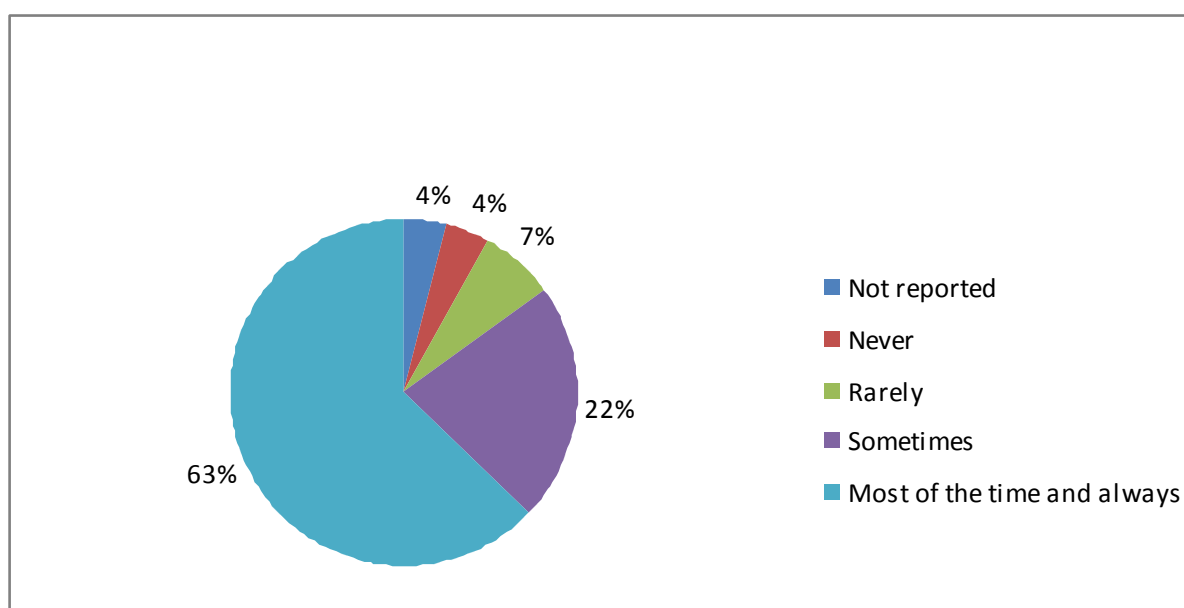


Figure 3-23: Appropriate referral of undiagnosed patients for voluntary HIV testing and counselling by other nurses

Almost two-thirds (63%) of participants reported that their colleagues appropriately refer undiagnosed patients for voluntary for HIV testing and counselling most of the time and always. This item shows adherence to VCT principles though this has been replaced by HTC at the time of reporting the findings of this data. Please see Table 3.25 for appropriate referral of AIDS patients for additional service (other nurses).

Table 3-25: Appropriate referral of AIDS patients for additional service (other nurses)

Variable	Not reported	Never	Rarely	Sometimes	Most of the time and always
C9. Nurses and midwives appropriately refer AIDS patients for additional services (e.g. nutritional, social) within our health care organization	3%	5%	9%	17%	66%

Figure 3.24 presents appropriate referral of AIDS patients for additional service by other nurses.

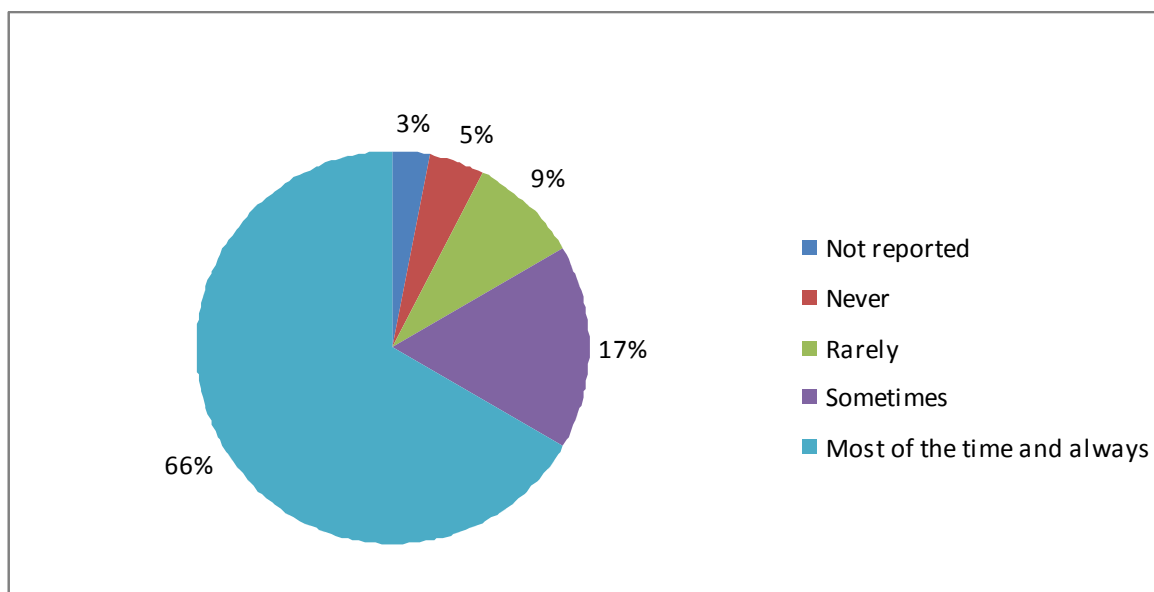


Figure 3-24: Appropriate referral of aids patients for additional service by other nurses

Almost two-thirds (66%) of participants reported that most of the time and always their colleagues refer patients for additional services within the organisation by other nurses. This response is positive and indicates observance of quality HIV and AIDS care.

Table 3-26: Appropriate referral family members of patients for voluntary HIV testing and counselling (other nurses)

Variable	Not reported	Never	Rarely	Sometimes	Most of the time and always
C11.Nurses and midwives appropriately refer family members of patients for voluntary HIV testing and counselling	3%	9%	12%	26%	50%

Figure 3.25 presents appropriate referral of AIDS patients outside the organisation by other nurses.

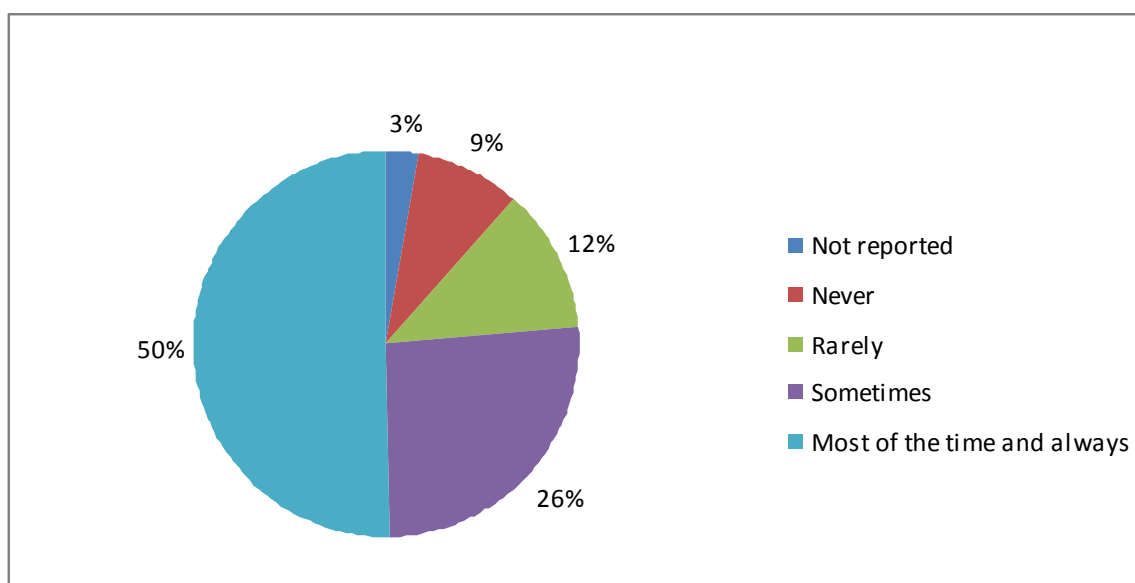


Figure 3-25: Appropriate referral of aids patients outside the organisation by other nurses

Half (50%) of the participants reported that nurses and midwives most of the time and always refer patients for additional services outside the organisation. This implies that holistic care is offered to HIV and AIDS patients. Patients might be referred for social care services e.g. pension grant, if such an individual's health warrants it.

Table 3-27: Monitoring of side effects of ARVs on patients with AIDS

Variable	Not reported	Never	Rarely	Sometimes	Most of the time and always
C13. Monitoring side effects of ARVs of patients with AIDS	2%	3%	7%	13%	75%

Figure 3.26 Presents monitoring of side effects of side effects of ARVs for patients with

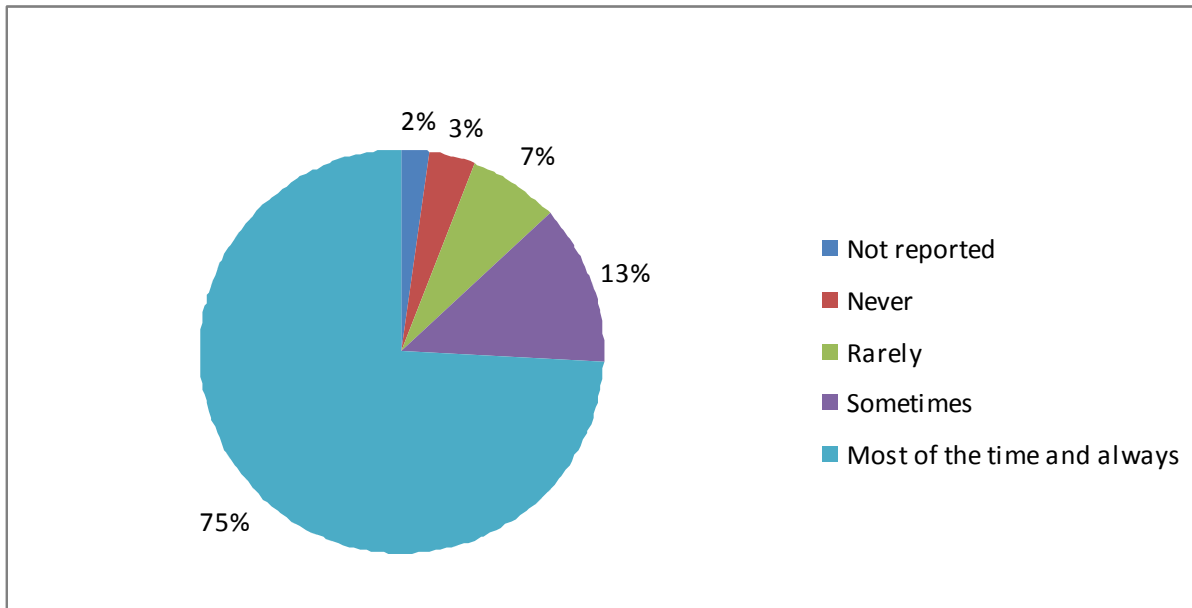


Figure 3-26: Monitoring of side effects of ARVS for patients with AIDS

Three-quarters (75 %) of the participants reported that their colleagues most of the time and always monitor side effects of ARVs for patients with AIDS. This also confirms that the care given to such patients is appropriate. Though they reported that the research component is 34.3% there is a perceived need for research capacity amongst nurses as they reported a negative response to this item. Makoroka (2014:9-7) argue that transforming research into practice is important as health service planners, decision makers and clinical nurses use the results thereof in clinical practice. The results on stigma in Figure 3.12 is a continuation of Phase One Objective One results.

Table 3.6 displays results on HIV and AIDS stigma. In this study a high percentage of participants reported never having acted in a way that stigmatizes HIV and AIDS patients and they are never stigmatized for nursing such patients. A narrative will follow immediately after Table 3.6 and no graphical representation will be done as the denominator is a positive confirmation of non-stigmatization and there are no differences in results.

- **HIV and AIDS and Stigma**

It is therefore concluded that stigma is a factor that results in patients seeking medical help late in the progress of the disease and consequently adds a greater burden to the work of the nurses. Having discussed the clinical management of HIV and AIDS patients and the effect of stigma and the prevention, care and treatment of HIV and AIDS, examining the workload of

professional nurses per facility is now embarked upon. This is therefore checked against the number of nurses in that particular facility. Table 3.28 presents the results of the number of patients per facility per shift.

Table 3-28: Provision of care

Variable	Not reported	Never	Once or twice	Several times	Most of the time
F1 .A nurse provided poorer quality care to an HIV AND AIDS patient than to other patients	2.3%	77.7%	14.3%	5.7%	0.6%

Figure 3.27 presents provision of care.

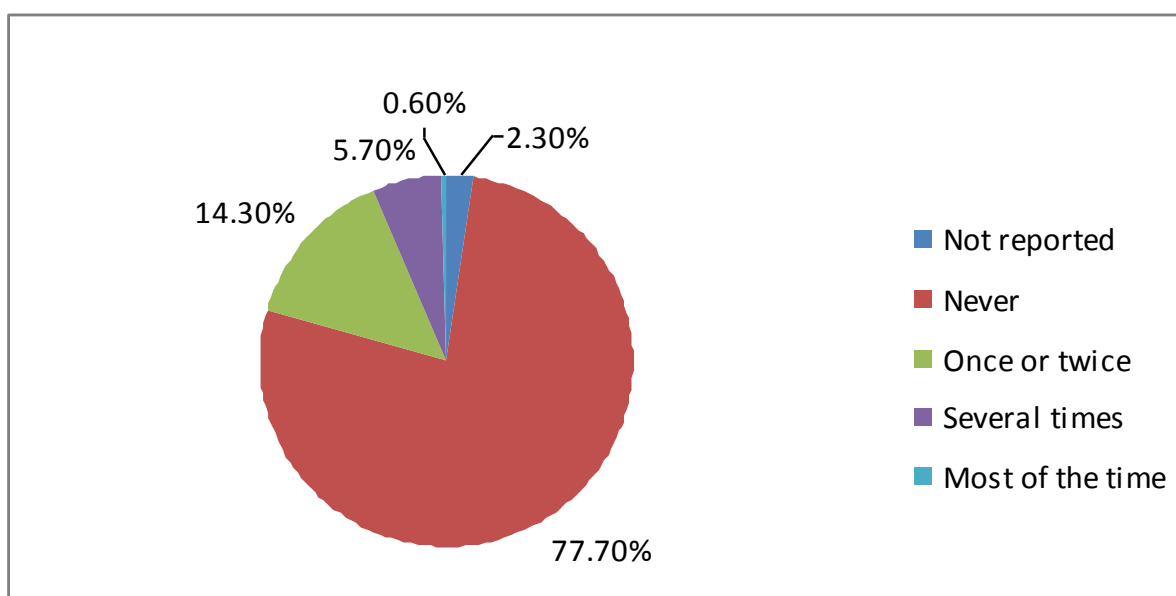


Figure 3-27: Provision of care

More than three-quarters (77, 7%) of participants never provided poor care to an HIV and AIDS patient. This indicates that quality care is provided to HIV and AIDS patients. No stigma is levelled against these patients. This is an indication that nurses in the Free State don't stigmatize HIV and AIDS patients. Though the stigma is not levelled against patients by nurses, it still increases the burden of HIV and AIDS as infected people visit the health care facilities late in the progression of the disease due to the fear of being stigmatized by other people rather than nurses. This is the reason that stigma is regarded as an important issue to be considered in HIV and AIDS care, research and policy interface.

Table 3-29: Behaviour towards HIV and AIDS patients

Variable	Not reported	Never	Once or twice	Several times	Most of the time
F2. A nurse shouted at or scolded an HIV and AIDS patient	2.3%	86.3%	8.0%	2.3%	0.6%

Figure 3.28 presents behaviour towards HIV and AIDS patients.

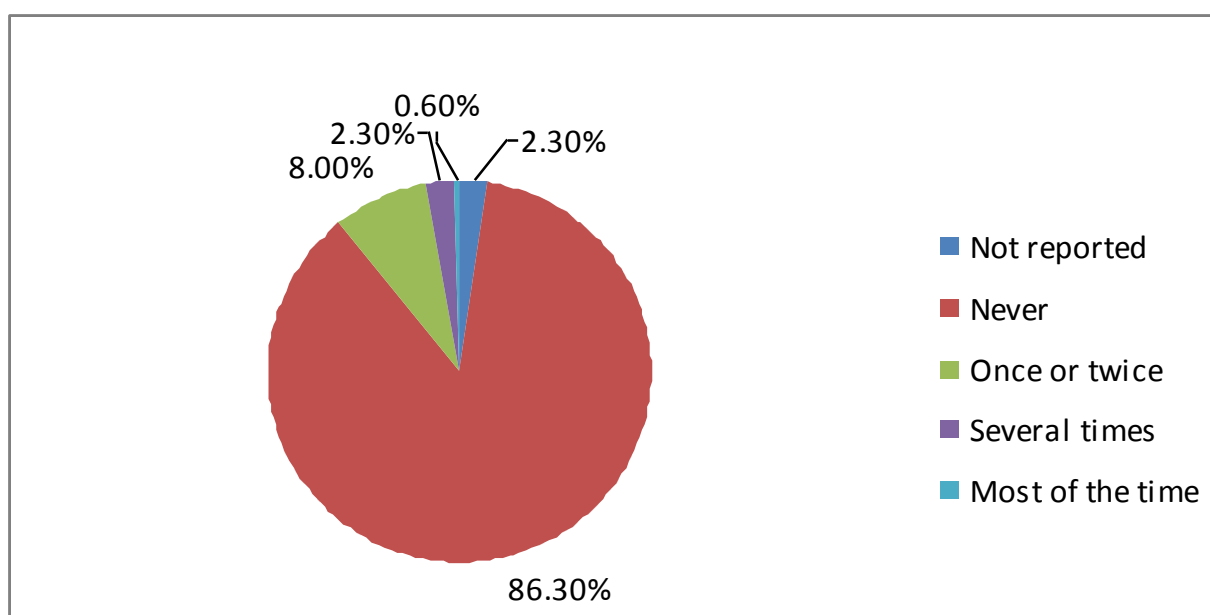


Figure 3-28: Behaviour towards HIV and AIDS patients

The majority (86.3%) of nurses never shouted at patients which shows non- discrimination against such patients. This item according to the results of this study shows a positive response to such patients, though most of the literature reports contradict it in this regard. Muhomba, (2007:62) describes HIV and AIDS related stigma as attitudes, behaviours, beliefs and policies, directed towards HIV and AIDS individuals due to their HIV status. In this study stigma is viewed as a barrier (in Chapter Four, interview data) against receiving proper care.

Table 3-30: Keeping distance in caring for an HIV AND AIDS patient

Variable	Not reported	Never	Once or twice	Several times	Most of the time
F3. A nurse kept her distance when talking to an HIV and AIDS patient	1.70%	90.30%	5.10%	2.30%	0.60%

Figure 3.29 presents results section F3 - Keeping distance in caring for an HIV and AIDS patient.

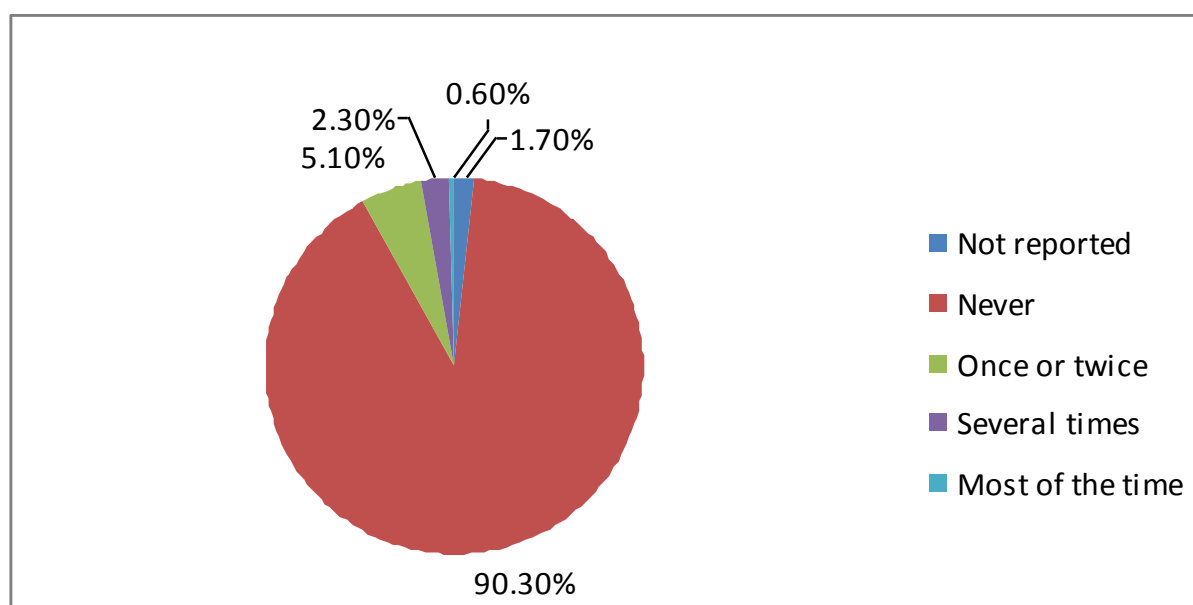


Figure 3-29: Keeping distance in caring for an HIV and AIDS patient

In the case of this study distance may be kept by a person who does not want to be near an individual for fear of contamination by a disease. People might be negated if they are marked or regarded as having a tarnished character. Liamputtong (2013:42-48) entails an act that constitutes severe disapproval from society for behaviour that is considered to be beyond the bounds of social norms. Nurses in the case of this study don't ostracize HIV and AIDS patients.

Table 3-31: Management of physical pain experienced by HIV and AIDS patients

Variable	Not reported	Never	Once or twice	Several times	Most of the time
F4. A nurse ignored the physical pain of an HIV and AIDS patient	5.7%	84.6%	9.1%	0.6%	0%

Figure 3.30 presents management of physical pain experienced by HIV and AIDS patients.

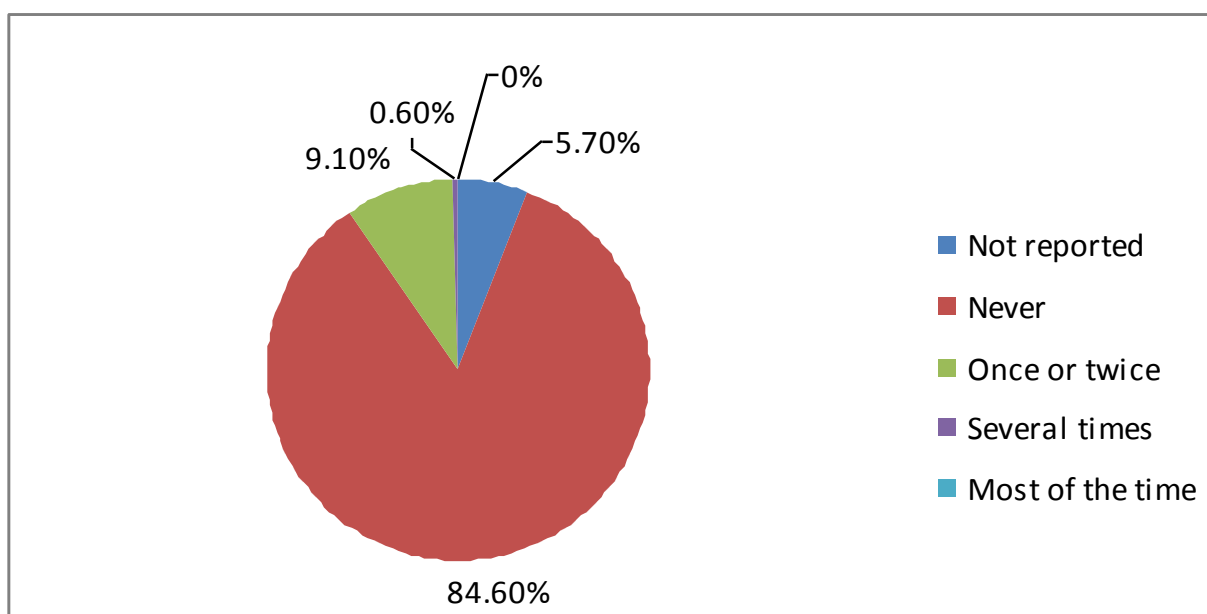


Figure 3-30: Management of physical pain experienced by HIV and AIDS patients

Almost eighty five per cent (84.6%) of participants reported that they never ignored the physical pain of an HIV infected patient. This is a confirmation of non-discrimination. Though amongst the communities as reported by Greeff et al., (2008:10) three forms of stigma still exist: Labelling: when people at the advanced stage of the disease are labelled because of the signs they manifest. Silence and secrecy: the stigmatised person becomes silent and isolates him/herself due to fear of being stigmatised.

Table 3-32: Refusal to feed HIV and AIDS patients

Variable	Not reported	Never	Once or twice	Several times	Most of the time
F5.A nurse refused to feed an HIV and AIDS patient	0.6%	85.1 %	1.7%	1.1%	1%

Figure 3.31 presents behaviour towards patients.

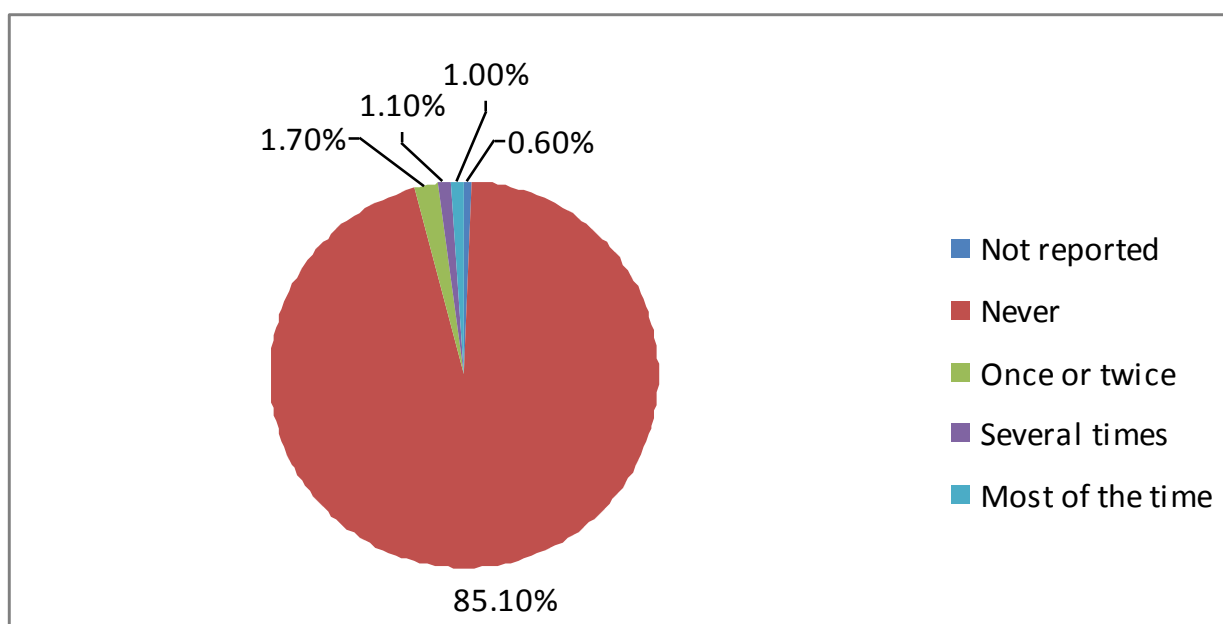


Figure 3-31: Refusal of to feed HIV and AIDS patients

By far the most participants (85.1%) reported never to have seen nurses refusing to feed HIV and AIDS patients. The nutritional status of an HIV and AIDS individual needs to be boosted with vitamins and other nutritional supplements as these people tend to be lethargic.

Table 3-33: Management of conditions of HIV and AIDS patients in the ward

Variable	Not reported	Never	Once or twice	Several times	Most of the time
F6. A nurse did not check the condition of her HIV and AIDS patient in the unit/ward	7.4%	82.9%	7.4%	1.1%	1.1%

Figure 3.32 Presents management of conditions of HIV and AIDS patients in the ward.

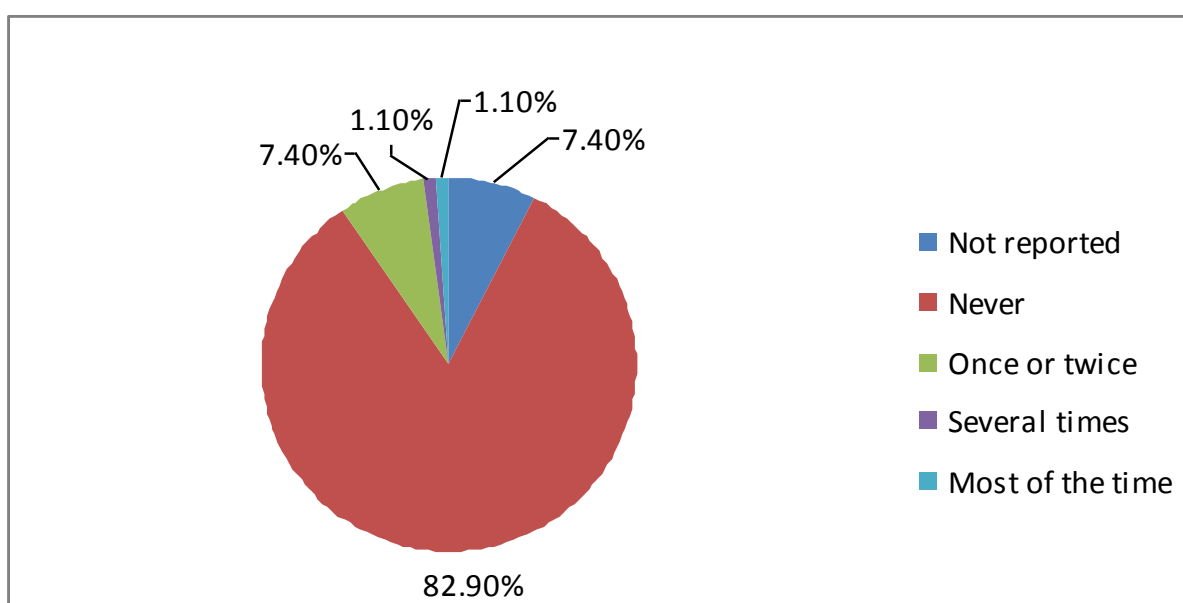


Figure 3-32: Management of conditions of HIV and AIDS patients in the ward

82.9% of participants reported that they have never refused to check the condition of an HIV and AIDS in the unit or ward. This is a confirmation that the perception of HIV and AIDS is improving generally as at the beginning, this disease these individuals were discouraged to seek help and to access resources, as they might have to disclose their status. This is also aggravated by the fact that people feel guilty that they acquired the virus. Disclosure issues appear to affect this type of stigma. On the other hand Muhomba (2007:64) discusses external stigma as experienced by the HIV-infected individuals from the outside world, including their families. This kind of stigma may include oppression, isolation, discrimination, harassment, categorizing, accusation, punishment, blame, exclusion and ridicule based on perceived or actual HIV positive status.

Table 3-34: Behaviour of nurses with regard to waiting time of an HIV and AIDS patient as opposed to others

Variable	Not reported	Never	Once or twice	Several times	Most of the time
F7. A nurse made an HIV and AIDS patient wait until last for care	4%	88%	5.1%	2.3%	0.6%

Figure 3.33 presents the behaviour of nurses with regard to waiting time of an HIV and AIDS patient as opposed to others

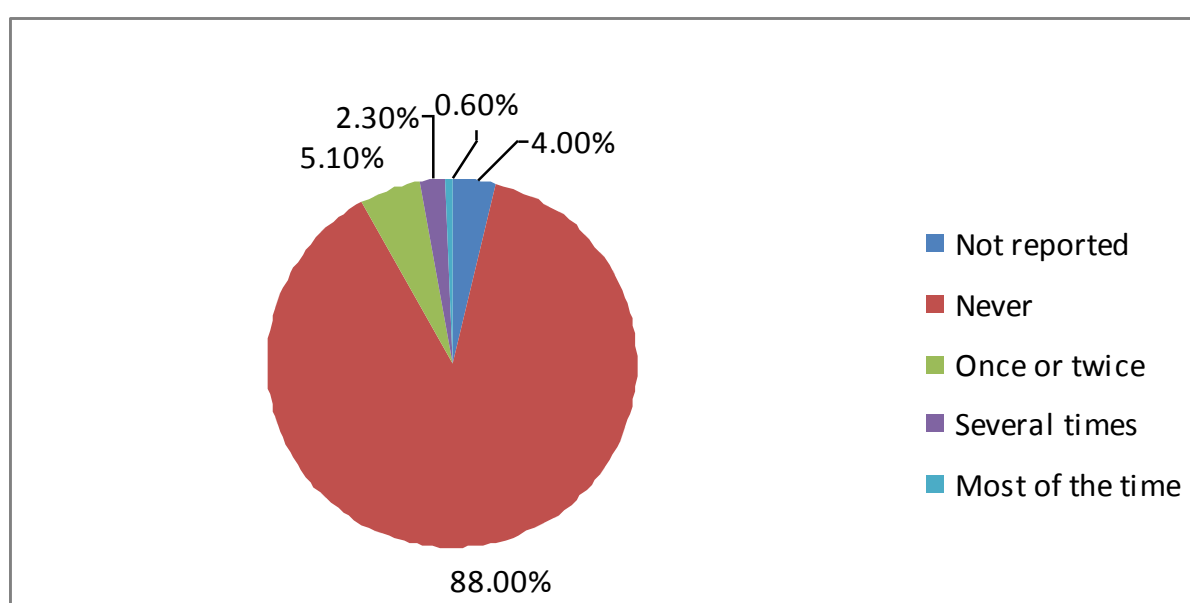


Figure 3-33: Behaviour of nurses with regard to waiting time of an HIV and AIDS patient as opposed to others

Almost 90 per cent (88%) of participants reported never to have made an HIV and AIDS patient wait until last for care. Krause (2007:63-64) states that access to health care services and medical services also determines the quality of life of HIV and AIDS patients and their mental, psychological, and physical health.

Table 3-35: Results with regard to touching an HIV and AIDS patient in giving care

Variable				Not reported	Never	Once or twice	Several times	Most of the time
F8. A nurse made an HIV AND AIDS patient do things for himself/herself to avoid touching him/her	5.7%	87.4%	5.7%	1.1%	0%			

Figure 3.34 presents results with regard to touching an HIV and AIDS patient in giving care.

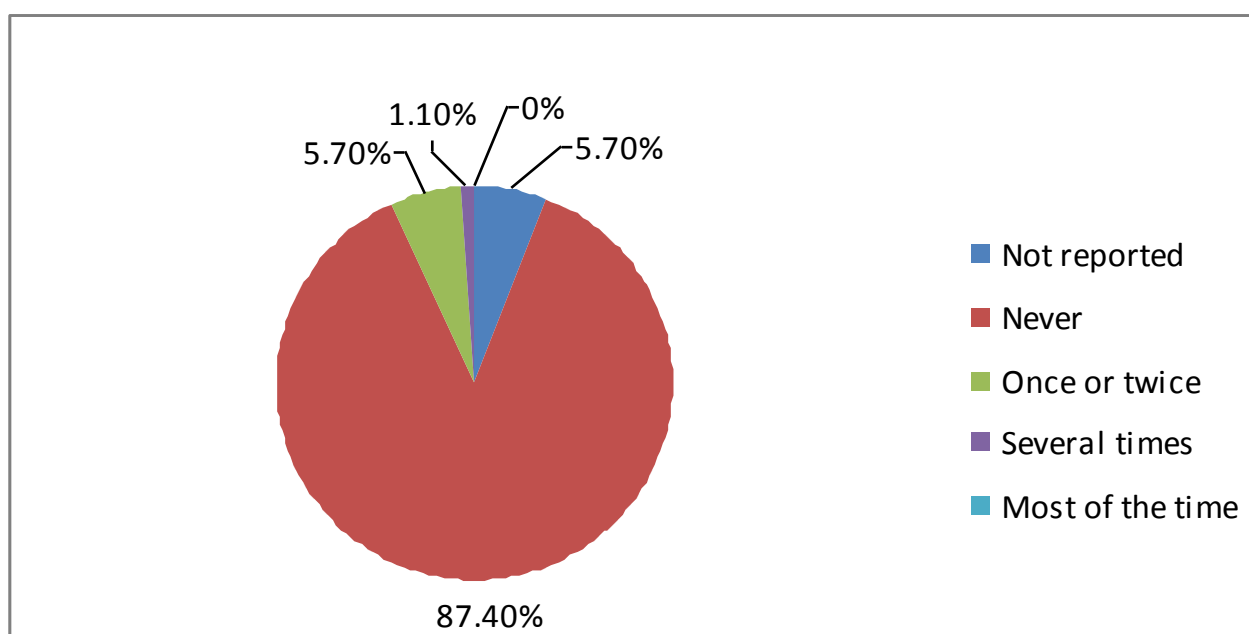


Figure 3-34: Results with regard to touching and HIV and AIDS patient in giving care

A great majority (87.4%) of participants reported that they have never made an HIV and AIDS patients do things for themselves to avoid touching them. This also indicated that the emotional aspect of the patients was considered as touch is regarded as therapeutic. Mogengege (2008:2) states that black women are more likely to develop psychological problems due to the many stressors that they are exposed to. They have a history of trauma, mental health disorder, and substance abuse. The information about quality of life as affected by stigma and how it varies from various social, gender socio-economic classes as well as racial and ethnic groups is necessary for development of a model for HIV and AIDS care, research and policy interface.

Table 3-36: Provision of hygiene of an HIV and AIDS patient

Variable	Not reported	Never	Once or twice	Several times	Most of the time
F9. A nurse left an HIV and AIDS patient for a long time in a soiled bed	0.6%	77.7%	14.3%	5.7%	0.6%

Figure 3.35 presents provision of hygiene of an HIV and AIDS patient

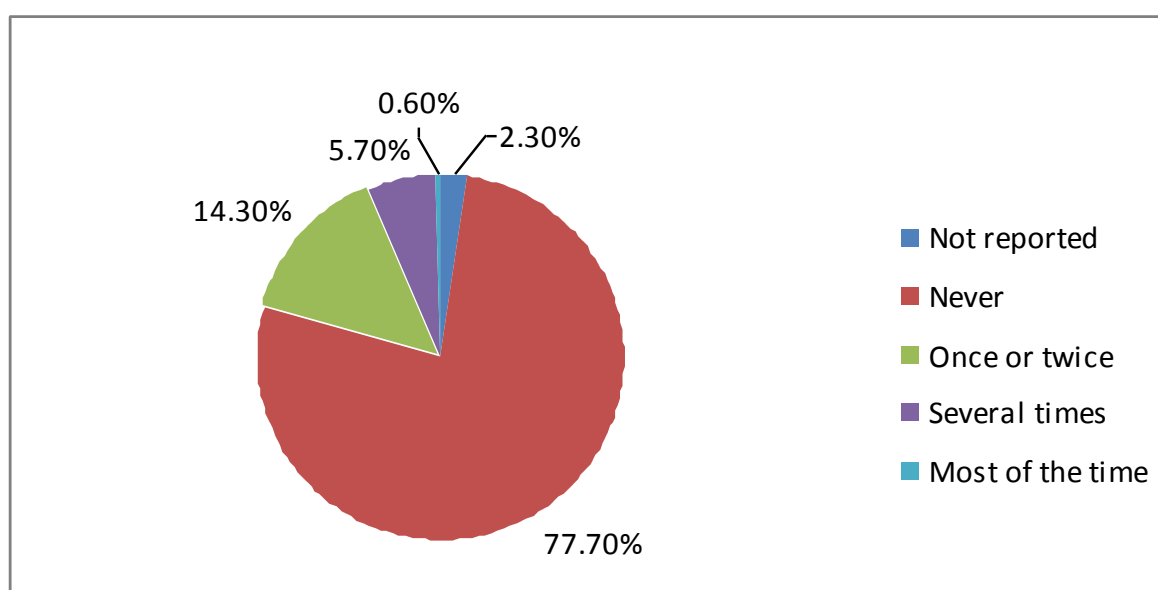


Figure 3-35: Provision of hygiene of an HIV and AIDS patient

More than three-quarters (77.7%) of participants reported to have never left an HIV and AIDS patient in a soiled bed. This indicates a positive attitude towards these patients. In this study, hygiene is regarded as important as health is promoted by cleanliness of a person and his environment amongst other aspects.

Having discussed the provision of hygiene, we now discuss HIV and AIDS patients' waiting time. This is presented in Table 3.37 and graphically represented in Figure 3.36.

Table 3-37: HIV and AIDS waiting time

Variable	Not reported	Never	Once or twice	Several times	Most of the time
F10.Nurses made HIV and AIDS patients wait for care	2.9%	84%	8.6%	2.9%	1.7%

Figure 3.36 presents HIV and AIDS waiting time.

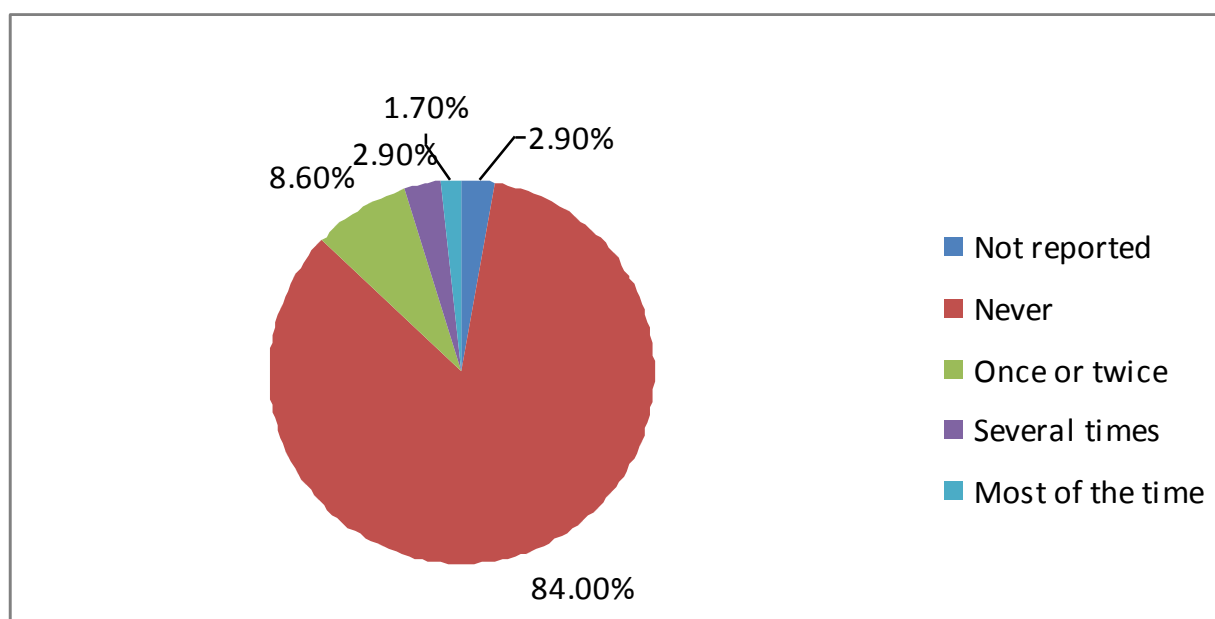


Figure 3-36: HIV and AIDS waiting time

No less than 84% of participants reported that they have never made an HIV and AIDS patient wait for care. This demonstrates that to these professional nurses patient care is executed without prejudice. Reduction of patient waiting is one the priorities of the Department of Health as the Minister of Health Dr. A. Motsoaledi, pronounced this as one of the core standards to be monitored in the South African health care facilities (National Health Core Standards, 2011:3).

Table 3-38: Results on suspicion that nurses providing HIV and AIDS spread the disease

Variable	Not reported	Never	Once or twice	Several times	Most of the time
F11. Someone said that nurses who care for HIV and AIDS patients spread the disease	2.3%	75.4%	12%	5.7%	4.6%

Figure 3.37 presents results that nurses providing HIV and AIDS are suspected to spread the disease.

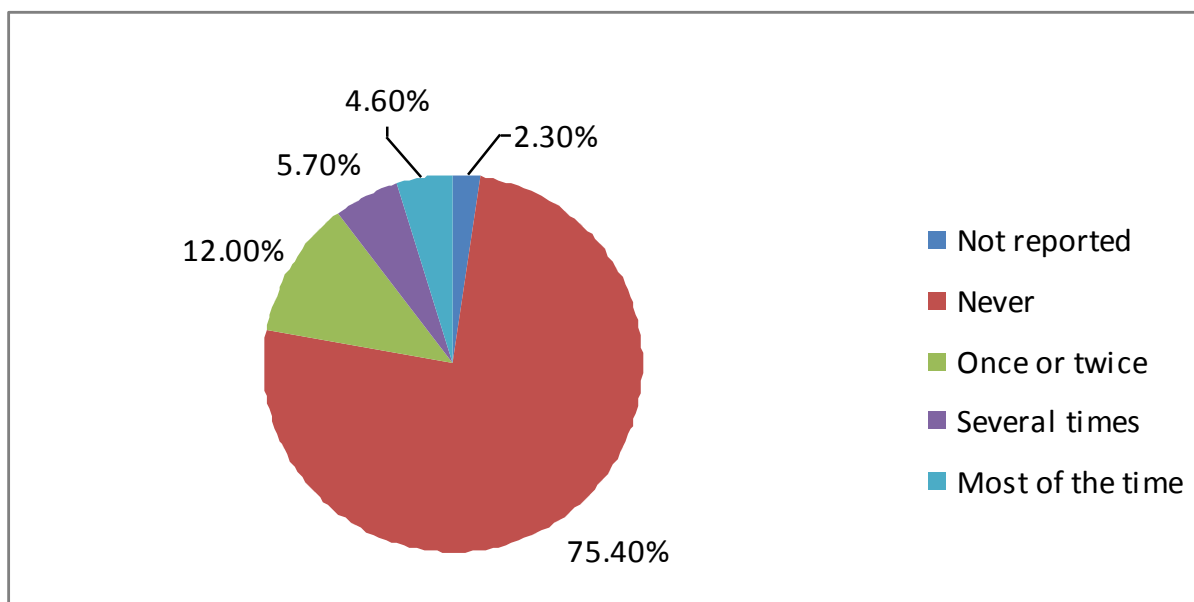


Figure 3-37: Results that nurses providing HIV and AIDS are suspected to spread the disease

Three-quarters (75.4%) of participants reported never having been suspected of spreading the disease. This is therefore an indication that gradually HIV and AIDS is being regarded as similar to other diseases and that the notion of stigma is slowly fading. For this reason, involvement of people in the care of HIV and AIDS patients is guaranteed.

Table 3-39: Provision of care to HIV and AIDS exposes nurses to HIV and AIDS infection

Variable	Not reported	Never	Once or twice	Several times	Most of the time
F12. People said that nurses get infected by taking care of people with HIV and AIDS	4.6%	48.8%	19.4%	10.8%	17.1

Figure 3.38 presents provision that care to HIV and AIDS exposes nurses to HIV and AIDS infection.

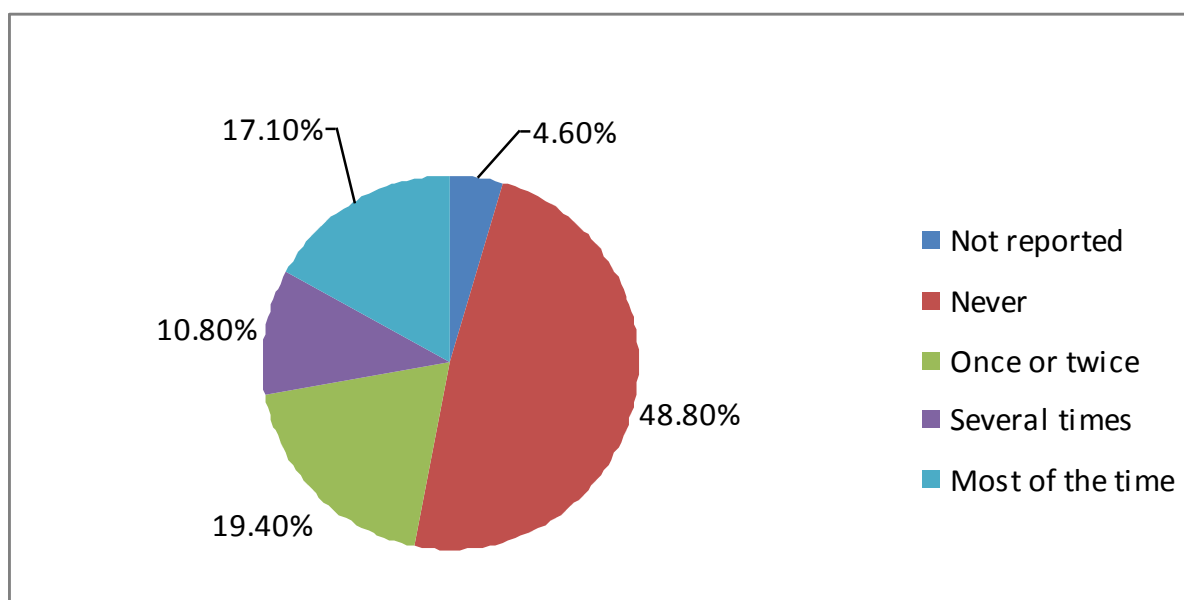


Figure 3-38: Provision of care nurses exposed to HIV and AIDS infection

Almost half (48.8%) of participants reported to have never been suspected of being infected by taking care of people living with HIV and AIDS.

3.2.2.4 Phase one – objective two results: to examine the impact of HIV and AIDS on the workforce- refer to chapter (four) 4 of this thesis.

This objective has been answered in chapter 4 which discusses the results of the interviews. It was explored qualitatively.

Phase One Objective 3: To examine the HIV and AIDS policies, HIV and AIDS interventions and the national HIV and AIDS strategic plans and identify gaps amongst these, will be discussed in the paragraph to follow.

3.2.2.5 Phase One Objective Three – to examine the HIV and AIDS policies, HIV and AIDS interventions and the national HIV and AIDS strategic plans and identify the gaps

The following questions are about quality assurance or quality improvement initiatives at the workplace. These are necessary to determine the ability of professional nurses to develop workplace policies. The significance of having such policies and procedures in this study is that, if professional nurses are able to develop facility al policies and standards of care for patients, this is an indication that they could be able to give inputs into HIV and AIDS policies. Table 3.40 presents results from Section D of the clinical survey.

Table 3-40 Quality assurance or quality improvement initiative in place to monitor the occurrence of occupational exposure to HIV

Variable	Not reported	Yes	No	Unsure
D1. At your workplace is there a quality assurance or quality improvement initiative in place to monitor the occurrence of occupational exposure to HIV?	1%	84.9%	4.0%	11%

Figure 3.39 presents the graphic representation of the results in this regard.

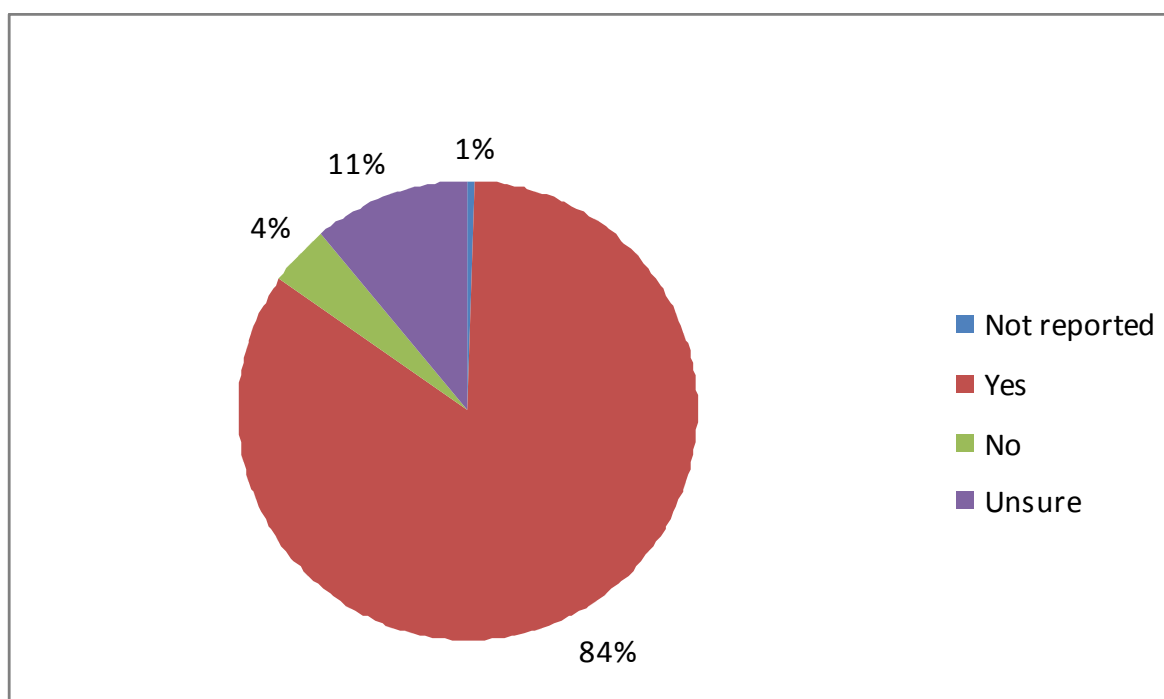


Figure 3-39: Initiatives to monitor the occurrence of occupational exposure to HIV

Altogether 84% of the participants reported that initiatives to monitor the occurrence of occupational exposure to HIV and AIDS exist, whilst 10.9% were unsure. A large percentage affirming the presence of the above shows that occupational exposure to HIV is monitored. This is supposed to indicate that nurses are protected and treated for occupational exposure to hazards which in turn is supposed to lead to retention of staff within the public sector.

Table 3.42 presents the results of quality assurance initiatives to ensure that staff receives standard treatment following exposure to HIV.

Table 3-41: Quality assurance or quality improvement initiative to ensure that staff receives standard treatment following exposure to HIV

Variable	Not reported	Yes	No	Unsure
D2. At your work place, is there a quality assurance or quality improvement initiative in place to ensure that staff receive standard treatment following exposure to HIV in the workplace?	1%	92%	3%	4%

Figure 3.40 presents graphically the results of initiatives to ensure patients receive standard treatment following exposure to HIV in the workplace.

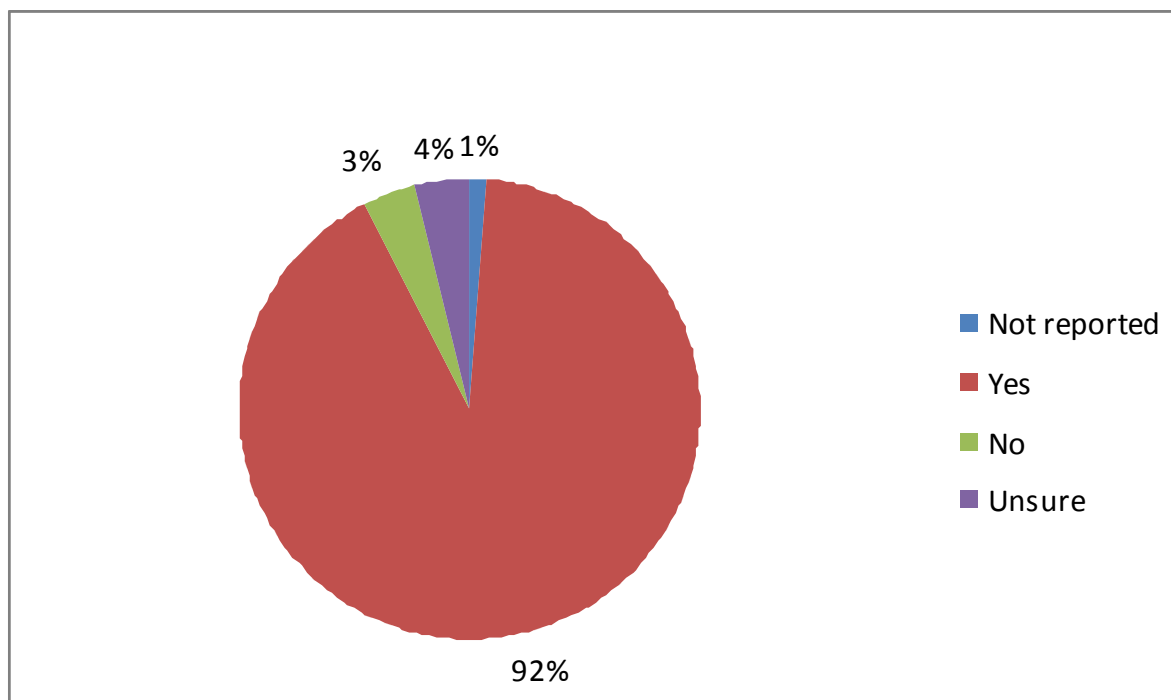


Figure 3-40: Initiatives in ensuring that staff receives standard treatment following exposure to HIV and AIDS

No less than 92% of the participants affirmed that there is a quality improvement initiative which ensures that staff receives standard treatment for post exposure to HIV and AIDS; 3. 4. % reported that this structure does not exist, whilst 4.0% were unsure. This is an indication that this initiative does exist. Therefore, there is a budget available in this regard.

Table 3.43 presents the results of quality assurance or quality assurance improvement initiative to ensure that information related to patients/client's voluntary counselling or testing is kept confidential.

Table 3-42: Quality assurance or quality improvement initiative to ensure that information related to patients'/clients' voluntary counselling and testing is kept confidential

Variable	Not reported	Yes	No	Unsure
D3 At your workplace is there a quality assurance or quality improvement initiative in place to ensure that information related to patients'/clients' voluntary counselling and testing is kept confidential?	1%	91%	3%	5%

Figure 3.41 presents initiatives place to ensure that information related to patients voluntary counselling and testing is kept confidential.

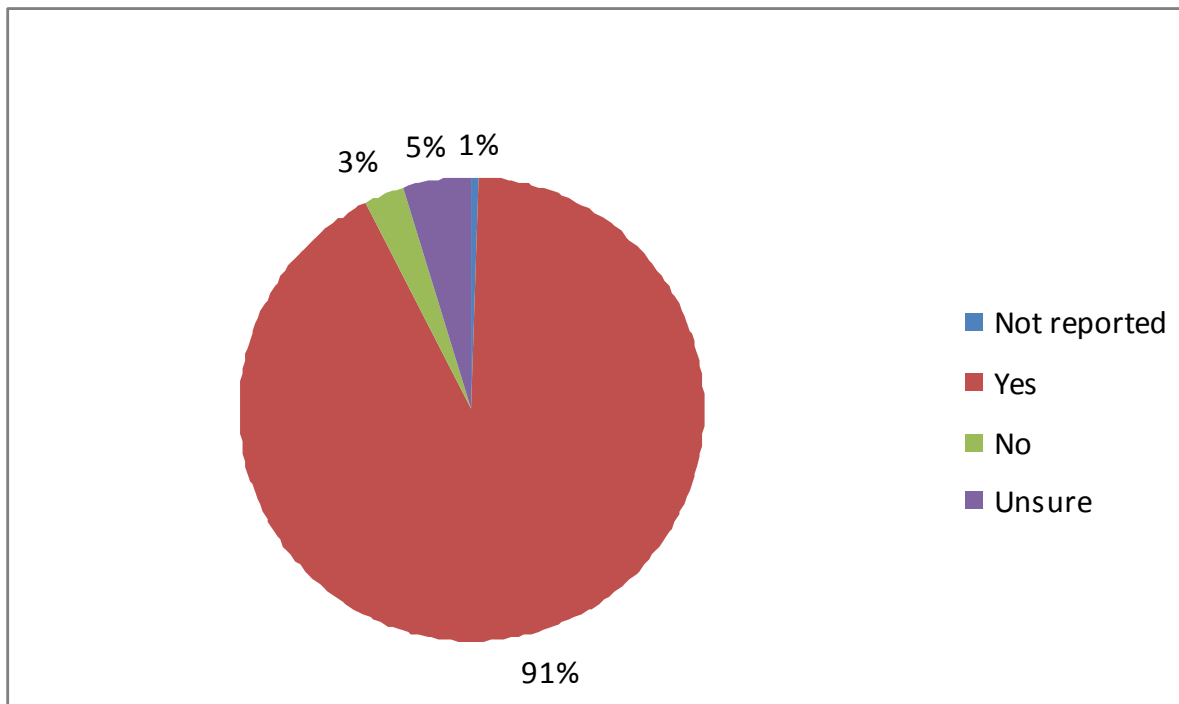


Figure 3-41: Initiatives to ensure that information related to patients voluntary counselling and testing is kept confidential

Over 91% of participants reported that there are initiatives in place to ensure that information related to voluntary counselling and testing of patients is kept confidential.

Table 3.44 indicates quality assurance or improvement initiatives monitoring adherence to facility-wide precautions protocol.

Table 3-43: Quality assurance or quality improvement initiative to monitor the adherence to a facility-wide standard precautions protocol

Variable	Not reported	Yes	No	Unsure
D4. At your workplace is there a quality assurance or quality improvement initiative in place to monitor the adherence to a facility-wide standard (universal) precautions protocol?	1%	82%	5%	12.0%

Figure 3.42 presents improvement initiatives in place to a facility wide standard (universal) precautions protocol.

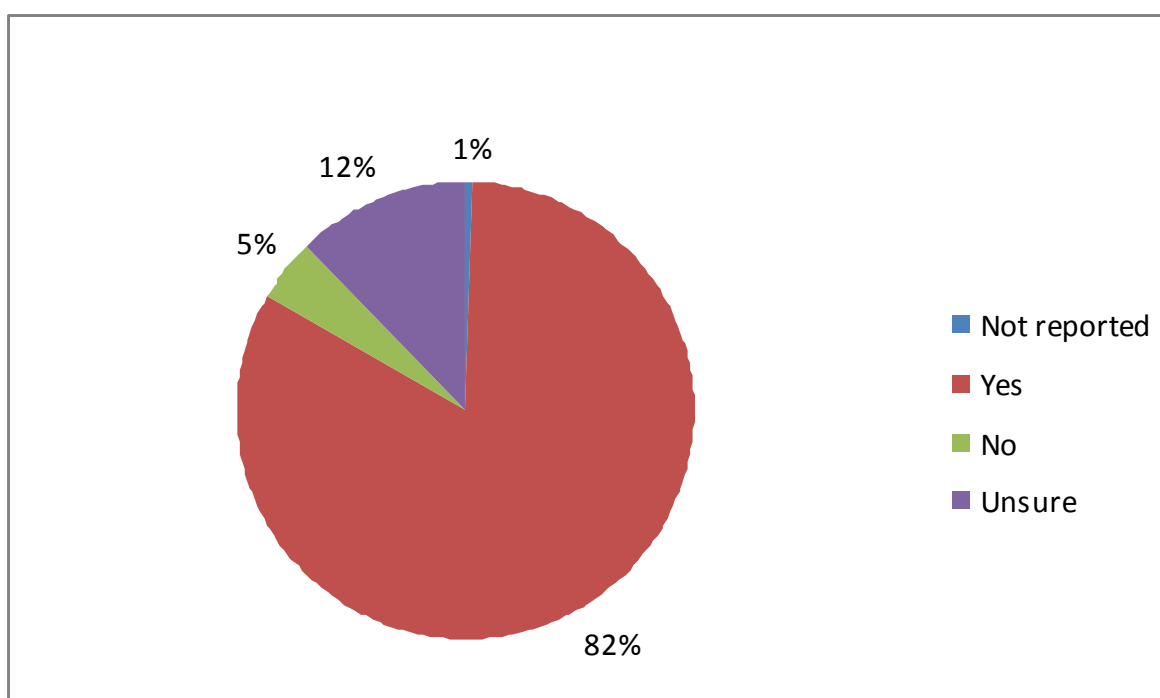


Figure 3-42: Initiatives to monitor the adherence to facility wide standard (universal) precautions protocols

Eighty two percent (82%) of participants reported that there are initiatives to monitor the adherence to facility-wide standard precautions and protocols. Adherence to protocols is necessary as this may ensure quality patient care.

Figure 3.43 presents the results of quality improvement initiative to ensure that nurses assess and document opportunistic infections among patients with HIV and AIDS.

Table 3-44: Quality assurance or quality improvement initiative to ensure that nurses assess and document opportunistic infections among patients with HIV and AIDS

Variable	Not reported	Yes	No	Unsure
D5. At your workplace is there a quality assurance or quality improvement initiative in place to ensure that nurses assess and document opportunistic infections among patients with HIV and	1%	76.0%	9%	14 %

AIDS				

Figure 3.43 presents quality improvement initiatives in place to ensure that nurses assess and document opportunistic infections.

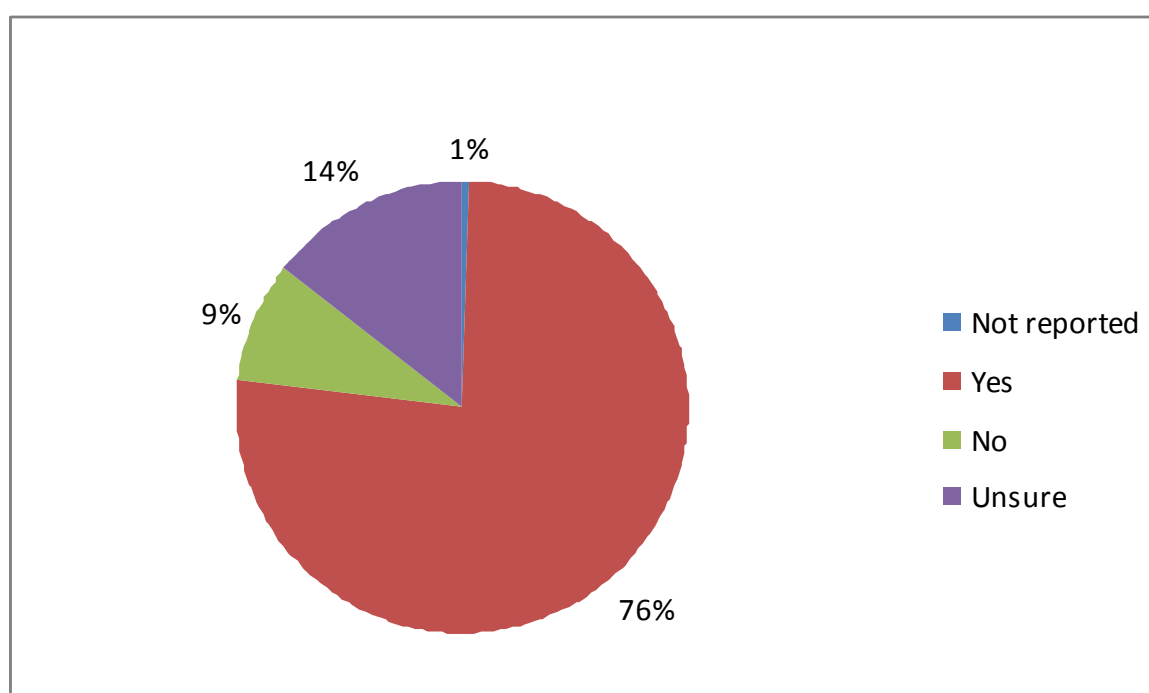


Figure 3-43: Quality improvement initiatives in place to ensure that nurses assess and document opportunistic infections

More than three-quarters (76%) of participants reported that there are initiatives in place to ensure that nurses assess and document opportunistic infections as part of the care of HIV and AIDS patients. Record-keeping is a necessary part of nursing care. It forms a frame of reference not only for care, but also as a legal document and a teaching tool.

Table 3.46 presents the results of quality assurance or improvement initiative to ensure that patients with HIV and AIDS receive a standard treatment protocol.

Table 3-45: Quality assurance or quality improvement initiative to ensure that patients with HIV or AIDS receive a standard treatment protocol

Variable	Not reported	Yes	No	Unsure
D6. At your workplace is there a quality assurance or quality improvement initiative in place to ensure that patients with HIV or AIDS receive a standard treatment protocol?	1%	90%	2%	7%

Figure 3.44 presents initiatives in place to ensure that patients HIV and AIDS receive standard treatment

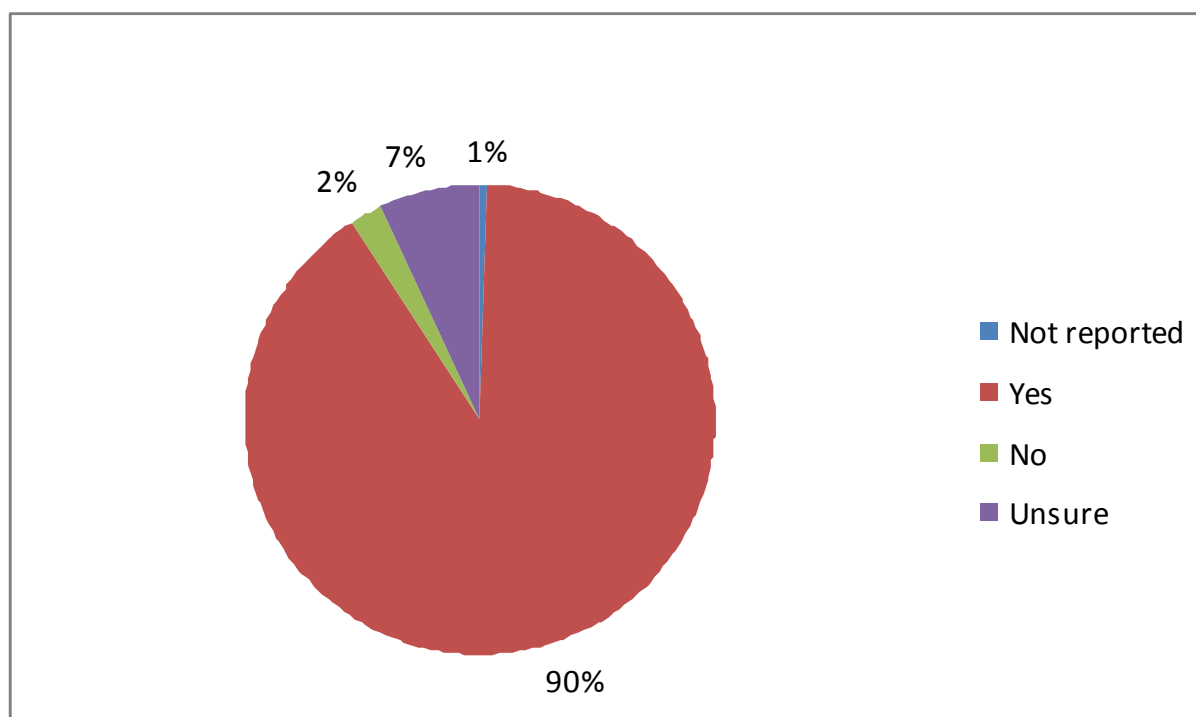


Figure 3-44: Initiatives in place to ensure that patients HIV and AIDS receive standard treatment

Almost all (90%) of participants reported that there are quality initiatives in place at the workplace to ensure that HIV and AIDS patients receive standard treatment. This is an indication that there is assurance that patients should receive standard treatment for HIV and AIDS. However, there have been some reports of shortages of anti-retrovirals in the province.

Table 3.47 presents the results of quality assurance or quality improvement initiative to monitor information exchange between care settings.

Table 3-46: Quality assurance or quality improvement initiative to monitor information exchange between care settings

Variable	Not reported	Yes	No	Unsure
D7.At your workplace, is there a quality assurance or quality improvement initiative in place to monitor information exchange between care settings (e.g., hospital to community or hospice) regarding AIDS patients' health status prior to discharge, transfer or referral?	2%	68%	8%	22%

Figure 3.45 presents quality improvement initiatives to monitor information exchange between settings.

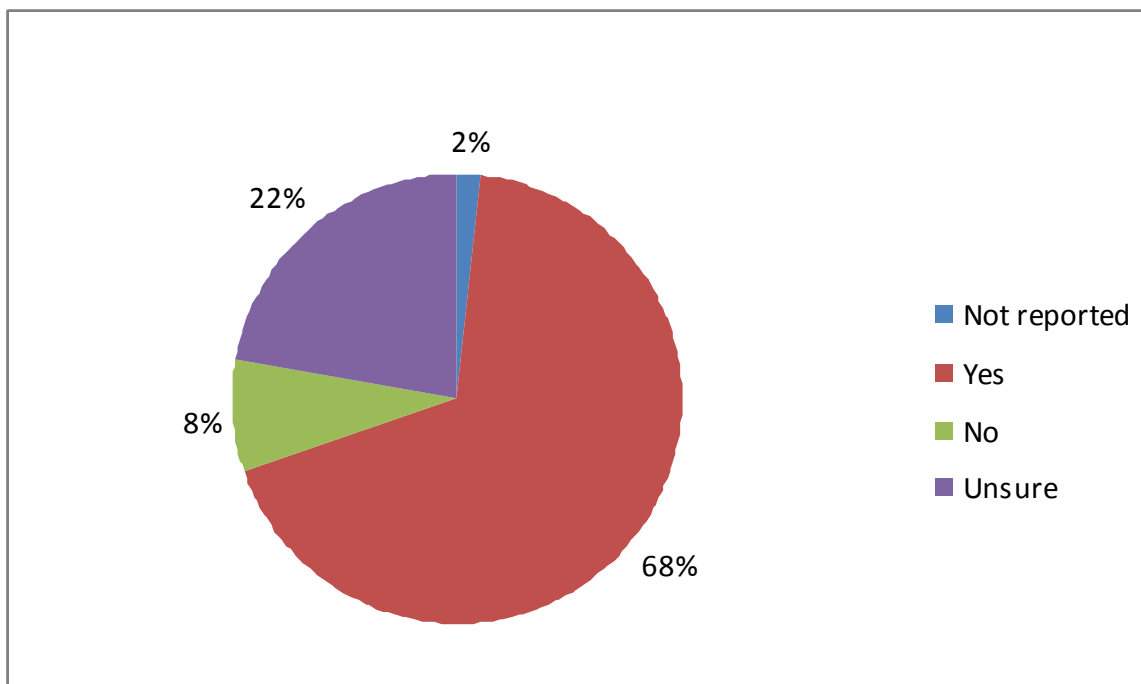


Figure 3-45: Quality improvement initiatives to monitor information exchange between settings

More than two-thirds (68%) of participants reported that there are quality improvement initiatives at their workplace to ensure that there is information exchange between settings. The information shared is basically with regard to continuity of care for patients. This is necessary as it ensures that patients do comply with care even when they are outside their locality.

Table 3.48 presents the results of quality assurance or quality improvement initiative to ensure that patients are educated about strategies to prevent HIV transmission

Table 3-47: Quality assurance or quality improvement initiative to ensure that patients are educated about strategies to prevent HIV transmission

Variable	Not reported	Yes	No	Unsure
D8. At your workplace, is there a quality assurance or quality improvement initiative in place to ensure that patients are educated about strategies to prevent HIV transmission?	1%	83%	6%	10%

Figure 3.46 presents quality improvement initiatives to ensure that patients are educated about strategies to prevent HIV transmission.

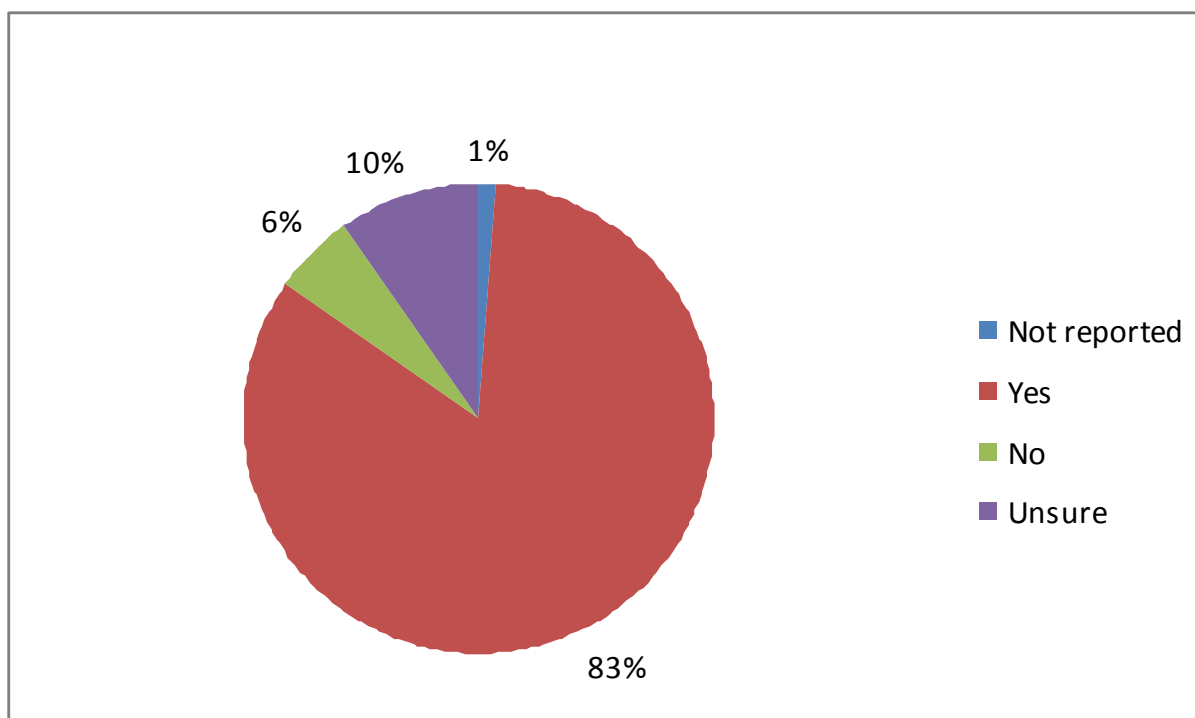


Figure 3-46: Quality improvement initiatives to ensure that patients are educated about strategies to prevent HIV transmission

An overwhelming majority (83%) of participants reported that there are quality initiatives in place to ensure that patients are educated about strategies to prevent HIV transmission.

Table 3.49 presents the results of quality assurance or quality improvement initiative to ensure that the families of patients are educated about strategies to prevent HIV transmission.

Table 3-48: Quality assurance or quality improvement initiative to ensure that the families of patients are educated about strategies to prevent HIV transmission

Variable	Not reported	Yes	No	Unsure
D9. At your workplace, is there a quality assurance or quality improvement initiative in place to ensure that the	1.1%	78.3%	7.4%	13.1%

families of patients are educated about strategies to prevent HIV transmission?				

Figure 3.47 presents Initiatives to educate families about strategies to prevent HIV transmission.

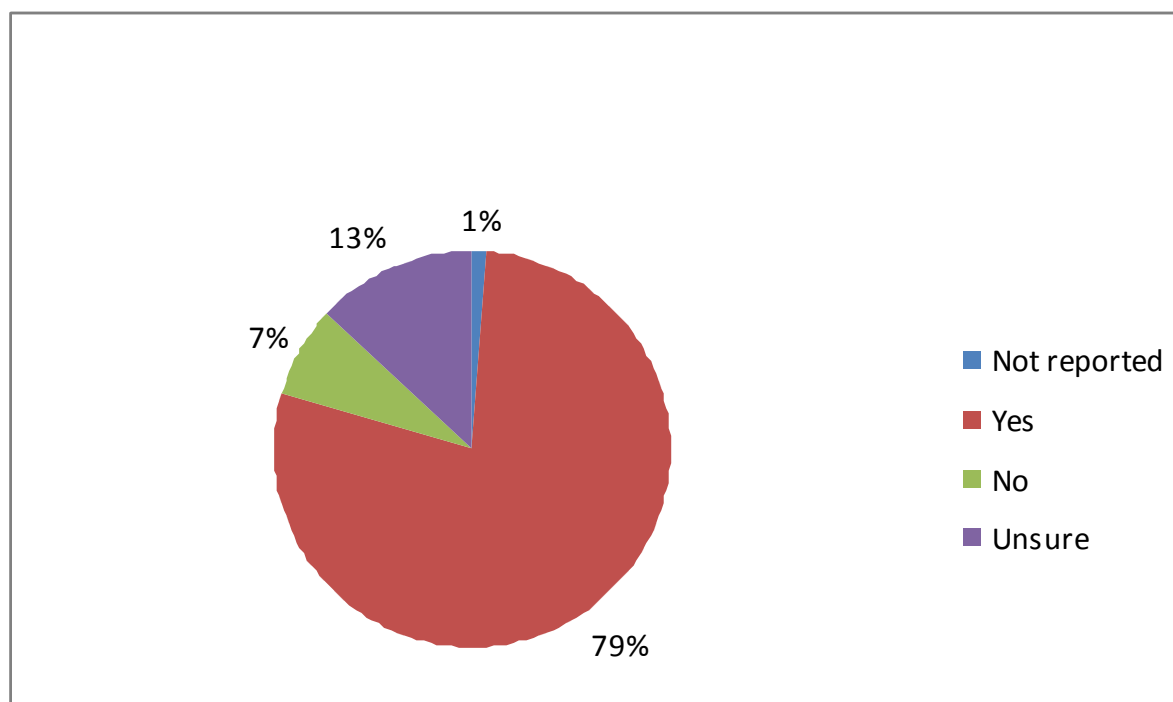


Figure 3-47: Initiatives to educate families about strategies to prevent HIV transmission

More than three quarters (79%) of the participants reported that there is an initiative to educate families on HIV and AIDS transmission whilst 7% reported that this initiative does not exist and 13% were unsure. This higher percentage of positive responses indicates that patient education in this regard is adhered to.

Table 3.50 presents the workplace policies regarding HIV and AIDS.

Table 3-49: Policies or procedure outlining how staff should report HIV exposure

Variable	Not reported	Yes	No	Unsure
E1.At your workplace, are there policies or procedures outlining how staff should report exposure to HIV in the workplace?	1.09%	94.93%	2.29%	1.69%

Figure 3.48 presents policies outlining how to report exposure to HIV.

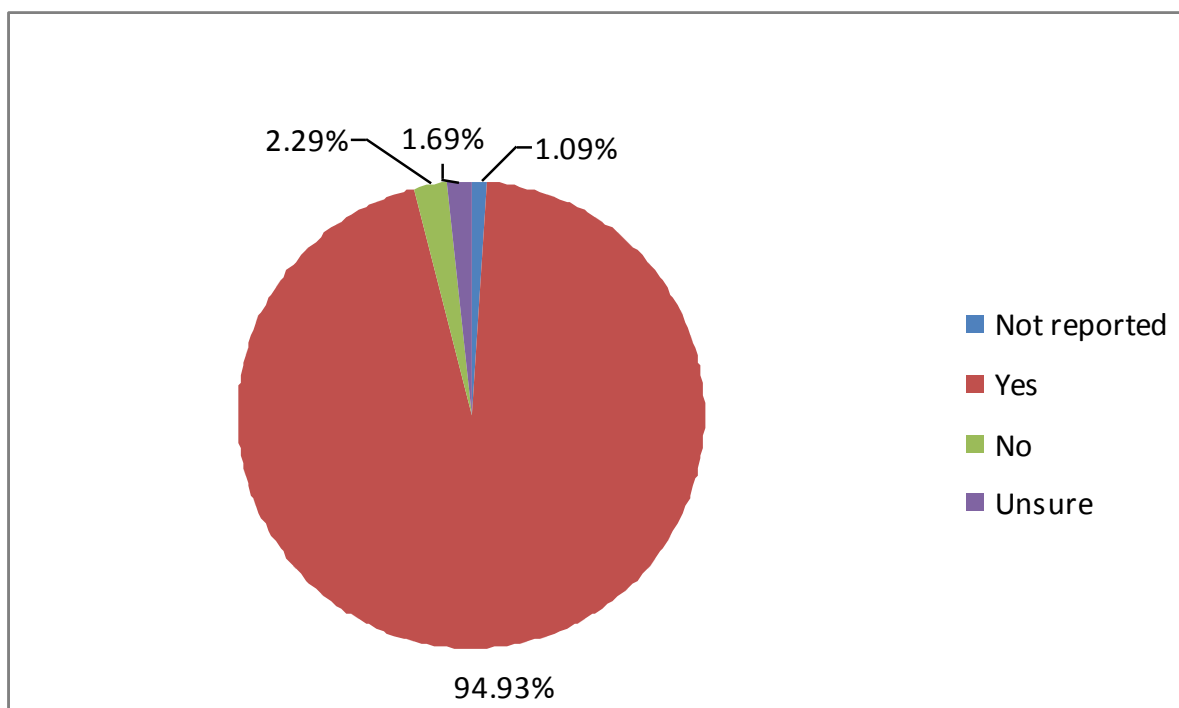


Figure 3-48: Policies or procedures outlining how staff should report exposure to

Nearly all (95.93%) of the participants affirmed that policies and procedures are in place for outlining how staff should report occupational exposure to HIV and AIDS, 0.6% reported that this structure does not exist, whilst 2.9% were unsure. The high positive response in this variable might be partly due to the presence of an employee assistance programme (EAP). Table 3.51 presents the results on policies outlining the standard treatment of staff following exposure to HIV.

Table 3-50: Policies outlining the standard treatment of staff following exposure to HIV

Variable	Not reported	Yes	No	Unsure
E2.At your workplace, are there policies or procedures outlining the standard treatment of staff following exposure to HIV in the workplace?	1.1%	94.9%	2.3%	1.7%

Figure 3.49 presents procedures outlining the standard treatment of staff following exposure to HIV in the workplace.

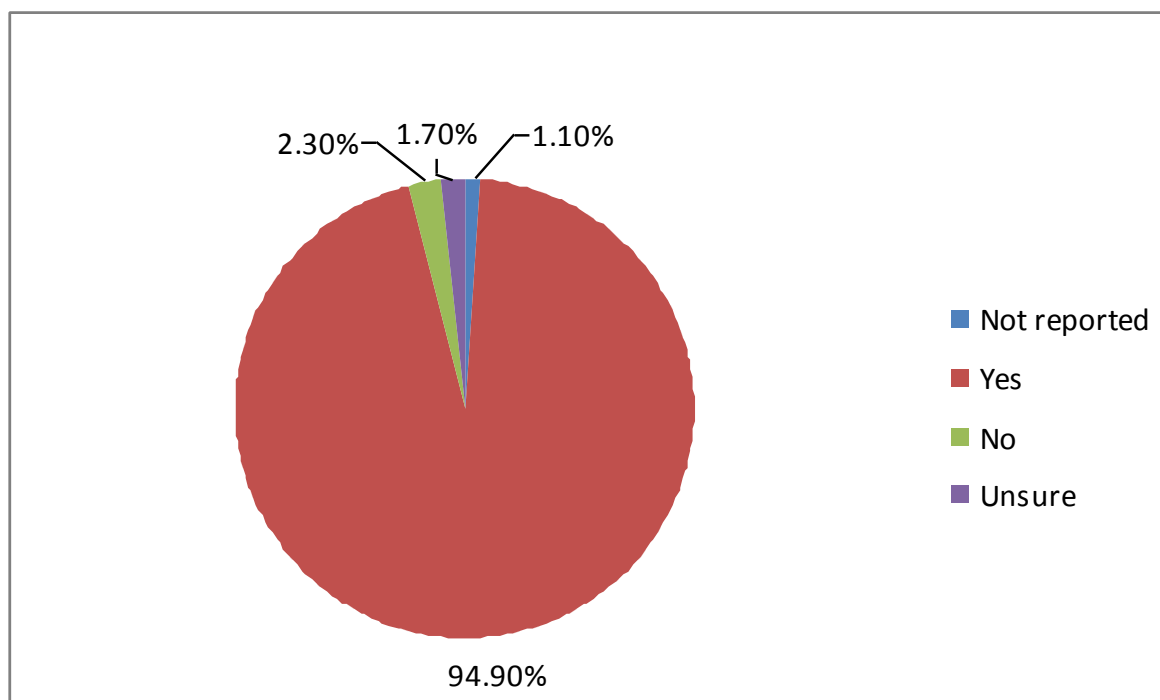


Figure 3-49: Procedures outlining the standard treatment of staff following exposure to HIV in the workplace

Almost all participants (94.9%) reported that there is a standard treatment for staff following exposure to HIV in the workplace. This prophylactic treatment is given as per policies and procedures in each facility. This is one of the common policies within all government health care centres. There is therefore compliance in as far as this initiative is concerned.

Table 3.52 presents the results of policies requiring confidentiality for patients/clients participating in voluntary counselling and testing.

Table 3-51: Policies requiring confidentiality for patients/clients participating in voluntary counselling and testing

Variable	Not reported	Yes	No	Unsure
E3. At your workplace, are there policies or procedures requiring nurses and midwives to ensure confidentiality for patients/clients and families participating in voluntary counselling and testing?	3.4%	89.7%	2.3%	1.7%

Figure 3.50 presents policies requiring confidentiality for patients/clients participating in voluntary counselling and testing

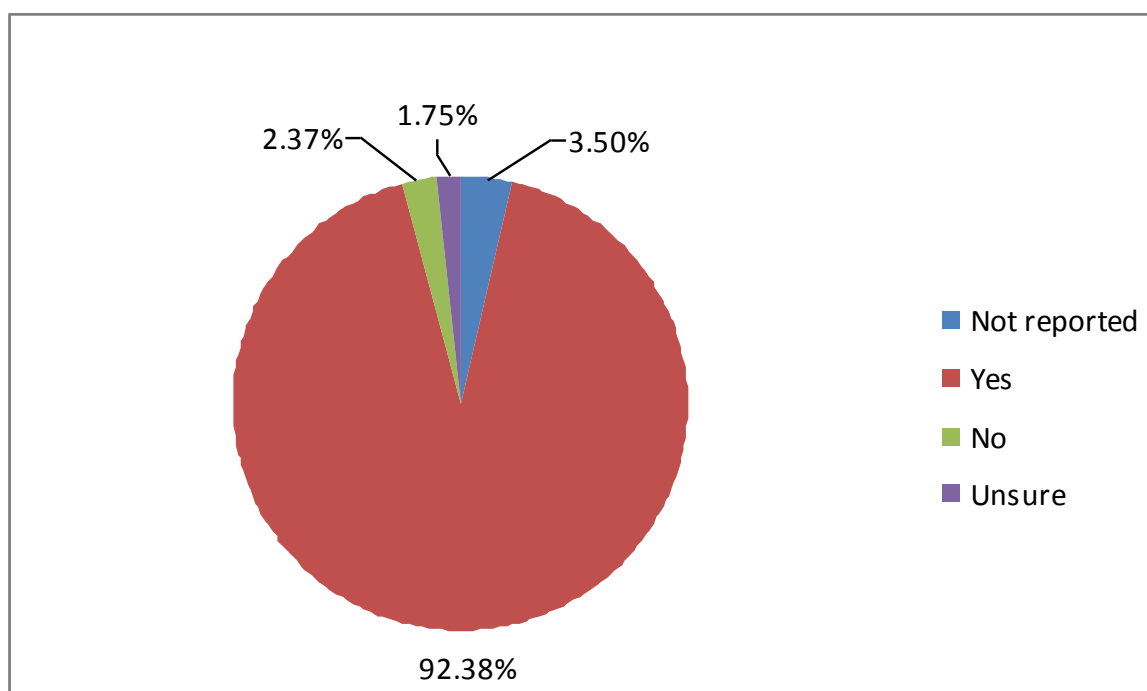


Figure 3-50: Policies requiring confidentiality for patients/clients participating in voluntary counselling and testing

An overwhelming majority (92.38%) of participants reported that there are policies or requirements in their workplace to ensure that confidentiality is kept for patients/clients participating in voluntary counselling and testing.

Table 3.53 presents policies or procedure requiring nurses and midwives to participate in universal (standard) precautions.

Table 3-52: Policies or procedure requiring nurses and midwives to participate in universal (standard) precautions

Variable	Not reported	Yes	No	Unsure
E4. At your workplace, are there policies or procedures requiring nurses and midwives to practice universal (standard) precautions?	2.31%	93.07%	2.91%	1.71%

Figure 3.51 presents policies or procedure requiring nurses and midwives to participate universal (standard) precautions.

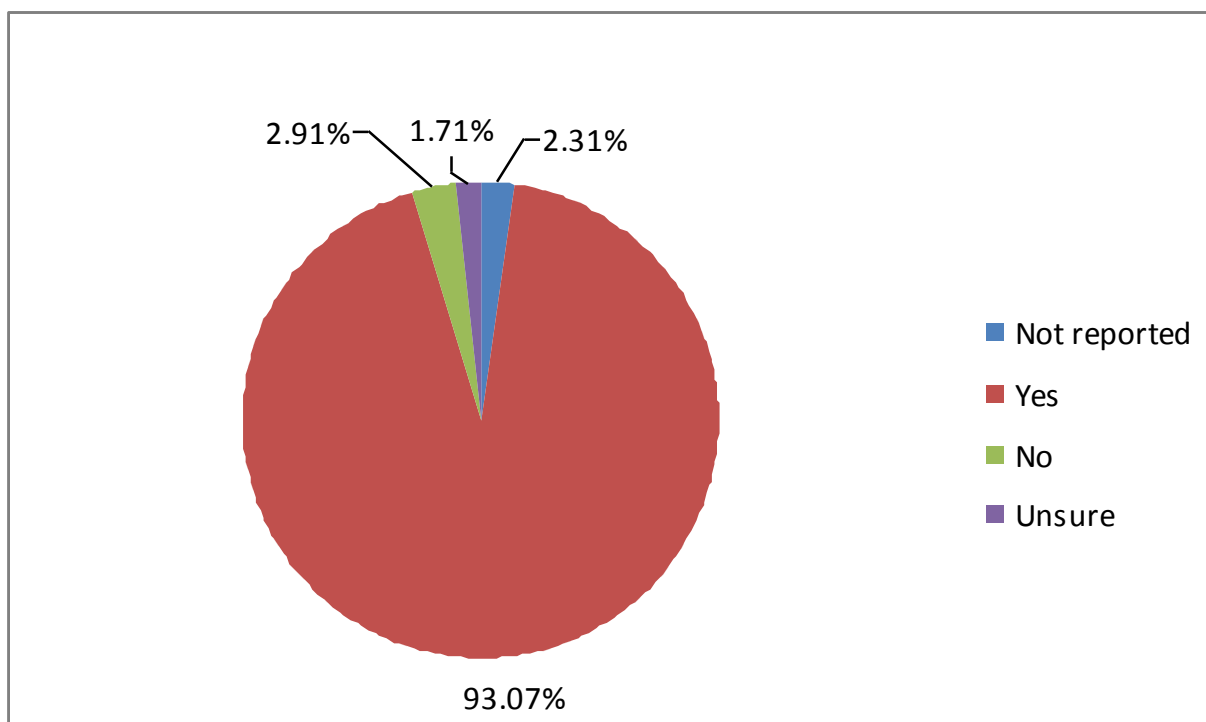


Figure 3-51: Policies or procedure requiring nurses and midwives to participate in universal (standard) precautions

There are standard universal policies and procedures outlining how to practice standard precautionary measures for HIV and AIDS as evidenced by 93.07% who affirmed this, 2.91 % reported that these do not exist, whilst 2.31% were unsure.

Table 3.54 presents the results of policies or procedure requiring nurses and midwives to participate in universal (standard) precautions

Table 3-53: Policies outlining how nurses should assess and document opportunistic infections

Variable	Not reported	Yes	No	Unsure
E5. At your workplace, are there policies or procedures outlining how nurses should assess and document opportunistic infections among patients with AIDS?	2.3%	75.4%	4.6%	17.7%

Figure 3.52 presents Policies outlining how nurses should assess and document opportunistic infections.

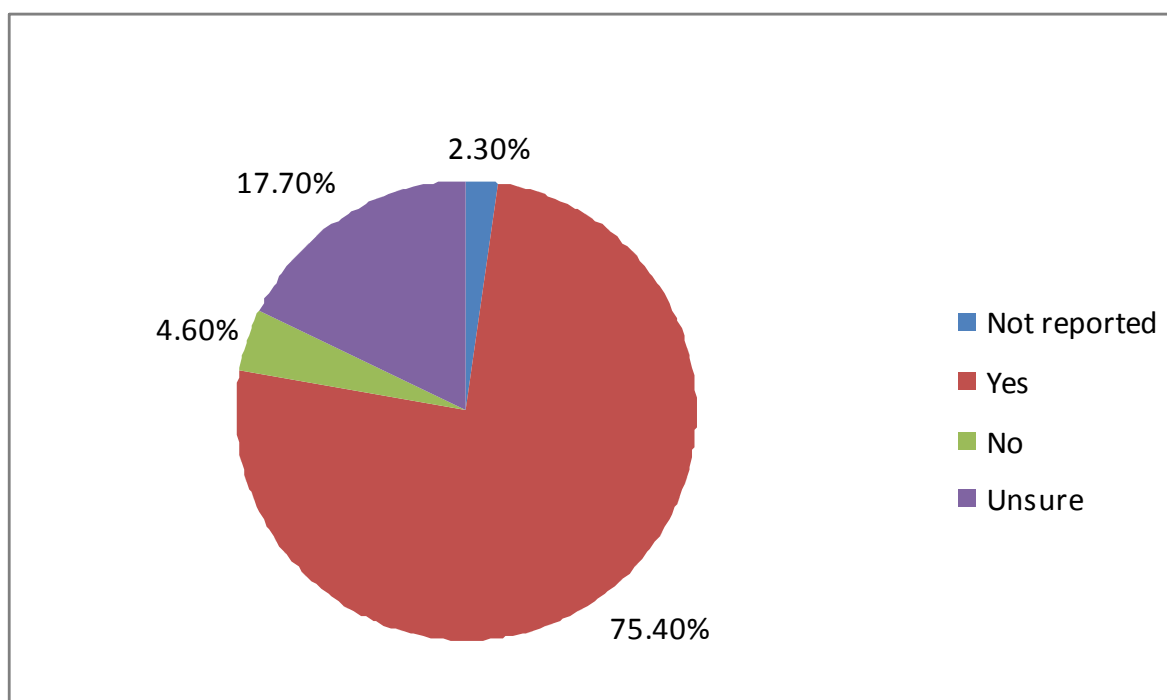


Figure 3-52: Policies outlining how nurses should assess and document opportunistic infections

Three-quarters (75.4%) of the participants reported that there are policies and procedures to outlining how to assess and document opportunistic infections among patients with AIDS. This is a clear indication that policies and procedures assessment of HIV and AIDS exist and this might be an indication of adequate care of HIV and AIDS patients.

3.3 Concluding statements on Phase One, Objective One: to examine the effects of HIV and AIDS stigma on the prevention, care and management of HIV and AIDS (clinical survey)

- Professional nurses rarely participate in research related to HIV and AIDS
- Professional nurses are involved in facility al policy development committees but never participate in national policy development.
- Professional nurses are involved in HIV and AIDS education of patients and families to prevent HIV and AIDS transmission.
- There is a need for specialized training of nurses for HIV and AIDS care.

- Professional nurses manage HIV and AIDS like any other condition without stigmatizing the patients.
- Professional nurses possess the knowledge of HIV and AIDS care, but lack the research component thereof.
- Research and evidence-based practice is not used for policy formulation.
- Research and policy interface should form an integral part of policy formulation.

3.4 Phase One, Objective Three: to examine the HIV and AIDS policies, HIV and AIDS interventions, and implementation thereof

The above mentioned objective was achieved by using the HRM Rapid Assessment tool for data collection. Table 3.55 displays findings and interpretations of the HRM Rapid Assessment Tool. These findings begin with HRM capacity. Table 3.55 presents the means in HRM capacity.

Table 3-54: Findings and interpretation of HRM capacity

Construct: HRM Capacity	Mean	Interpretation
HRM Staff	2.18	There is adequate HRM staff in the organization to do basic functions but HIV and AIDS policies are not dealt with.
HRM Budget	2.14	Budget to support human resource activities, e.g. recruitment, training, workplace prevention programme, is available but staff benefits in respect of HIV and AIDS are limited to HIV and AIDS drugs only
Human Resource Planning	3.10	A formal human resource planning system exists for attracting employees to work i.e. the occupation-specific dispensation that determines salary upon entry to the organization.

The individual constructs were examined with regard to items that constitute each construct. The mean value is the average obtained by computing the sum of items falling under each construct (Babbie, 2010: 429).

3.4.1 HRM Capacity

In every facility HRM staff exists basically to see to it that there is adequate staffing in accordance to its purpose and goals. The workload is also taken into consideration in this

regard. Therefore the main function of human resource is availability and development of staff (Armstrong, 2010:7). The HRM capacity consists of three items, HRM staff, HRM budget and human resource planning. The average mean of this construct is 2.5. This indicates that the HRM capacity is good. If one looks at the mean value of the individual items it is clear that human resource planning seems to function well in all the participating facilities. Each item that constitute this construct will be discussed.

- **HRM Staff**

The mean is 2.18. This mean is below 2.5 and this means that this item's mean is low. capacity mean is while HRM staff is adequate for performing basic HRM functions, there is a lack of capacity for development of HIV and AIDS policies within the facility. HRM staff only addresses issues like handling forms regarding needle facility ricks.

- **HRM budget**

The average mean value in this regard is 2.14. The mean is below 2.5 meaning that HRM does not function well regarding this item. There is a need to be some improvement in staff benefits in respect of HIV and AIDS.

- **HRM planning**

The mean in HR planning is 3.10 which is excellent. There is a system in place for attracting employees into the health department. This determines the entry level of staff, grade progression, and the all-inclusive package within a post.

Having examined HRM capacity, we will now discuss personnel practice and policy results. This construct consists of, compensation system, benefits programme, staff retention, recruitment hiring, transfer and promotion, policy of non-discrimination based on HIV and AIDS status, orientation programme, HIV and AIDS workplace prevention programme, employee manual, policy regarding treatment of people with HIV and AIDS, discipline, grievance and termination procedures, relationship with unions and labour compliance.

Table 3.56 presents means of personnel policy and practice results.

Table 3-55: Interpretation of personnel policy and practice results

Construct: Personnel policy and practice	Mean	Interpretation
Compensation system	3.26	The occupational specific dispensation (OSD) attracts staff for permanent posts. This is standardized nationwide.
Benefits programme	2.33	A programme exists to address benefits and not necessarily HIV and AIDS, e.g. temporary incapacity leave. No funeral benefits.
Staff retention	1.58	Data on staff turnover rates available. HIV and AIDS related data on staff retention is not available except in an EAP register which is not accessed by all staff. Reasons for resignation of staff are not clear.
Recruitment, hiring, transfer, and promotion	2.27	Formal procedures exist for recruitment, appointment and transfer; promotion is dependent on application for a higher post.
Policy of non-discrimination based on HIV and AIDS status	3.65	The policy of non-discrimination on the basis of HIV and AIDS is available, but it is not known as to whether or not this is adhered to as HIV and AIDS is not disclosed.
Orientation Programme	2.67	The orientation programme is adhered to with regard to mission, vision and goals of the facility but no special emphasis is put on HIV and AIDS in general.
HIV and AIDS Workplace Prevention Programme	3.16	An HIV and AIDS programme is in place and focuses on using appropriate protocols to limit the risk of infection as well as education about HIV and AIDS.
Employee manual, e.g. organizational chart, work hours, health insurance, sick leave, grievances	2.33	Whether or not this is up to date is not known by staff, but newly introduced agendas seem to be captured in the manual.
Policy regarding treatment	2.87	There are policies on how staff and clients living with HIV

Construct: Personnel policy and practice	Mean	Interpretation
of people (employees and patients living with HIV and AIDS)		and AIDS are to be treated, but these are not always used as a basis for personnel decisions.
Discipline, Grievance, and Termination Procedures	3.33	Discipline, grievance and termination procedures exist and are practiced. Protection against discrimination on the basis of HIV status is done although staff do not disclose their status; once suspected by an individual professional nurse, the incumbent is protected like any other sick individual.
Relationship with unions	3.28	Shop stewards are invited to union management meetings and are involved by management in work-related disputes.
Labour law compliance	2.62	Labour law is reviewed at the national bargaining chamber and followed accordingly by facilities but it is not known whether this relates also to HIV and AIDS issues.

The mean for recruitment, hiring, transfer and promotion is 2.27. This denotes that though formal procedures are available, adherence to such procedures is not consistent. Staff retention rates are calculated, but analysis of reasons for resignation are not done, hence reasons for resignation and migration of nurses to the private sector or overseas would not be established at facility level. But on the other hand job dissatisfaction, burnout and workload have been cited by Coetzee & Kloppe (2010:235) many authors as a reason for fatigue.. This has also been indicated both in the clinical survey and interviews as one of the factors that causes burnout at the work- place, especially when nursing HIV and AIDS patients.

Impact of the global nursing shortage on quality patient care and nurses' quality of work life is confirmed both nationally and internationally. There is a shortfall of 600 000 nurses if the millennium development goals (MDGs) of improving health and well-being of the global population are to be met (Buchan & Calman, 2013: Executive summary).

South Africa also reported a shortage of nurses and brain drain of the health profession. It is estimated that between 1989 and 1997 nearly 250 000 health professionals left the country. As mentioned in the preceding paragraph, there were five constructs in the questionnaire. Each

had 2 (two) to twelve (12) items as shown in the table for means above. The total number of items was 26.

A mean of 2.27 is lower than 2.5 in promotion to a higher post, as this is not based on performance, but is dependent on application and selection to a higher post though formal procedures exist for recruitment and hiring.

A mean of 2.33 on the existence of an employee manual indicates that some staff members are not aware of such a manual. Those that have knowledge thereof do not know whether the manual is updated regularly.

A mean of 2.27 on policy regarding treatment of employees living with HIV and AIDS is available, but it is used as a basis for making personnel decisions.

Compensation and benefits

Compensation refers to the remuneration system which includes the salary package, benefits and allowances. The housing subsidy, medical scheme, car, cell phone allowance and modem according to the post occupied (Burke & Cornell 2008:25).

- **Staff Retention**

Competencies, skills and applicable training, and whether or not the psychological contract of an employee is satisfied, determines staff retention. This item is important as it determines whether or not the staff turnover within the facility is high or not. If staff turnover is higher, then costs to orientate and train newly appointed staff and time invested in these new people is also a costly process (Armstrong, 2010:126). Muller (2010:128) state that staff retention is worsened by inequitable deployment of staff. In figure 3.57 the mean on staff retention is 1.8 which indicates poor retention strategies.

- **Recruitment, hiring, transfer and promotion**

This is a crucial element in HRM, as it contributes to appointment of the appropriate and skilled personnel. Promotion, transfer and appropriate placement of personnel increase staff motivation. The Free State Department of Health embarked on a strategy of appropriate placement of managers and senior managers within the province which led to increased motivation and excellent functioning within the various sections of the department as these incumbents excelled in their new positions. This is also compatible with the ten-point plan of the health department which emphasizes overhauling of the health system to achieve improved patient outcomes. Muller,(2010:129) confirms this by indicating that if recruitment, hiring,

transfer and promotion are dealt with by effective HRM and applied correctly, this results in a low staff turnover. Armstrong (2010:126) also indicates that the capabilities of employees to fulfil the demands of their work is the function of correct recruitment, hiring and promotion.

- **Policy of non-discrimination on the basis of HIV and AIDS status**

This policy exists as part of the provincial policies on HIV and AIDS. The mean in this regard is 3.6. This is an excellent mean and no improvement is needed in this regard.

- **Orientation programme**

An orientation programme is available. The programme directs management on introducing new staff to the health facility as well as the specific department in which they will work. The programme consists of an introduction of the vision and mission of the facility , providing the necessary information about the facility and relevant work policies. Job descriptions, roles and responsibilities of staff, policies and procedures are related to new staff for them to adjust easily to their work. This also includes allocation of a mentor who will guide them with problems experienced within the first months (Jooste and Jasper , 2012:130).

- **HIV and AIDS workplace prevention programme**

An HIV and AIDS workplace prevention programme focuses on using appropriate protocols for infection control. Conditions of service e.g. work hours, medical aid, sick leave, financial and non-financial benefits. An updated employee manual that includes policies that refer to HIV and AIDS should be available. This manual is updated, though not regularly. The mean in this regard is 3.16; this is an excellent mean.

Policy regarding treatment of people (employees and patients living with HIV and AIDS) Policies on how staff and patients living with HIV and AIDS are to be treated should be up-to-date and available to all and adherence should be monitored. Policies and guidelines in this regard that were available at the time of this study in participating facilities were:

- Management of occupational exposure to HIV.
- HTC.
- Prevention and treatment of opportunistic and HIV-related diseases in adults. National antiretroviral treatment guidelines.
- Paediatric HIV and AIDS tool kit (guidelines).

- Managing HIV in children.
- Ethical considerations of HIV and AIDS clinical and epidemiological research.
- National management guidelines for sexual assault care.
- HIV and AIDS and TB management guidelines.
- Discipline, grievance, and termination procedures.
- Post-Exposure Prophylaxis.
- Needle Prick Policy.
- **Relationship with unions**

Management works hand-in-hand with unions in solving work-related disputes and deployment of staff and the mean in this case is 3.28. This is an excellent mean and no improvement is needed in this case.

- **Labour law compliance**

Labour unions are adamant on protecting their members against contracting HIV and treating infected members. This is the reason why COSATU emphasised that companies not complying with safety regulations and HIV and AIDS should be declared 'worst employers'. The mean in this regard is 2.62 which means it is appropriate.

- **Work planning and performance review**

A mean of 3.20 is an excellent mean implying supervisors adhere to carrying out performance reviews though this is not done regularly.

Table 3.58 shows the results of the means on performance and interpretation. These include job descriptions, organisational strategies for HIV and AIDS, Staff Supervision, Training of Supervisors with Regard to HIV and AIDS, and work planning and performance review. A mean of 2.23 on training of supervisors (table 3.58) denotes that supervisors receive training on general HIV and AIDS care, but do not undergo sensitivity training on dealing with staff questions on HIV and AIDS. For instance, how to handle staff members who are HIV positive is not part of the training.

3.5 Performance management

Performance management is presented in terms of job description, organisational strategies for HIV infection and staff supervision with regard to performance management training. Table 3.57 presents the results of performance management.

Table 3-56: Findings and interpretation on performance management

Construct: Performance Management	Mean	Interpretation
Job descriptions	3.52	Job descriptions are available for all staff members and are adjusted according to functions added to each of them. Changes in performance areas are taken into consideration.
Organizational Strategies for HIV infection Prevention, Care and/or Treatment of Clients	2.93	There is an organizational strategy for HIV infection prevention, care and support of clients and the responsibilities of employees are well-defined. Standards are followed.
Staff Supervision	2.89	Lines of supervision are well established and supervisors understand their roles and functions. Supervisors are trained in general supervisory skills as well as in HIV and AIDS policies but not trained in sensitivity issues towards HIV and AIDS
Training of Supervisors with Regard to HIV and AIDS	2.23	Supervisors receive general training on the issues and policies related to HIV and AIDS, but there is no sensitivity training on how to respond to employees' questions related to HIV and AIDS.
Work planning and performance review	3.20	A formal system for work planning and performance review is in place. Quarterly reviews are done by some supervisors whilst others do not adhere to such a policy.

We will now proceed to discuss the means on performance management as it forms an integral part in human resource management. This construct consists of the following:

- **Job descriptions**

Mean in this case is 3.52; this mean is excellent and only minor improvements should be effected in this regard e.g. inclusion of additional tasks in to the job description.

- **Organizational Strategies for HIV infection Prevention, Care and /or Treatment of Clients**

The mean 2.93 mean, (see Table 3.58) is above 2.5 mean meaning that strategies for HIV infection prevention, care and or treatment of clients are adhered to.

- **Staff Supervision**

The mean for staff supervision (2.89, see Table 3.58) is close to 3 and above 2.5, which is also good. Supervisory tools are utilised to monitor staff supervision e.g. the supervisory manual used in Primary Health Care (PHC), the red flag and the district health barometer to monitor the indicators in each programme within the district health system.

- **Training of Supervisors with regard to HIV and AIDS**

This have a mean of 2.23 (see Table 3.58) which is low. There needs to be improvement in training of supervisors on sensitivity issues regarding HIV infected staff. This includes provision of light duty. Having completed the performance management we will now analyse staff training.

Table 3.58 presents the staff training results.

- **Staff training**

Table 3-57: Findings and interpretation on training

Construct: Training	Mean	Interpretation
Staff training	2.89	Training forms a formal component of the organization and is linked to staff and organizational needs, but, it is not implemented in order to reduce staff absence from their posts during training.
Staff Training on HIV and AIDS protocols	3.23	Training related strategies in dealing with HIV and AIDS are provided as an official priority of the organization but do not address absence of personnel from their posts during training; however, not all employees receive the training.

Construct: Training	Mean	Interpretation
Management and Leadership programmes	3.12	Management and leadership development opportunities target senior-level staff. They focus on other diseases including HIV and AIDS. This assists senior managers and CEO's to develop operational plans to implement the national strategic plan on HIV and AIDS.
Links to External Pre-Service Training	2.05	A loose relationship exists between the organizations and pre-service training facilities . Pre-service facilities do not use this relationship to formally update their curricula to meet the growing need for management capacity within the health sector, nor to prepare nurses to work in HIV and AIDS prevention and or/treatment programs, only adherence to a pre-determined curriculum is done. Community service professional nurses are trained at service level regarding HIV and AIDS related newly introduced programs.

- **Staff training**

The mean in this regard is 2.89 (see Table 3.59 below). This is an acceptable mean as training contributes to quality patient outcome and staff motivation.

- **Staff Training on HIV and AIDS protocols**

The mean in this case is 3.23 (see Table 3.59 below). This is an excellent mean and knowledge of HIV and AIDS protocols is a crucial part in HIV and AIDS care.

- **Management and Leadership programmes**

The mean in this case is 3.12 (see Table 3.59 below). This is excellent and management and leadership development opportunities target senior-level staff. They focus on other diseases but include HIV and AIDS. This assists senior managers and CEOs to develop operational plans to implement the national strategic plan on HIV and AIDS.

- **Links to External Pre-Service Training**

This mean is very low (see Table 3.59) as a mean of 2.05 indicates a loose relationship exists between the organizations and pre-service training facilities . Per-service facilities do not use this relationship to formally update their curricula to meet the growing need for management

capacity within the health sector, nor to prepare nurses to work in HIV and AIDS prevention and or/treatment programmes, only adherence to a pre- determined curriculum is done. Community service professional nurses are trained at service level regarding HIV and AIDS related newly introduced programmes.

In consideration of the means under staff training the lowest item mean is that of links between pre- service training. It has a mean of 2.05 (see Table 3.59 above). In this case the mean is low because training facilities only concentrate on the curriculum regarding HIV and AIDS and integration of such content with national and provincial agendas regarding HIV and AIDS is lacking. According to Muller (2010) health workers should work hand-in-hand with pre-service, in order to ensure provision of informed and skilled nurses to deal with HIV and AIDS in the workplace as well as to provide outstanding service to HIV and AIDS sufferers. All other means are acceptable in this construct.

Nursing is at the forefront of healthcare delivery and is responsible for the majority of care provided to AIDS and AIDS-related conditions. This confirms that nursing must assume a leading role in providing education to its members and other health care professionals. This is also the case in this study of HIV and AIDS care research and policy interface.

The Lancet Commission on transforming education to meet the health systems demands is centred on providing an educated workforce to meet the demands for professionals to be equipped with skills to work in the health system. Transformative learning and interdependent learning are emphasized in this report as important to employees. This implies learning in health systems that are meaningful and responding to the relevant needs of the communities we serve (Frank et al., 2010:1923-1924).

The above paragraph is an indication that there is a need in training of all employees in health care facilities to be able to respond to the changing needs of the communities including the changes posed by the HIV and AIDS pandemic. Muller (2010) asserts that training is an encompassing process for acquiring, capturing and using information Muller (2010) further alludes to Armstrong's (2010:7) argument that HRM has as one of its objectives as 'support to the development of the facility specific knowledge and skills to capacitate staff.'

Table 3.59 is a presentation of HRM data results.

Table 3-58: Interpretation of HRM data

Construct: HRM Data	Mean	Interpretation
Employee tracking system	3.05	Data on number of staff, position, location and gender, age, year of hire does not project HIV and AIDS prevalence as well as the rate of attrition. Data generated on absenteeism rate does not address reasons for such absenteeism as related to HIV and AIDS. Data is available on an EAP regarding staff but such data is confidential and not used for planning purposes.
Personnel Files e.g. individual training records that track performance, promotion and salary history.	3.76	Personnel files are kept confidential. Management does not use this data to plan for HIV and AIDS programmes except the training data where staff trained in an aspect of HIV and AIDS are utilized to perform such functions e.g. HIV and AIDS counselling. Salary history data is utilized, as each personnel templates are not updated, basing management decisions on the template is not beneficial.

HRM data consists of employee tracking system, personnel files, files such as individual training records that track, for example performance, promotion and salary history.

- **HRM Data**

HRM data is the last construct in the HRM Rapid Analysis Tool and this consists of employee tracking system, personnel files, files such as individual training records that track, for example performance, promotion and salary history.

Though HRM data is not reliable as it is a dynamic construct. It was analysed in order to determine whether or not facilities do keep statistics to generate reports on attrition, absenteeism and staff turnover which could be utilized for effective human resource planning. Muller (2010) confirms the unreliability of the HRM data by referring to Field (2005:668) and indicated in her study that HRM data was not analysed because of its unreliability. Below is the interpretation of the HRM data. This also is congruent with Objective 2, the impact of HIV and AIDS on the workforce as the disease also affects the workforce. This could also be used to make decisions regarding the effects of HIV and AIDS on staff workload.

- **Employee tracking system**

The mean in this item is 3.05 (see Table 3.60). This is an excellent mean. Data on number of staff, position, location and gender, age, year of hire are kept. The health care organisations under study do not keep HIV and AIDS prevalence projections in relation to the rate of attrition. Data generated on absenteeism rate does not address reasons for such absenteeism as related to HIV and AIDS. Data is available on an EAP regarding staff but such data is confidential and not used for planning purposes.

- **Personnel files e.g. individual training records that track performance, promotion and salary history**

The mean in this item is 3.76 which is excellent and closer to 4 (see Table 3.60). Personnel files are kept confidential. Management does not use this data to plan for HIV and AIDS programmes except the training data where staff trained in an aspect of HIV and AIDS are utilized to perform such functions e.g. HIV and AIDS counselling. Salary history data is utilized, as all personnel templates are not updated, so that basing management decisions on the template is not beneficial.

A summary of the constructs used in the HRM Rapid Assessment Tool which includes the sample of (n) participants and the means obtained in each construct is presented in Table 3.60.

Table 3-59: Summary of means in the HRM Rapid Assessment Tool

HRM Construct	n	Mean
HRM Capacity	46	2.5
Personnel Policy And Practice	45	2.7
Performance Management	45	2.9

Training	45	2.6
HRM Data	45	3.4

Table 3.60 summarises the means in the HRM Rapid Analysis Tool. Since all these means are above 2.5, they are all acceptable. This shows that policies on HRM capacity, Personnel practice and management, training and HRM data are in place though there is a need for review and modification of such policies.

3.6 Summary of means in the HRM Rapid Assessment Tool

A mean value is equal to the average obtained by adding the sum of the items falling under each construct and dividing the answer by the number of items under the same construct (Babbie, 2010: 429). The results indicated that professional nurses and nurses and nurses' managers agree in principle about the construct under study. In all these constructs, the mean range is from 2.5 to 3.4.

Staff contentment is demonstrated in personnel policy practice, performance management, training and HRM data. A mean of above 2.5 is a high mean and it denotes satisfaction of personnel e.g. a mean of 2.7 (Babbie, 2010:432).

HRM data is a mean of 3.4, performance management is a mean 2.9, personnel practice is a mean 2.7, training is a mean 2.6 and HR capacity is a mean 2.5. In discussing the results of the HRM Rapid Assessment Tool are interpreted and concluding statements drawn against the study of 'HIV and AIDS care research and policy interface'. The functioning of human resources management was therefore determined

The HRM Rapid Assessment Tool for HIV and AIDS environments

The HRM capacity: This part of the questionnaire contained questions regarding the existence of HRM staff, their training in basic HRM functions and HIV and AIDS related to functions e.g. filling of forms of a staff member exposed to a needle prick etc.

Personnel policy and practice: This section of the questionnaire contained questions relating to the compensation system, which determined the presence of formal salary system for each job category. Staff retention, recruitment, hiring, transfer and promotion, were also explored and described in this section. This section also contained questions regarding the presence of a policy of non-discrimination based on HIV and AIDS status.

Performance management: This component contained questions regarding job descriptions, organisational strategies for HIV and AIDS infection prevention, care and/or treatment of clients,

staff supervision and training of supervision with regard to HIV and AIDS. The last part of this component contained questions regarding work planning and performance review.

Training: questions related to staff training, staff training on HIV and AIDS protocols, management and leadership programmes as well as links that the organisation has with pre-service training facility i.e. hospital nursing schools, colleges, universities of technology and universities.

HRM data: This component, included questions on the employee tracking system e.g. data on the number of staff, positions of each staff member, location, gender, age, year of commencement of work, salary level and projected HIV and AIDS prevalence, rate of attrition and absenteeism by staff.

A space was provided for more comments in the questionnaire. The rating on the HRM Rapid Assessment Tool ranged from 1 to 4 and the mean of 2.5 is regarded as good and that above 3 is excellent. The construct responses vary from 1 to 4. This meant that in the assessment of human resource management policies and procedures such policies and procedures do exist or not. Constructs classified as stage 1 or 2, indicate the existence of the policy, though not all staff members are aware of such a policy. On the other hand, stages 3 and 4 indicate that staff are aware of the existing policy, and adhere to the prescripts thereof. Lastly, what should be done to improve the implementation HRM policies was to be written on the blank space provided for such.

The concluding statements drawn from the HRM Rapid Assessment Tool are as follows:

3.7 Concluding statements on the HRM tool

- Workplace Policies on HIV and AIDS are available although these are not used to plan for staff absenteeism, hence the high workload still exists in facilities .
- Training forms an integral part for HIV and AIDS care although this lacks the research component.
- Stakeholder involvement is important in HIV and AIDS policy development, including training of professional nurses in HIV and AIDS policy influence and pre-service.
- HRM staff exists and perform basic functions but there is a lack of capacity building regarding the development of HIV and AIDS policies.

- Training forms an integral component of the organisation and is linked to staff and organizational needs.
- Professional nurses are involved in facility al policy but never form part in HIV and AIDS policy development.
- A top-down approach is followed in HIV and AIDS policy development.
- Nurses lack skills in the policy arena, locally, nationally and internationally
- Job descriptions are available for all staff members and are adjusted according to additional staff functions, changes in performance areas are taken into consideration.

3.8 Summary

This chapter discussed preparation of data for analysis and interpretation thereof. Preparation and coding was done in order to facilitate data entry into the SPSS programme. Concluding statements were drawn from all the analysed data in order to facilitate the development of a conceptual framework. Chapter Four consists of the qualitative data analysis.

CHAPTER 4: RESULTS OF QUALITATIVE DATA ANALYSIS

4.1 Introduction

Chapter 3 dealt with coding, analysis, presentation and discussion of the quantitative data. In this chapter, the focus is on the analysis, presentation and description of qualitative data. Before presenting the results a detailed discussion of the process followed in the interviews is provided.

4.2 Realization of data

Data collection was realized by gaining access to the organisations and preparing for data collection, using an interview guide and giving information to the informants.

4.2.1 Sampled organisations

For the sake of accessibility, interviews were held at Thabo Mofutsanyane District in Dihlabeng and Setsoto Local Municipalities respectively. These included one district hospital, one regional hospital, two fixed clinics, the local area office and one mobile clinic. Table 4.1 presents the number of organisations in which interviews were collected.

Table 4-1: Sampled facilities for interviews

Hospitals	Fixed Clinics	Mobile Clinic	Local Area Office
1 Regional	2 clinics	1 mobile clinic	1 Local area office
1 District			

4.2.2 The interview guide

The interview guide that contained questions on 'Workplace policies: Follow-up to Human Resource Management Assessment' was used to collect data. The interview guide questions were:

- (1) Can you tell me what factors prompted your organisation to develop policies about HIV in the workplace?
- (2) Please describe the process for developing the HIV workplace policies in your organisation?
- (3) Who has been involved in the development of these policies?

- What disciplines have been represented?
 - What role do these individuals fulfil in your organisation? (e.g. managers, care-givers, directors)
- (4) Can you describe how the HIV policies in your organisation fit in with the policies that have been developed at the national level?
- (5) Can you please describe the policies that are still required in your organisation related to AIDS care?

The above interview guide was used and tested for yielding the relevant results as it contained constructs relevant to 'Strengthening Nurses' Capacity in HIV and AIDS Policy Development'.

Participants were told that the individual interviews would last for 30 to 45 minutes, whilst the focus group interviews lasted for 30 to 60 minutes. All participants were able to respond in English as they were professional nurses. Probing techniques were done in order for the participants to elaborate on each dimension of the interview (Burns & Grove, 2010:367).

4.2.3 Using the voice recorder

The researcher listened to the voice recorded data and submitted the data to the project manager at North-West University, (Potchefstroom Campus). Verbatim transcriptions of data were done by a skilled transcriber. The transcriptions were read, and correctness was ensured by comparing them with the voice recorded data by the researcher. The corrected version of the data was coded manually after reading it several times (see Paragraph 2.2 for the detailed description of the method followed). This was done to identify the emerging themes and subthemes. In cases where more than one theme emerged, different colour codes were used.

4.3 During the interview

The researcher adhered to the principles of good qualitative research when conducting qualitative research. The principles as discussed by Van der Wal (2001:3) were used as basis. Bracketing and intuiting in each phase of the research process

4.3.1 Context flexibility and the researcher's adaptability

The researcher has to be reflexive and acknowledge the fact that she continues to have new insights on the phenomenon under study. This is the case in this study, where the researcher learnt that in a particular district the prophylactic treatment for post exposure of employees to blood and products is centralized, and as long as the time lapse between the exposure and the

actual obtaining of treatment is less than 24 hours, this is appropriate according to their circumstances. This provided a new insight as opposed to the norm of having prophylaxis at the site.

4.3.2 The emic perspective

The emic perspective (insider view) which the researcher sought to obtain with regard to the information provided in this study indicates that qualitative inquiry is both a function of higher order thinking but yet being adaptive to a situation in which the researcher finds her/himself at a given moment. The interviewer always keeps the objectives of the study in mind, and always remembers what has been said in her dealing with the data. An example of this is that as the interviewer in this study interviewed one respondent, she has to acknowledge what was said before, whilst keeping in abeyance such information to avoid contamination of the present information. This, the researcher chose to term avoidance of retroactive contamination, a term she derived from retroactive inhibition.

In the case of qualitative research the researcher used bracketing in order not to allow preconceived ideas to contaminate the data. This means that all information known by the researcher was put in abeyance during the interviews. Nevertheless there is some anticipation of 'what the situation calls for'. This may include the venue, time schedules, refreshment as in the case of this study. These were prepared prior to going to the research site (Kvale, 2009:89).

4.3.3 Naivety

Naivety refers to the researcher's ability to learn, as she adopts a frame of mind in which she/he sets aside his/her assumptions. The difficulty in being naive in this case is that assumptions are generally useful for simplifying our relations with others. This is the case in this study of 'HIV and AIDS care, research and policy interface'. As explained in Chapter One of this thesis, the researcher clarified her assumptions as adopting an open frame of mind in conducting this research, and being open to multiple realities regarding the phenomenon under study as described by Glesne and Peshkin, (1992:80).

4.3.4 Analytic

Adopting an analytic view throughout the research process is one of the significant aspects in qualitative inquiry. In the case of this study analysis was done in the early stages of data collection as well as during the coding. After data collection analysis of all transcripts was done and themes emerged. Meaning was derived from the transformation of data to themes and sub-themes (Burns & Grove, 2010:254).

4.3.5 Being dominant but also submissive

As mentioned earlier in this thesis, the researcher holds a position higher than that of the target group of the study. The power differential was questioned by academics in the doctoral evaluation committee and questions asked included the process that would be used by the researcher in assuring that coercion to participate in the study does not occur with regard to the participants. This gave the researcher the indication that she should be more thoughtful than ever in adopting a non-hierarchical position as far as possible. On the other hand, a dominant role of the researcher's definition of the purpose of the study was maintained. Phrases like 'please tell me what you know, the way you know it, as you are an expert in your field' and 'The information obtained in this interview will be utilized only for the purpose of the study' were used, following Glesne and Peshkin (1992:83). However, the paradoxical nature of this research, of the dominance and submissiveness is unavoidable in qualitative enquiry as it entails human interaction.

4.3.6 Being non – reactive, non- directive and non- therapeutic

The self as a human instrument in the interview situation is significant. This may either maintain or distort the interview. The interviewer has to acknowledge what the interviewee feels and means. She/he should share these exact meanings with the interviewee. This helps the interviewees to shape their own meanings accordingly. This is the case with this study, where the interviewee felt emotional about a situation and was off the subject interview subject. It was necessary to check in summary with the interviewee the response considered to be consistent with the interview subject. Following Glesne and Peshkin (1992:85) this was done to alert the interviewee to her being off the interview subject.

4.3.7 Probing

Brink (2010:153) argues that qualitative researchers explore topics. Therefore probing helps in acquiring more knowledge. However, the interview may be stopped for many reasons. Sometimes the interviewer may run out of time, lack energy to continue collecting data or being satisfied with partial conceptualization of the phenomenon (Glesne & Peshkin, 1992:86). On the other hand the more one probes, the longer the interview becomes.

After having looked at the above aspects of the interview, it is important to examine the researcher's understanding of the meanings put forth by the participants. As explained in Chapter Two a semi-structured interview guide was used to capture the meaning of the phenomenon under study in its entirety. In so doing the twelve modes of understanding as identified by Kvale (2009) were considered. These are:

4.3.8 Life worlds

Qualitative research deals with the life world of the interviewee. This denotes that the setting of the interview is a natural one (at a place where the interviewee is working). Hence Lincoln and Guba (1985: 27) term this a naturalistic setting.

4.3.9 Meaning

The qualitative research interview is aimed at describing the meaning and the themes of the interviewees' life world. This assists in understanding the meaning of what is said. This also implies the discourse that takes place during an interview.

4.3.10 Adopting a qualitative attitude

The qualitative interview seeks to obtain a variety of qualitative aspects of the interviewees' life worlds. The soft qualitative issues were kept in mind during the interviews. Issues like, the varying tone of the interviewee's voice, her emotions including her state of comfort in dealing with the interview subject. Understanding of the interviewee as human beings who are not pre-programmed and unpredictable in their actions and communication style were borne in mind, in the event of any untoward behaviour.

4.3.11 Description rather than presupposition

The qualitative research interview aims at obtaining descriptions and the respondent describes what she/he experiences. Qualitative interviews aim to gather information that bears descriptions of the participants' world rather than presuppositions. The interviewer has to be curious of what is said and not said, but critical of his/her presuppositions during an interview (Kvale 2009:177). This is also alluded to by Lincoln and Guba (1985:16) as they explain that the reflexivity has to be maintained in qualitative research. In this study, this was maintained by keeping in abeyance all what the researcher knows regarding the phenomenon under study in order not to impose her views during interviews or data analysis.

Kvale (2009:176) argues that qualitative interviews seek to describe specific situations and action sequences in the life world of the interviewees. General opinions are not investigated though they might yield information of interest. This was the case also in this study, where opinions were listened to but evaluated carefully during data analysis as these may not have yielded information of interest regarding the phenomenon under study.

4.3.12 Focussed yet not structured

According to Kvale (2009:176) the interview focuses on certain themes of the life world of the interviewee. The interview is neither strictly structured nor entirely nondirective. In this case the task of the interviewer is to guide the informants towards certain themes and not to influence their opinions. Hence a semi-structured interview guide was used in the qualitative part of this study.

4.3.13 Ambiguity

Some statements derived from the interview might be ambiguous and the researcher should be able to deal with this ambiguity. Ambiguity may arise from expressions in the research questions which imply several alternative interpretations. This is the reason that the interviewer has to clarify the ambiguity if the interviewee so requires because these ambiguities might be context bound or reflect real inconsistencies in the tool. In this study, some of the interviewees did not quite understand the term 'disciplines' in a question that asked 'Which disciplines were represented in the formulation of your facility al policies'. This necessitated the interviewer to explain what the meaning of the question was (Kvale, 2009:178)

4.3.14 Change in responding to similar questions administrated or posed differently

During the interview, the interviewee may discover new aspects regarding the phenomenon under study and may discover relationships that he /she never became conscious about. This is true in the case of this study, as the HRM Rapid Assessment Tool (HIV and AIDS environments) contained questions the responses to which might be similar to those of the interview guide, and three of the participants took part in the HRM Rapid Assessment and also participated in interviews, the information obtained was not exactly the same in both instances, though not totally contradictory (Kvale, 2009: 177)

4.3.15 Sensitivity of the researcher

Sensitivity might yield different information in terms of richness due to varying levels of sensitivity of the interviewer; this may also vary from interviewer to interviewer (Kvale, 2009:177). To convey the sensitivity, a varying tone of voice, seating arrangements and the use of silence as a sensitive interview method were utilised.

4.3.16 Interpersonal situation

The interviewer is the human instrument in data collection, given the fact that it is an interaction between two people. The dynamics of the interview situation is therefore taken into

consideration in the collection and analysis of data. In this instance the reciprocal relationship between the interviewee and the interviewer on the cognitive and the emotional level should be recognized and taken into consideration. This, as Kvale (2009:181) explains, is a strong point in qualitative interviews rather than a source of error. This situation arose during the interviews in this study as one respondent became emotional in the process as she reflected on the effects of HIV and AIDS to the workforce. This knowledge as suggested by Kvale (2009:181) should be recognised and applied rather than ignored and reduced. Hence the non-verbal cues were recognised during the interviews.

4.4 Taking field notes

It was necessary to take field notes in order to remember what transpired during the interview though a digital voice recorder was used. Field notes help to capture the non- verbal communication cues. This proved to be very significant as these conveyed certain meanings to the researcher, which could not have been evident, if interviews were not conducted. The researcher captured everything that the respondents said in the form of sentences or paragraphs, and not single words in isolation. This was done in order to give an accurate description of what they meant (Field & Morse, 2004:81).

Lincoln and Guba (1985:81) assert that field notes can be divided into four categories, and these categories have been used in this study.

4.4.1 Observational notes

Observational notes were written as an account of what the researcher watched, heard and observed during the interview (De Vos :2011:320)

Below are the results of Objective 3, where tool 4 (interview open ended questions) was used after indexing of data was done in specific categories (Field & Morse, 2004:96; Van Rensburg & Smit, 2004:106; Polit & Beck, 2004: 401)

4.5 Coding and analysis of the qualitative data

The themes which emerged were HIV and AIDS knowledge, stakeholder participation in HIV and AIDS policy formulation, Impact of HIV and AIDS on the health system, de-stigmatization of HIV and AIDS in HIV and AIDS care and the importance of research in HIV and AIDS care. Table 4.1 displays the data. The data chunks are presented according to themes in table format in order for the reader to realize how these emerged. The reason that this was done is to avoid a biased selection of data and 'anecdotalism' which could decrease the trustworthiness of the

research. Since data analysis is a higher synthesis order, thinking capability, and understanding of the full sentence or paragraph in this regard is more important than the individual respondent's errors, fluent expression in language or other linguistic abilities. The researcher in this regard read and captured the meaning of the paragraph in its entirety (Van der Wal, 2001:2).

Burns and Grove (2010: 541) state that data obtained is affected by the characteristics of a person being interviewed. These may include age, ethnicity, gender, professional background, educational level and the relative status of the interviewer and interviewee. In this study, some of the interviews were conducted at night, or even after hours in which case the interviewees were tired. This accounts for the linguistic and grammar problems which were encountered.

4.6 Results of the interviews

The interview results are discussed according to the objectives and the interview questions.

4.6.1 Phase one objective two: To examine the impact of HIV and AIDS on the workforce

Data was collected in the form of interviews conducted individually and focus group interviews. The interviews were done at the clinics and hospitals and offices of operational managers, which confirmed what Kvale (2009:18) suggested to be the natural context of the interviewee. The context is therefore important to the phenomenon under study.

Interview results are presented in accordance with the objectives set in the study and the themes that emerged during data analysis. Table 4.2 presents themes and sub- themes which emerged from the interviews.

Table 4-2: Themes and sub-themes

Themes	Sub-themes
1. Knowledge of HIV and AIDS	1.1 Standardisation of care
	1.2 Protection against infection
	1.3 Involvement of family member
	1.4 Participation in HIV and AIDS research
2. Destigmatizing HIV and AIDS	2.1 Local knowledge
	2.2 Improved patient outcomes
	2.3 Quality of life

3 .HIV and AIDS impact	3.1 Impact on health system
	3.2 Impact on HR
4. Stakeholder participation	4.1 Participation in policy formulation.

Qualitative data may be analysed and presented in various ways (Polit & Hungler 2010:331). In this study, data analysis began as soon as the first set of data was collected and ended up in the last phase. The following steps were followed: Indexing: which was done by means of colour codes, writing of analytical notes to guide the process of analysis, and segmentation of data into small units. Categorization of data segments into themes and sub themes.

'Method is not the way to truth; on the contrary, truth eludes the methodological man. Understanding is not conceived as a subject process of man over and against an object, but the way of being of a man' (Van der Wal, 2001:1)

The researcher followed van der Wal's (2001) method of not conforming with a particular method in data analysis, but adopting a mentally constructed picture of one's study and how data analysis emerged. The final goal in this analysis was the emergence of a representative larger picture which denoted an analytic way of higher order thinking as opposed to following a hard and fast rule of a scientific and mechanistic way. This is also consistent with the researcher's paradigmatic view of postmodernism as mentioned in Chapter One.

Data extracted from the interviews was referenced by the interviewer's code, the interviewee's code, and the page number. The codes in this regard were e.g. VN550003 (1) where VN55 is the interviewer's code, 0003 is the code of the interviewee and (1) is the page number. The interviewer had to be assigned a code because this study is part of an international project. In the case of a focus group, the coding bears the interviewer's number, focus group number, the participant's number and the page number e.g. VN550002 (I) (2).

Although the verbatim statement of the individual is non- compulsory, the researcher, following Van der Wal (2001:2) to state verbatim, what the interviewee said in order to facilitate member checking.

4.7 Discussion of themes and sub-themes and embedded literature

Knowledge of HIV and AIDS emerged as one of the major themes in this study. Professional nurses indicated that it is necessary to understand the pandemic in order that care to infected and affected people should be standardised. Adherence to policies and systems of care form a crucial part in quality patient care.

4.7.1 Theme 1: Knowledge of HIV and AIDS

Table 4.3 presents knowledge of HIV and AIDS in the discussion of themes and sub- themes.

Table 4-3: Knowledge of HIV and AIDS

1. Knowledge of HIV AND AIDS	1.1 Standardisation of care
	1.2 Protection against infection
	1.3 Involvement of family members
	1.4 Participation in HIV and AIDS research

The theme emerged from the question on reasons that prompted the professional nurses to develop facility al policies. These were cited as empowerment of the staff regarding the pandemic.

4.7.1.1 Standardisation of care

Professional nurses believed that this knowledge could be enhanced by developing policies on standardization of certain procedures for uniform care to patients. Protection against cross-infection by staff also came up strongly as a point of departure in HIV and AIDS care. Family involvement also emerged in this study as professional nurses believed if families understood the dimensions of this pandemic, they would be able to assist the patients in their care.

Regarding the above theme: 'Knowledge of HIV and AIDS respondent said:

For the organization to develop the policies... eh.. this was done so that the health team in that organization should have knowledge about what is HIV and what is AIDS, ...and...how does it affect an individual (VN55002(1)(3).

4.7.1.2 Protection against infection

This sub-theme also emerged as a common one in the theme of knowledge about HIV and AIDS. This in the case of this study includes educating the family of the people living with HIV and AIDS.

One of the professional nurses explained:

*We should know what is the treatment and maybe what are the **precautionary** measures that we can take to prevent ourselves from contracting it, in short, so to say, how nurses can protect themselves against HIV at the workplace (VN55002(1)(2).*

4.7.1.3 Involvement of family members

Involvement of family members in the care of HIV and AIDS has been reported as one of the important measures to increase knowledge of HIV and AIDS amongst both the nurses and the community. In this regard, a respondent said:

Ok, I would like that policies like.... all family members should be... Should be educated... should have information about HIV, like maybe we could do, or make door to door campaigns so that they all have information in order to support one another, so that they don't stigmatize the infected and the affected people (VN550004(8).

Betancourt, Abrams, McBain- Smith- Fawzi (2010) state that family centred approach has a potential to improve patient outcomes. It is therefore important to involve families in the care of HIV and AIDS patients.

When asked to elaborate more on what she meant about stigma as a deterrent to HIV and AIDS treatment. One of interviewees said:

Because in some cases we find out that we advise the client not to breast feed when she chooses to formula feed the child, and when she arrives at home it becomes a problem because the mother in law and the husband do not understand why this person is not breast feeding, so I think the policies that we develop should have that accommodation to... Let the family members or the community be educated as part of destigmatization... eh disclosure so that if the mother doesn't breast feed, then it doesn't become a problem for the mother (VN550008(8).

- Participation in research

Professional nurses reported that research-based knowledge is not used to contribute to policy formulation. When asked about suggestions that could improve HIV and AIDS care to patients and families respondent said

If we could....be allowed that with the knowledge we have and have gathered.....all these years be allowed to contribute to all these policies...it would be a good thing. As we normally receive indications that this and that has changed without us actually forming part of contributing to such changes.

4.7.2 THEME 2: Destigmatization of HIV and AIDS

Various factors influence HIV and AIDS prevention and care. These factors range from stigma and discrimination, culturally imposed gender roles, sexuality, the global impact of the disease as well as myths. Literature was reviewed regarding stigma and its consequent effects to HIV and AIDS care and prevention. Table 4.5 presents information on destigmatization.

4.7.3 Theme two: Destigmatization of HIV and AIDS

Table 4-4. Destigmatization of HIV and AIDS

Destigmatizing HIV and AIDS	• Local knowledge about stigma
	• Destigmatization improves patient outcomes

It is important to destigmatize HIV and AIDS as professional nurses suggested that this might enhance care of patients with HIV and AIDS. In the past people were marginalized and stigmatized at first as HIV and AIDS was attributable to homosexuality and other socially deviant behaviours. This disease was given a social construction and even today as this thesis of 'HIV and AIDS care, research and policy interface' is written there are still socially constructed myths regarding the disease.

When asked about policies they thought are still required related to HIV and AIDS care, one respondent said:

Stigma...it makes our job as professional nurses very difficult because we do guide as professional nurses... we give patients...options...we give different options, feeding options that they can choose from, but if they are stigmatized they fail to adhere to their method of choice, like in case she is afraid of an abusive partner uhm...like if the community around value breastfeeding...values matter, even if the woman has chosen to breastfeed she wouldn't comply because she wants to impress the relatives and maybe the partner, and she will end up breastfeeding because of societal values, she will breastfeed to impress them and on the other side would practice replacement feeding (VN0004(2)).

The excerpt above indicates that stigma interferes with the care of HIV and AIDS.

4.7.3.1 Local knowledge about stigma

Stigma is regarded as a tarnished moral character by Holzemer and Uys (2008:166). . Whilst Khadidiatou, (2008:1) describes stigma as a concept used in classical Greece and it was used in reference to physical markings in individuals who were seen as having 'tarnished moral character because of their actions' as traitors and criminals, or slaves. .

One of the interviewees answered that:

The stigma...they are afraid of the stigma and that people will associate them with this disease, and because they are uhm, uhm...you know?... the old teaching...Uhm...that one gets HIV because of misbehaving or promiscuity. If people can be educated that you can get infected innocently like being raped or needle pricked or by blood transfusion and all that... without associating it with being a person who is not behaving well.

Herek (200:66) views stigma as 'an attribute that is deeply discrediting within a particular social interaction, as a spoiled social identity and a deviation from the attributes considered normal

and acceptable by society and when it is related to AIDS it means prejudice, discounting, discrediting and discrimination against HIV and AIDS infected people'. Muhomba, (2007:63) states that stigma refers to an undesirable attribute that damages the reputation of an individual or his/her status in the eyes of others. Among some societies certain attributes are regarded as worthless and convey negative attitudes or behaviours towards an individual or group due to their behaviour.

4.7.3.2 Destigmatization improves patient outcomes

Personal and emotional reaction and changes with regard to whether or not a person has social support are attributed to stigma. Perceived discrimination, disclosure to others, as well as coping strategies, depend on whether or not there is stigma levelled against a person with HIV and AIDS. People living with the disease sometimes perceive themselves as victims of their own behaviour because of the label put on them by others who perceive them as victims. People might therefore refrain from care because of stigma. In this regard one respondent said:

I will be happy if the written formal consent could be abolished and HIV be treated as any other condition, and be investigated like any condition...like if the patient has come for, or you suspect diabetes...where you ask for a consent form from a patient verbally and then test the patient. Because it takes a long time, it's a process to fill in a consent form, and it is time consuming for the patient and the staff. On the other hand this alerts other patients that if a written consent is required, a patient is HIV positive (VN55002 (8)).

Greeff et al.,(2008:89) state in their definition that stigma is an outcome that occurs when the negative social meanings attached to the discrediting attitude becomes linked to the individual. The authors above further contend: 'When we speak of stigma we are discussing the entire field of people who are regarded negatively, some for having violated rules, others just as being sort of people they are or having traits that are not highly valued(Greeff et al.,2008:89). A further definition referred to by Greeff et al. (2008:81) is that stigma encompasses a perception of negative characteristics and a global devaluation of the possessor of the characteristic. Having examined the effects that HIV and AIDS stigma has on the care of HIV and AIDS patients, theme 3: The impact of HIV and AIDS on the workforce is now discussed.

4.7.4 HIV and AIDS impact

HIV/ AIDS imposes a burden on the health care sector, as this disease may complicate into a debilitating condition. It stands to reason that with complications there will be an increased demand on care. Therefore this theme emerged under Objective Two 'To examine the impact of HIV and AIDS on the workforce'.

Table 4.5 displays the theme of HIV and AIDS impact.

Table 4-5: HIV and AIDS impact

1.HIV and AIDS impact	1.1 Impact on the health system
	1.2 Impact on HR

4.7.4.1 Impact of HIV and AIDS on the health system

Some respondents reported that HIV and AIDS poses an added burden on the health care system as far as workload is concerned.

Uhm...the worst of them all is that we have been complaining, that we are having a challenge...we have less staff, we are expected to see more than the required number of patients in as far as the nurse patient workload is concerned...like...the workload is too much for us, because we see about 68 patients, but we are three...and we are required to execute proper and quality care to each and every individual. So at the end of the day we end up not fulfilling whatever we want to do to the patients. In future if everyone can be trained. Each and every nurse can be trained to know how to handle eh...HIV and AIDS issues, because not all the nurses are trained to do that, in cases where those that are trained are not available (VN550003 (3)).

Staff dealing with HIV and AIDS should go for counselling as they empathize with the patients and become burnt out as they deal with this overwhelming disease (VN55003(3)).

Burnout has been identified as a significant problem in health care professionals who work with chronic illness individuals like HIV and AIDS, cancer and intensive care patients. Effects of HIV and AIDS burnout range from ineffective coping with occupational stress, chronic emotional stress of dealing with individuals with health problems, emotional exhaustion, dehumanized response to people receiving care from a burnt out person. Burnt out people also have reduced personal accomplishment (Heuy, 2008:8-11; Van Rensburg et al., 2006)

4.7.4.2 Impact on human resources

Burnout may have serious mental, physical, psychological, social and occupational effects. Low morale, impaired work performance as well as reduced productivity. There are also incidences of a high absenteeism rate in people who have burnout syndrome. Health professionals also develop low job satisfaction and adverse interpersonal relations with clients (Heuy, 2008:11-12) Burnout is a combination of negative behavioural, attitudinal and physical changes in response to work-related stress (Van Rensburg et al., 2006:2). Van Rensburg further indicates that the

burnt out professional exhibits loss of concern for the client, fatalism about one's work, decline in motivation, effort and involvement at work, apathy, negativism, frequent irritability and anger with clients and colleagues. The professional further becomes preoccupied with work comfort and welfare on the job. Other symptoms include a tendency to rationalise failure by blaming the clients or the facility /system. Resistance to change, rigidity, and loss of creativity may also occur in such professionals.

This then leads us to the next theme which emerged from the question that needed a clarification on who was involved in the process of HIV and AIDS policy development at the facility level. The theme on stakeholder participation emerged.

This theme emerged from the broad question that was posed on policies that are still required related to HIV and AIDS care, one respondent said:

You see...because, sometimes we are overworked, and we feel that uh...having patients with HIV and AIDS poses a lot of overload, because of the workload to us...s there are so many things that we actually attend to when the patient is having HIV and AIDS, so...sometimes we feel that we are having burnout due to the illness because we can't cope sometimes with this illness...Eish...(VN5555005 (8).

4.7.5 Theme 4: Stakeholder participation

Stakeholder participation was cited as an important part in HIV and AIDS policy development. An extract in this regard is:

We started...we thought that if we involve people like uhm...the clinic cleaners, the...the clerks er...the pharmacy assistants the supporters, it will be very good, because they are the people who work with us on day-to-day basis (VN5500018(3).

A situational analysis was done to make an impact on knowledge, to people like the community leaders and the committee...clinic committee members, and key leaders etc. were involved as they are people who know the community better than us and then uhm...policies were developed from their input.

This is what led us to involving the community, and I mean and the key figures like eh..... the councillors and the clinic committee members (VN5500013) (3) and (4)

Table 4.6 displays the theme of stakeholder participation.

The theme, stakeholder participation in HIV and AIDS policy development emerged out of the extractions from the interview transcripts. Table 4.6 presents stakeholder participation.

4.7.6 Stakeholder participation

Table 4-6: Stakeholder participation

1 Stakeholder participation	1.1 Participation in policy formulation.

Isn't it that there are policies from national or from the province, but we gather as staff as to how can we achieve them, then we develop our own policies....., the staff members I am referring to us professional nurses, and we have the home based carers at the clinic, we do include them, and we also include the HIV counsellors. Eh...even the cleaner is there, the administrator is there, the pharmacist is there, so we include everyone (VN550009 (11)(4).

On the other hand, respondent (VN5500013 (4) reported that

There will be slight changes which will be done on the policies, it is not such a wise ehm...decision because now, what should happen is that, let those at lower level...us at the lower level to develop the policies, and from our own policies maybe see if there is a general agreement or general information, which is general for all people, then from there, they could develop a national policy.

The same respondent said

The first reason is maybe at times if something is from national we just feel that we have to do it. Yes, but now since we are in daily contact with the patient you are the one who is more close to this patient.

Another said

These patients of HIV and AIDS, if maybe we can involve them, in the...in the care because there is still stigma attached...to HIV. If maybe there can be a policy in how to really involve the family without uhm...without the family...ah stigmatizing their member (VN550005 (7)..

This is beneficial because these are the people who are, who live with these people on day- to-day basis. They know them better than we do, that is the reason why I say this is very...these people are very influential to us (VN5500018(3).

To confirm and embed the issue of stakeholder involvement in HIV and AIDS policy development the Human Sciences Research Council's audit on the process of HIV and AIDS policy development was reviewed. Table 4.8 shows an audit of the process of HIV and AIDS policy development that was done by Human Sciences Research Council in 2004 in six countries. This table shows that in Southern Africa, when The White Paper on Transformation of Health Systems was developed, a wide spectrum of stakeholders was included. It is not specified whether or not such stakeholders included nurses. Table 4.7 presents the participation of stakeholders on policy development in different countries.

Table 4-7: HIV and AIDS policies and process of development (Zungu-Ndirwayi, Shisana, Udjo, Mosala & Seager, 2004)

Country	HIV AND AIDS policy yes/no	Title of policy	Participation of stakeholders
Botswana	Yes	National policy on HIV and AIDS	All stakeholders involved
Lesotho	Yes	Policy framework on HIV and AIDS prevention Control and Management	Participative – nongovernmental organisation(NGOs), People living with HIV and AIDS(PLWHAs) and all stakeholders involved in all stages
Mozambique	Yes	HIV and AIDS policy	A wide array of stakeholders involved
South Africa	Yes	White paper Transformation of Health Systems	Wide spectrum of stakeholders involved
Swaziland	Yes	National Policy on HIV and AIDS	NGOs involved to some extent
Zimbabwe	Yes	National HIV and AIDS policy	Broad based, participatory and consultative

4.8 Concluding statements: interview guide (tool 4) results

Concluding statements are deductively derived from the interviews conducted. These are:

- Knowledge of HIV and AIDS forms an integral part in HIV and AIDS care and includes standardisation of care, protection against infection, involvement of family members and knowledge of programmes
- Destigmatization of HIV and AIDS enhances understanding of local knowledge regarding HIV and AIDS, improved patient outcomes and quality of life of HIV and AIDS patients

- HIV and AIDS impact is caused by, and not limited to impact on the health system, additional programmes, cross-border migration, stigma, burnout, staff shortages
- Stakeholder participation is necessary in HIV and AIDS care and this includes participation in policy formulation, involvement of family members in the care of HIV AND AIDS patients and knowledge of HIV and AIDS programmes in the community.

4.9 SUMMARY

Data analysis in this chapter uncovered themes which were supported in literature as a literature review was done in order to embed the results of the study. HIV and AIDS knowledge in the care of patients came up now and then as participants responded to the question on reasons that prompted the organization to develop HIV and AIDS policies. It was obvious that knowledge of this pandemic needs to be taken into consideration as not only the nurses are involved in the care of HIV and AIDS patients, families and community members are involved.

Destigmatization was reported as hindering the care of HIV and AIDS patients because of labelling and blaming that the disease bears. This deters treatment as sufferers do not disclose their illness and sometimes show up in healthcare facilities when their condition has deteriorated. This then necessitates increased care demands.

Impact of HIV and AIDS on the workforce is needs to be considered and, health care staffing patterns need to be changed in order to include non-professional health care givers. These should be incorporated in the healthcare system endeavour to cope with the healthcare demands. All stakeholders need to be included HIV and AIDS policy as the pandemic requires local and indigenous knowledge on the values of the community as well as their health beliefs. Chapter Five will present the conceptual model in HIV and AIDS care, research and policy interface.

CHAPTER 5: CONCEPTUAL FRAMEWORK

5.1 Introduction

In chapter three and chapter four the results of quantitative and qualitative data were discussed. Concluding statements, through deductive logic, were deduced from the results discussed in Chapter three and Chapter four.

This chapter will discuss the conceptual framework developed from the concluding statements from both Chapters three and four, including literature reviewed. According to Bodrick (2011:187) the logical development of the framework of the study must be clear. Assumptions upon which relationships are based must be made explicit and the investigator may choose to diagram the hypothesized relationships among the concepts and include this diagram on the written report. Schneider, Elliot, Lo-Biondo-Wood and Haber (2003:133) state that the significance of a conceptual framework is in linking the proposed or current study to the previous knowledge base on the concept of interest either by examining relationships between concepts or building on known and established theories or models. This is the reason that policies, capacity building, research, workforce outcomes and stigma and HIV and AIDS care formed the core concepts of the conceptual framework.

5.2 The scientific context of knowledge for development of this conceptual framework

The scientific context of knowledge for an intended conceptual framework should be harmonized with the world of nursing practice. Since science and knowledge deal with valid ways of knowing and the means of validating what is known Walker and Avant (2005: 18) agree in principle that constructing a model starts with the development of the conceptual framework. According to Bodrick (2011:187) the usefulness of the conceptual framework is not necessarily known at the outset, the broad context of concepts are known and are aimed at being congruent with nursing practice.

In this study the three orders of research are used. These are divided into the first order which is the reality or practice field. The second order is theory or research methodology, the third order the paradigmatic perspective.

5.2.1 First Order: Reality/practice order

Botes (2006:20) describes practice as an environment with lay and prescientific interpretations. In the case of this study the practice / reality level is the environment in which the registered

nurse and the person living with HIV and AIDS have an encounter. A problem was identified at this level that nurses form the first encounter with HIV and AIDS patients and care for these patients. Yet they are not included in HIV and AIDS policy. The characteristics of practice act as the determinants of research decisions.

5.2.2 Second order: Theory- research methodology order

The lay or prescientific interpretations of the registered nurse and a person living with HIV and AIDS and his family constitute theory that would direct the practice of registered nurses. In this study the research decisions of initiating, conceptualization, formulation, research design and implementation are taken within the framework of the research field, assumptions of the researcher, research context and the research objectives are also formulated. At the inception of this study the researcher made a decision to conduct research from the research idea that she had. This is: “Investigating the interface among, HIV and AIDS care, research and policy’.

At this level according to (Bodrick, 2011:188) a person produces actions based on what to do and how to do it. It embraces pragmatic and useful actions that involve ‘objects’ or ‘entities’ to include human beings and social practices as a collective of actions occurring in society, organisations, facilities and groups that pertain to the physical world. It is within this physical world that acquired knowledge is applied to gaining understanding or agreement within the world of everyday living.

Conceptualizing was done in order to ensure justifiability of the study and its relevance to the field of nursing. The disciplinary relevance of the study is that at the nursing practice level, nurses encounter HIV and AIDS patients, become aware of the issues relating to their care and may transform these into policy inputs. It is at this level of practice that the empirical data were collected in relation to HIV and AIDS care, research and policy interface.

5.2.3 Third Order: Metascience

According to Bodrick (2011:189) world two kinds of knowledge are connected by critical inquiry and reflection to world three. ‘The critical interest’ at the level of world three may include the aim to criticize, deconstruct, dissect, de-contextualize, or analyze within a scientific activity targeted at the improvement in the practice of science. It is at this order that the constructivist and postmodernist paradigm was applied to critically review interrelationships for the generation of knowledge in the three orders.

5.2.3.1 Postmodernism

Postmodernism is widely used because it represents a new understanding or interpretation of the world (Rossouw, 1995: preface). It can be used in different ways to contribute to our understanding of science. It rejects unified explanation of the nature of science. No one definition applicable to all sciences is possible. The present-day nursing theory researchers ascribe to is the notion of putting into action principles that form the core of the self-corrective process of science. The idea of a scientific community is the core of this notion, because scholars who work in independent research environments do come together at a certain point to critique each other's work. They therefore follow the principles of critique and replication (Walker & Avant, 2005:9). This is also true with regard to this study as the existing policies and programmes of HIV and AIDS care are reviewed and research is conducted in order that they should be either modified, maintained as they are or changed in totality. This is the crux of postmodernism, being open to other ideas rather than the original standpoint of a researcher. Postmodernism is congruent with humanistic existentialism and constructivism because they both subscribe to the notion of making meaning out of what has been observed and interpreted. This notion also rejects value freedom, as in social policy values are taken into consideration.

This is true in the sense that in postmodernism both positivism and naturalistic inquiry may be used in combination as no single explanation of truth is accepted. As mentioned earlier, this is a notion central to the development of a model in this thesis.

5.2.3.2 Constructivism

Proponents of the constructivist approach understand the complex world of lived experience from the point of view of those who live it (Lincoln & Guba, 1985:118). According to this knowledge and truth are created and not discovered.. As the study is intended to develop a model for HIV and AIDS care, research and policy interface it is necessary to elicit meaning from the registered nurses in order to be able to understand the views of these social constructors of the knowledge about what actually matters in caring for HIV and AIDS patients.

This notion is consistent with what should be done in the development of social policy. As social policy development is a social process which should comprise dialogue, discourse and narration.

Lincoln and Guba (1985:125) argue that for constructivists knowledge and truth are the result of perspective and emphasize the pluralistic nature of reality. This study adopts both naturalistic inquiry and positivist views as the researcher is a proponent of postmodernism. Reality in this

study is viewed from multiple perspectives. Quantitative and qualitative methods are used to examine reality from all perspectives. .

5.2.3.3 Constructivist thinking

Human beings do not find or discover knowledge so much as they construct it. Concepts, models and schemes are invented to make sense of experience and are further continually tested and modified in view of new experience (Lincoln & Guba 1985:126). This is why it is important to revisit HIV and AIDS policy in view of the experiences of the registered nurses and modify this policy required by the new experience. Development of a model is congruent to constructivist thinking because as Lincoln and Guba confirm, concepts and ideas are invented and these represent a set of human constructs that have meaning. The constructivist's philosophy of Goodman as explained by Lincoln and Guba (1985:127) is pluralistic and pragmatic.

The above as applied to this study means subscribing to multiple realities as well as taking into consideration the views of people who understand the phenomenon under investigation. Registered nurses caring for HIV and AIDS patients have a pragmatic experience in such patient care as some live among such patients, beside the fact that they nurse them.

According to Denzin and Lincoln (2011: 127) 'world making as we know it always starts from worlds already on hand; the making is remaking'. In the case of this study what is known by the registered nurses are the experiences of people living with HIV and AIDS and the researcher who is the knower of the policies of care should remake these policies by developing a model out of the experiences (what is known) of the registered nurses . This will only be achieved by bracketing. In this study, bracketing of any known information was done when relevant in the study.

According to Denzin and Lincoln (2011:128) constructivism is congruent with naturalistic inquiry, and these authors argue that constructivist, interpretive, naturalistic, and hermeneutic approaches are all similar notions. Their constructivist philosophy is idealist; that is, they assume that what is real is a construction in the minds of individuals. The above authors further elaborate on constructions as attempts to make sense of or to interpret experiences which are most sustaining and renewing. The range and scope of information available to a constructor and how he/she deals with such information determines the nature and quality of the construction. In this case a model will be constructed out the range of information available to the researcher from the professional nurses.

5.3 The identification of concepts in this study

Understanding the concepts began with understanding the three orders of knowledge development used by Botes (2006). These concepts were identified in Phase Two of the study. The scientific understanding of the concepts in this study stemmed from the concluding statements, drawn from Objectives 1, 2 and 3 in accordance with the three different questionnaires, themes that emerged in Chapter Four (qualitative data) and literature reviewed in this chapter.

In the process of identifying the concepts, the concluding statements were reviewed to ensure consistency and congruency. In this instance Bodrick's (2011:193) method was used.

- The concluding statements were read to identify concepts at the first order.
- The process was supported by linguistic constructions by means of which people order and categorize reality.
- A list was generated that tentatively identifies key concepts and other concepts that appear to be interrelated.
- The coloured statements were then reduced to concepts.
- The list of the key concepts was then, supported by literature, was then drawn up.
- A main list of the related statements was then drawn from the identified concepts. This method followed Mouton and Marais (1996).
- The dictionary or Thesaurus was used to explain terms connotatively.

Table 5.1 presents the concluding statements from quantitative and qualitative data.

Table 5-1: Concluding statements from qualitative and quantitative results

Concluding statements on research	Concluding statements on policy	Concluding statements on HIV AND AIDS care
- Professional nurses rarely participate in research related to HIV and AIDS. - Research and evidence-based practice is not used for policy formulation. - Professional nurses possess the knowledge of HIV and AIDS care, but lack the research component thereof. - Research and policy interface should form part of policy formulation. - Training forms an integral part for HIV and AIDS care although this lacks the research component.	- Professional nurses are involved in facility al policy development committees but never participate in national policy development. - Workplace policies on HIV and AIDS are available although these are not used to plan for staff absenteeism, hence the high workload still exists in facilities . - Stakeholder involvement is important in HIV and AIDS policy development including training of professional nurses in HIV and AIDS policy influence and pre-service. - HRM staff exists and perform basic functions but there is a lack of capacity building regarding the development of HIV and AIDS policies - A top-down approach is followed in HIV and AIDS policy development - Nurses lack skills in the policy arena, locally, nationally and internationally.	- Destigmatization of HIV and AIDS enhances understanding of local knowledge regarding HIV and AIDS, improved patient outcomes and quality of life of HIV and AIDS patients. - Professional nurses manage HIV and AIDS like any other condition without stigmatizing the patients. - Job descriptions are available for all staff members and are adjusted according to additional staff functions. Changes in performance areas are taken into consideration. - There is a formal human resource planning system to attract nurses into the healthcare system, i.e. the occupational specific dispensation that determines salary upon entry to the organisation. - There is a policy of non-discrimination on the basis of HIV and AIDS is available but there is doubt whether or not this is adhered to as HIV and AIDS is not disclosed. - An HIV and AIDS programme is in place and focuses on using appropriate protocols to limit the risk of infection as well as education about HIV and AIDS. - Training is a formal component of the organisation and is linked to staff and organisational needs, but it is not implemented in order to reduce staff absence from their posts during training. - Professional nurses are involved in HIV and AIDS education of patients and families to prevent HIV and AIDS transmission. - There is a need for specialized training of nurses for HIV and AIDS care. - Increased workload on health system is caused by additional programmes, cross-border migration, stigma and burnout.

Table 5-2: Identification and classification of concept

Concluding statements		Step 1 Reduction	Step 2 Reduction	Concepts
- Professional nurses are involved in facility al policy development committees but never participate in national policy development. - Workplace policies on HIV and AIDS are available though these are not used to plan for staff absenteeism, hence the high workload still exists in facilities . - Stakeholder involvement is important in HIV and AIDS policy development including training of professional nurses in HIV and AIDS policy influence and pre-service. - HRM staff exists and perform basic functions but there is lack of capacity building regarding the development of HIV and AIDS policies. - A top-down approach is followed in HIV and AIDS policy development. - Nurses lack skills in the policy arena, locally, nationally and internationally.		Professional nurses have to influence HIV and AIDS policy.	Nurses as stakeholders should be involved in policy development.	Policies
- Professional nurses are involved in HIV and AIDS education of patients and families to prevent HIV and AIDS transmission. - There is a need for specialized training of nurses for HIV and AIDS care. - Professional nurses rarely participate in research related to HIV and AIDS. - Research and evidence-based practice is not used for policy formulation - Professional nurses possess the knowledge of HIV and		Professional nurses lack research capacity and yet this is an important part of HIV and AIDS.	Research is important in HIV and AIDS care.	Research

AIDS care, but lack the research component thereof. • Research and policy interface should form an integral part of policy formulation. • Training forms an integral part of HIV and AIDS care though this lacks the research component.				
• Job descriptions are available for all staff members and are adjusted according to additional staff functions. Changes in performance areas are taken into consideration • There is a formal human resource planning system to attract nurses into the healthcare system i.e. the occupation-specific dispensation that determines salary upon entry to the organisation. • A policy of non-discrimination on the basis of HIV and AIDS is available but there is doubt whether or not this is adhered as HIV and AIDS is not disclosed. • An HIV and AIDS programme is in place and focuses on using appropriate protocols to limit the risk of infection as well as education about HIV and AIDS. • Training is a formal component of the organisation and is linked to staff and organisational needs, but it is not implemented in order to reduce staff absence from their posts during training. • Increased workload on health system, additional programmes, cross- border migration, stigma and burnout impact negatively on staff outcomes. Destigmatization of HIV and AIDS enhances understanding of local knowledge regarding HIV and AIDS, improved patient outcomes and quality of life of HIV and AIDS patients. • Professional nurses manage HIV and AIDS like any other condition without stigmatizing.		HIV and AIDS escalates the workload of nurses due to new programmes that are introduced in the management of the disease, and though there are some retention strategies within the health-care facilities , workload still supersedes the staffing levels. HR planning and performance management are integral parts of ensuring positive staff outcomes. Knowledge of HIV and AIDS forms an integral part in HIV and AIDS care. This includes: • Standardisation of care • Protection against infection • Involvement of family members in HIV and AIDS educational programmes • Knowledge of programmes Specialized training is important in HIV and AIDS care. Including destigmatization .	Increased capacity on HIV and AIDS contributes to better patient and staff outcomes. HIV and AIDS impacts on the health care system negatively Knowledge of HIV and AIDS enhanced care of people living with the disease. HIV and AIDS stigma hampers quality patient care.	Staff outcomes and HIV and AIDS care Stigma and HIV and AIDS care

5.4 Development of the conceptual framework

The key concepts of the conceptual framework were deduced from the concluding statements. In the logical construction of the conceptual framework, the steps followed are discussed.

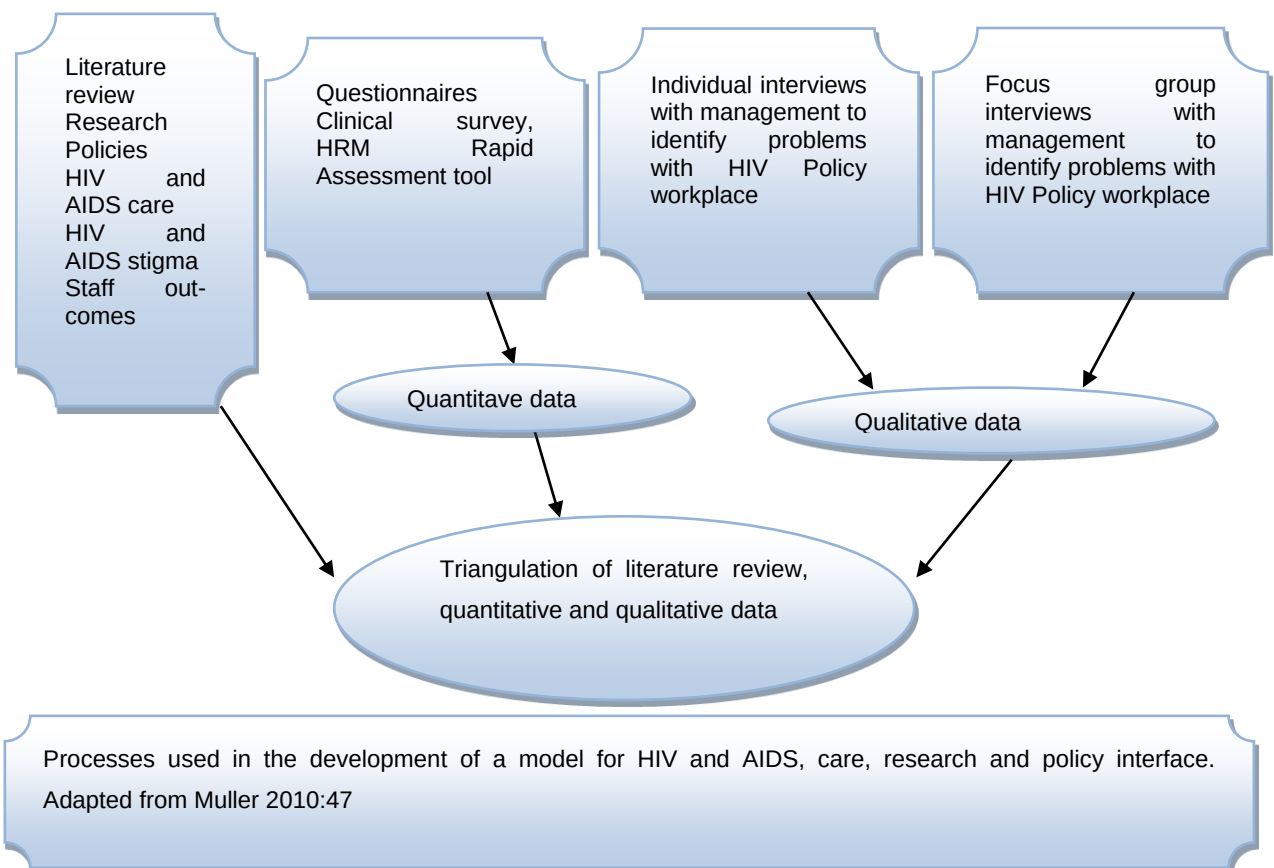
5.4.1 How the conceptual model was developed

Chapter 2 of this thesis explained the paradigmatic perspective on which this study is based. Postmodernism was indicated as the philosophical view that the researcher subscribes to, a belief in multiple perspectives in knowledge development was cited as significant and compatible with this study. As the study is both qualitative and quantitative this is confirmation of a postmodern view (Renpenning, 2001:162-163).

5.4.2 Assumptions of the study

- Knowledge is constructed through subjective and multiple, co-existing and contextual truth as perceived and created by the scientific community. This constitutes a move away from objective positivists' view as the only form of scientific knowledge. The researcher adopted multiple realities as the nature of good science. The research field was approached with openness of mind that allows for discourse, debate and dialogue. The experiences of nurses were taken into consideration in exploring concepts relevant to HIV and AIDS care, research and policy interface. This presupposes a postmodern view towards knowledge construction.
- Postmodernism allows for use of emerging themes during interviews to develop a model to enhance HIV and AIDS care, research and policy interface. The data collected during the interviews was complemented with quantitative findings.
- The use of both qualitative and quantitative research methods is a confirmation that in a postmodernist perspective acceptance of multiple views in knowledge construction should be considered.

These assumptions form the basis of theoretical reasoning employed in this study as well creativity and critical thinking methods used. Figure 5.1 presents the process of data collection in the development of a conceptual framework.



5.4.3 Creativity and critical thinking methods used in the conceptual framework

The questions used in critical analysis reflected the process of praxis for emancipatory knowledge and change (Chinn & Kramer, 2011:11). This includes critical reflective nursing practice. At this juncture new awareness of nursing problems begin to take shape (Chinn & Kramer, 2011:11).

The anticipated social change that comes from praxis leads to emancipation in nursing regarding socio-political awareness and influence in HIV and AIDS policy process (Bester, 2010:201).

5.4.4 The use of literature

Literature was used in order to embed the findings of the study and to examine the extent of the phenomenon of concern i.e. HIV and AIDS care, research and policy interface. This involved the location of evidence related to HIV and AIDS care, which was uncovered by discussing the history of HIV and AIDS, programmes used in HIV and AIDS care, issues related to care e.g. stigma, gender stereotypes, socio-cultural factors and other healthcare determinants this regard.

The approach to conducting a literature review to embed the conceptual framework on the discussion of the concepts that were classified required a search strategy. Polit and A model for HIV/AIDS care, research and policy interface

Beck (2013:109) support this notion that the concepts identified during data collection should be supported by literature. A literature search was done as alluded to by Polit and Beck (2013:109)

- Searching for references using bibliography databases.
- The ancestry approach that follows footnotes that cite relevant studies.
- The descendancy approach that locates a pivotal early study and tracks recent studies that cite the original key study (Bodrick, 2011:205):
- Literature tracking that involves devised methods to track limited distributions, conference papers and posters, unpublished reports, media e.g. SA FM.

5.4.5 The steps used in the process of literature searching and review

The following steps were used in literature search and review

- (i) Identify key words that pertain to the search topic e.g. HIV and AIDS, care, research, policy, politics, public health policy.
- (ii) Defining the key words and concepts using dictionaries or the glossaries of textbooks.
- (iii) Using search engines of electronic literature sources, select publications that have supportive and non-supportive contributions on the search topics, key words and concepts.
- (iv) Reviewing the selected literature specifically for perspectives that (a) discuss key concepts (b) define the research approach used, (c) describe theoretical components, and (e) include expert opinion.
- (v) Considering the analysis of the selected literature within the specified and related context of the research study.
- (vi) While analysing literature be aware of (a) areas that would require further clarification or more research, (b) gaps in knowledge or un- answered questions, (c) controversy or inconsistency in the literature, (d) aspects from past experience or logic that are possibly relevant to the phenomenon under study, and (e) perspectives that are common or uncommon in occurrence.

- (vii) Making a judgement on the component parts that are analysed, then utilise these to generate justifications and arguments using deductive and inductive reasoning in relation to the points of focus.
- (viii) Synthesize the ideas by combining points, themes, opinions and arguments into a logical complex whole that integrates judgement theory into a single flow of reasoning in response to the dimension of the search topics that compromise the key words and concepts (Creswell, 2003:33; Silverman & Marvasti, 2008:365; Marshall & Rossman, 2011:77).

According to Walker and Avant (2005:110) 'literary synthesis' is required in conducting literature searches. This aims at acquiring new insights about the phenomenon under study. As stated in this chapter as well as in Chapter One, a pragmatic process of knowledge construction was followed. The pragmatic view about meaning making includes a wider variety of related situations. According to Mouton (1996:198) the identification of the above major characteristics contribute to a conceptual framework in which phenomena are classified in terms of their concepts.

5.4.6 Research methods used to gather data

Qualitative research methods e.g. interviews were conducted to collect data on HIV and AIDS policies as well as a quantitative method was used through the use of structured questionnaires. Literature search was conducted to examine the phenomenon under study. This included a search on public policy development, HIV and AIDS care, research and model development).

Since the conceptual framework was developed after the reduction of concluding statements to single concepts, this means that it was developed deductively. Data collected from objectives one, two and three gave rise to concluding statements. These statements are indicated in the conceptual framework. i.e. figure 5.8.

- **Data collected from the clinical survey, the HRM Rapid Assessment tool and the interview guide**

The far left part of the conceptual model light blue (quadrant) represents the quantitative and qualitative data results and the instruments used to collect the data. The clinical survey collected the quantitative data, whilst the HRM rapid Assessment tool collected both the quantitative and qualitative data. Lastly the interview guide was used for qualitative data collection.

The clinical survey was used to collect data for objective one, The HRM Rapid Assessment tool collected data for objective two and three, whilst the interview guide collected data for objective three.

- **The central part of the conceptual model**

The middle part of the conceptual framework consists of a rectangle with concluding statements numbers from both quantitative data. These consists of research concluding statements, policy, statements, HIV and AIDS care, HIV and AIDS stigma, and staff outcomes. The concepts stated here are written in a circle.

- **The far right part of the conceptual model**

This part of the conceptual model consists of concluding statements from literature review. These are statements on policy influence presented in table 5.1, statements on the role of nurses in politics and policy development presented in table 5.2, research statements presented in table 5.3, statements on HIV and AIDS care presented in table 5.4. and statements for staff outcomes and HIV and AIDS care, and stigma. Figure 5.2 depicts the process of the conceptual framework employed in this study.

Concepts used in the conceptual framework are discussed hereunder:

5.5 Discussion of the concepts of the conceptual framework

The concepts identified after logical deduction will each now be discussed.

5.5.1 Policies

In the 1990s valuable lessons were learned in how political forces influenced health care policy in the public and private sectors. Nursing was also one of the political forces that influenced health policy (Mason, Leavitt & Chaffee, 2014:12). Both globally and nationally nurses are viewed as the backbone or heartbeat of health care. They could therefore be role players in policy agenda setting. These role players could work with people who are elected political office bearers receiving a mandate from the electorate to shape and give content to public policy (Shamian, Skelton, Green & Villeneuve, 2006: 110). Appointed officials, who are also career public managers, receive and answer policy problems. The courts of law contribute to the policy-making process by identifying inherent policy weaknesses and draw the attention of both legislature and the executive to issues on the public agenda. The interest groups mobilise their members as they have the desire to access the policy agenda. In South Africa interest groups play a major role in the public agenda, e.g. women's interests and the treatment action group for HIV and AIDS. The

media also play a very important role in shaping the public opinion and hence the policy agenda (Cloete & De Coning, 2011:114-115).

Mason et al., (2014:2) state that in 1991 the American Nurse Association Political Action Committee (ANAPAC) became the first health professional organisation to endorse William Jefferson Clinton for president of the United States, because his health platform was consistent with 1991s nursing agenda for health care. Nursing's agenda reflected the centrality of a nursing perspective to quality health care. Both Clinton and nursing's leaders embraced a belief that government had a responsibility to guarantee access to quality healthcare for all. Clinton mentioned nurses in his organized rallies, interviews with the press and policy statements. Nursing political activists held leadership positions in the Clinton Campaign. In November 1991 Bill Clinton was elected as president endorsed by organized nursing (Mason, Leavitt & Chaffee, 2014:12). Nurses grew in the world of policy and politics and most of them understood that they had to be players in shaping public policy and private policies that determine the nature of health care in America.

5.5.2 HIV and AIDS policy changes in South Africa

In 1990 The African National Congress (ANC) reiterated the importance of preventing HIV and AIDS (Policy project, 2003a). The ANC briefing document (2001) concentrated on mobilizing resources in HIV and AIDS prevention. In 1992 the establishment of the National Convention of HIV in South Africa (NACOSA). This guided South Africa in its response to HIV and AIDS. The Strategic Plan for South Africa 2002-2005 and 2010-2014 serves as a broad policy framework for a comprehensive plan for the management, care and treatment of HIV and AIDS.

As a response to the Strategic Plan, government established the South African AIDS Council in April 2002 for advising government on HIV and AIDS issues. This body advised on the use of Nevirapine for Prevention of Mother to Child Transmission (PMTCT). At the same time the Post Exposure Prophylaxis for rape cases was put into place. In December 2010 a comprehensive plan for HIV and AIDS was tabled by the President of South Africa, Jacob Zuma, which included changes regarding the use of antiretroviral treatment which indicated that vulnerable groups with a CD4 count of 350 should be put on antiretroviral treatment. SADAC countries and opposition parties agreed to this strategy.

In 2010 the Ministry of Health in South Africa introduced a new strategy, in which the HIV and AIDS care and treatment was initiated, which instructed that all patients with a CD4

count of 350 should be put on antiretroviral therapy. This also resulted in new programmes including Provider Initiated Therapy.

This endeavour, in the view of nursing education, would facilitate the development of a nursing curriculum that would incorporate the innovative processes in the South African Health care system for example the NHI, the Re-engineered Primary Health Approach; HCT Provider-Initiated treatment of HIV and AIDS.

5.5.3 National trends in policy awareness of nurses

In the early 1990's nurses in South Africa became aware of workplace policies that were uncomfortable for them. They started organizing themselves and raised awareness of such unfair policies. The National Health and Allied Workers Union NEHAWU nurses contested the unfair labour policies in 1992 at the Free State. Other unions followed with protests, and this led to a variety of unions and staff associations rising up against unfair labour practices. They started complaining about for instance uniforms, certain basic conditions of their employment, e.g. off duties.

The Democratic Nurses Organisation of South Africa DENOSA complained of quality staffing levels in 2003 and appropriate nursing care rendered by appropriately staffed nursing units. In 2006 a national nurse's strike broke up regarding better salaries and general conditions of service. In 2007 the OSD was implemented. This is an indication that nurses can organise themselves and insist on having their input recognised at a national level.

As mentioned in Chapter One of this thesis, nurses are the backbone of the healthcare system. For this, reason, their inclusion in the policy platform might be of great value. Nurses involved in policy in the South African healthcare system are those in management positions of the national Department of Health and not necessarily those who deal directly with the patients. This implies the top-down model of policy development as discussed earlier in this thesis, because nurses working at a higher level of government have more opportunity in influencing HIV and AIDS policy (Muller, 2010:100). Disregarding the importance of frontline professionals like nurses might lead to discrepancies or gaps within the policy on HIV and AIDS.

In 2011 a nursing education and practice strategy (2012/13-2016/17) was developed. This required the nursing profession to reflect on its social recognition. Hence nurses from academia, management and practice gathered at Sandton to discuss the issue. The researcher in this case demonstrated leadership in the pre-summit preparation as the

topic HIV and AIDS care, research and policy interface also investigated the policy changes within the public health care sector.

5.5.4 Policy subsystems and stakeholders

Policy subsystems include a network of elected or appointed officials, legislative subcommittees, and interest group representatives and individuals directly involved in shaping a policy. The term stakeholder is applied to actors that may be directly affected by its outcome.

Stakeholders are also relevant in private sector policy-making, although they may not be as highly visible. To address specific policy decisions over time, analysts must also consider the substantive input from researchers, specialist reporters, professional associations, and facility al policy specialists (Sabatier, 1991).

Leavitt, Chaffee and Vance (2013:31) argue that when the status quo is no longer acceptable and one's consciousness is raised because of injustice, there is recognition that change is imminent. Nurses do reach such a stage at one time or another in their lives and start taking action regarding health care policy issues. By implication, nurses participating in this study suggested that policy development should be bottom-up, rather than top-down.

In this study of HIV and AIDS care, research and policy interface, it is therefore suggested that the approach that should be followed in policy development should be as depicted in Figure 5.2, which shows the suggested process of policy development which is inclusive of all stakeholders.

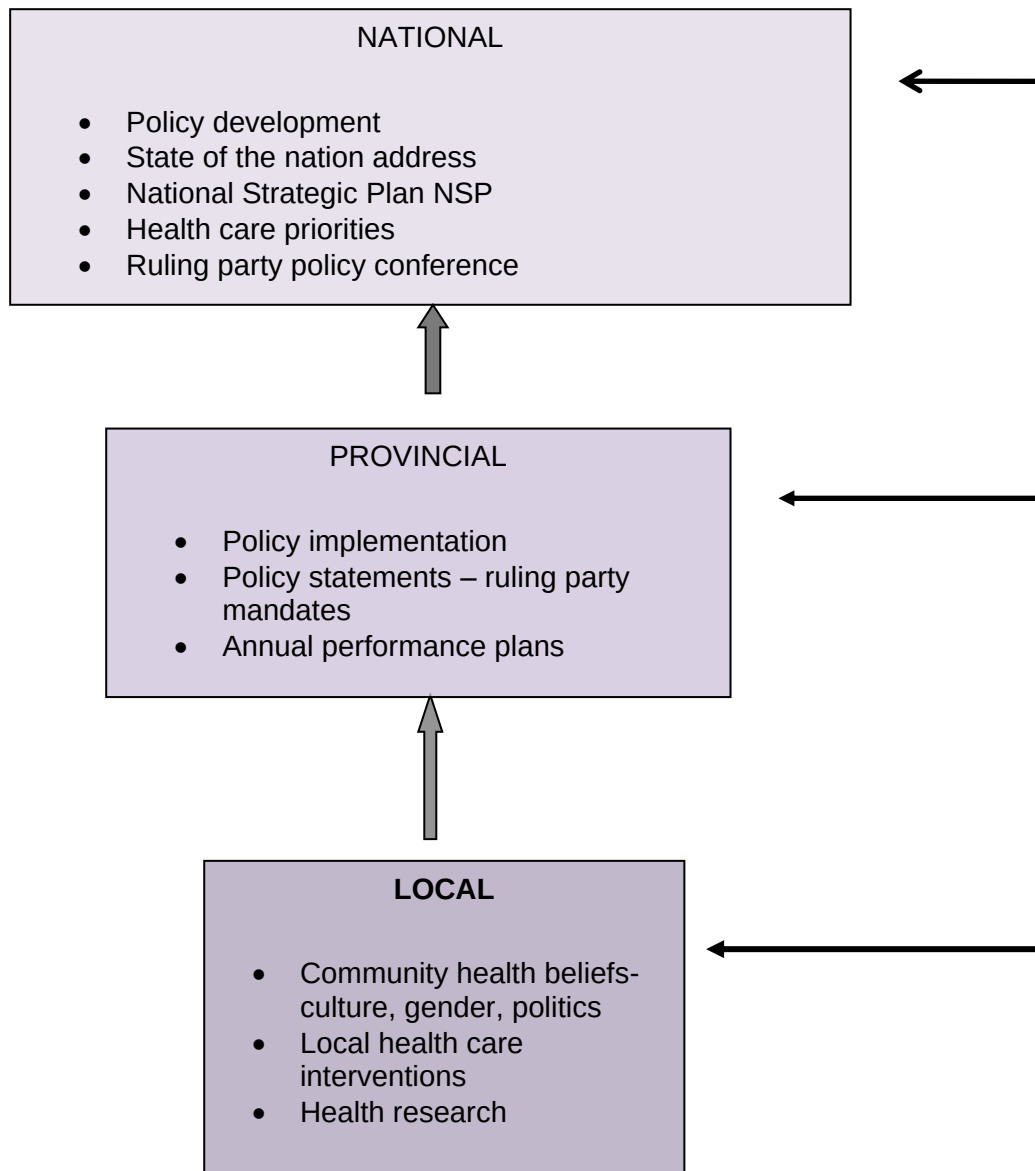


Figure 5-1: Proposed inclusive health policy development

There is a growing need for professionals including nurses to take part in policy subsystems. The significance of nursing research, nurse legislative and political action at local, state, and national level has been recognised by many organisations in nursing. This includes DENOSA and NEHAWU's recognition of the presence of nurse policy-makers and analysts. Nurse practitioner coalitions in South Africa such as NEHAWU's nurses core group included nurse management, lecturers in nursing and nurse practitioners to discuss general nursing issues that would ensure a unified nursing approach in key policy debates. This demonstrates that South Africa is slowly moving towards an era that upholds the notion of entrusting authority for decision-making to its alliance partners both in political stakeholders meetings and policy subcommittees. In

2011 NEHAWU developed a national health subcommittee which had to perform amongst other roles and functions the following:

- Assisting NEHAWU in developing organisational perspectives on the transformation of the health sector including on government policies and particularly for those on which campaigns should be undertaken.
- Participating in national health subcommittee meetings and make presentations when necessary.
- Assisting designing education workshops, including curriculum development, for members in provinces on:
 - (a) The transformation of the health system with particular focus on NEHAWU priority areas; and
 - (b) Accountability of health workers in delivering service to our people.
- Assisting with information relating to NEHAWU health activities.
- Assisting in the preparation of articles for distribution to members through NEHAWU media and/or publication in the printed media.

5.5.4.1 Cultural values, politics and policy

Political insight is an essential component of most successful policies and entails a process of social influence that includes activities of persuasion, attitude change, compromising and decision-making. This is why the final prerequisite for influencing policy is political insight that was obtained throughout the process. It is important for nurses to realize that to control nursing practice and the nursing profession they should play a major role in the health-care arena. Nursing and nurses need to become politically involved in influencing and formulating policy (Shamian, et al., 2006). Culture influences the level of health care of the individual, the family and the community. This is particularly relevant in the context of Africa, where the values of extended family and community significantly influence the behaviour of the individual.

5.5.5 Research

According to Edwards and Roelofs (2007:188) managers, researchers, decision- makers and community representatives have to build a critical mass of nurse researchers with a leadership role in addressing local health priorities. Professional nurses provide holistic care to HIV and AIDS patients but lack the research content in this regard.

A model for HIV/AIDS care, research and policy interface

The Declaration of Commitment on HIV and AIDS (United Nations General Assembly Session on HIV and AIDS, 2001:32) emphasized that investment in and acceleration of research should be encouraged especially in developing countries. This helps inform nurse clinicians on nursing models, and interventions on health care practices. Edwards *et al* (2009:90) confirm this statement by stating that decision-making and practice is a critical need in building research capacity amongst nurses. In this regard Lomas (2000:236) asserts that the idea of better informing practice with research findings has grown from medicine to management and policy decisions. Hence people who have sufficient research background have to use the most up-to-date findings from health services to inform policy and decision-making. This is the reason that Milner and Humphrey (2006:) advocate that clinical nurses should possess competencies in promoting best practice by mentorship, acting as resource persons and assisting in the development of policies grounded in research.

The understanding of research utilization in health care decision-making has to shift from simply measuring the use of research evidence to making health care decisions (Makoroka 2014:28). Professional nurses as leaders in nursing have to possess knowledge, keep up-to-date on continuing education, give answers and direction to find answers and solutions (Feltner et al., 2008:363). This according to the Nursing Act, Act no. 33 of 2005. The Nursing Act indicates that research is an important component in health care hence this study focused on the interface amongst, HIV and AIDS, research and policy interface. The results gave answers to whether or not nursing research is important in HIV and AIDS policy development.

Since there are a lot of changes in the health care arena, such changes go with challenges that unprepared nurses will not be able to cope with. Hence research preparation and evidence-based care focus on understanding the perceptions of clients/patients on health and health behaviour, as well as relationships amongst clients and providers (Cobb & Chabert, 2006:546). The level of research that nursing has attained should be translated into policy (Mason, 2014:73).

5.5.5.1 The link between research, practice and theory

Since it is important for the reader to notice the links among practice, theory and research, in this study the findings are embedded in literature that strives to show the intricate relationship amongst them. Figure 5.4 depicts this relationship. Cabinet Reference no. 59/2009 of the Social Protection and Development Cluster referred to the ten health priorities which include research and development in the health care system. The priorities of the Department of Health (South Africa, 2009:2) are:

- Research and development
- Implement the national health insurance plan
- Improve quality of health services
- Overhaul management system
- Improve human resource management
- Physical infrastructure revitalization
- Accelerate implementation of the HIV and AIDS and STI plans
- Attending better health for the population
- Social mobilization for better health
- Drug policy review.

The interface amongst, research, theory and practice is illustrated in Figure 5.3 as extracted from Lo-Biondo-Wood and Haber (2006:2).

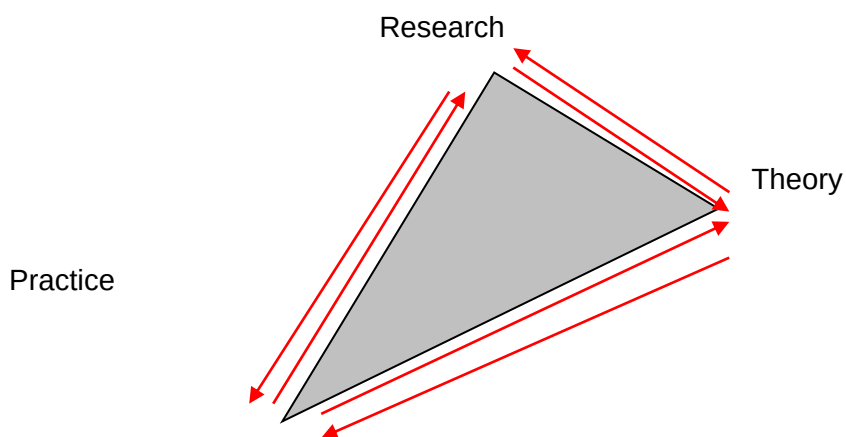


Figure 5-2: Theory-practice-research (Lo-Biondo-Wood & Haber, 2006)

Research conducted through inputs from professional nurses can contribute much to policy. As Rousell *et al* (2006:369) states that professional nurses are the largest group of health care professionals in the country and are providers of direct and continuous care to individuals. As such they can make positive policy changes. For this reason this study intended to develop a model for HIV AND AIDS care, research and policy interface. A model for HIV/AIDS care, research and policy interface

Nurse administrators according to Rousell *et al* (2006:369) can foster an environment and culture of political awareness and sensitivity to policy issues.

Theory guides practice and research and practice enables testing of theory and generates questions for research. Therefore what is learned through practice, theory and research is used to develop practice guidelines (Chinn and Kramer, 2008: 25 – 51). Therefore theory helps the researcher give a meaningful interrelationship of facts, hence the observation by professional nurses for the importance of this link. This shows that there should be a research policy establishment within the health care arena.

Nurses in higher-income countries are at the advantage of sourcing funds for research, and this excludes nurses from lower income countries. The results of which is fewer research-empowered nurses in low income countries (Edwards, *et al*. 2009:89). There is therefore a need for empowering nurse researchers in low income countries. These initiatives assist in the fast-tracking of research preparation for nurses Edwards *et al*, 2009:91); Strong mentorship arises from creating learning opportunities to do research that is supported by high level scientists with resultant quality nursing research. Nurses have innovative and effective knowledge translation strategies in place to disseminate research findings and to ensure that nursing research evidence is taken up in best practice guidelines that influence health policies effectively, but this is prevented by lack of funding (Muller, 2010).

The next concept that emerged after the reduction of statements is HIV and AIDS care.

5.5.6 HIV and AIDS care

The World Health Organisation (WHO, 2009:2) emphasizes that to provide comprehensive care for HIV and AIDS entails enabling people to know about their HIV and AIDS status, maximising the health sector's contribution to HIV prevention and accelerating the scaling up of HIV treatment and care. In this case the professional nurses provide information on care of HIV and AIDS for clinical management and care of HIV and AIDS as indicated in the results for Objective 1.

. In educating patients on HIV and AIDS care, it is important to consider theories of care, related to HIV and AIDS one such theory is that of Gibney *et al.*, (1999:90).

5.6 Stigma

Destigmatization of HIV and AIDS enhances understanding of local knowledge of the communities served by nurses. At this juncture, it was important for the researcher, to embed the results on stigma in the conceptual framework by Greeff *et al.*, (2008:21). This A model for HIV/AIDS care, research and policy interface

was done in order to relate the findings of this study to the existing knowledge as it is necessary to link the current study to a conceptual framework as a previous knowledge base on HIV and AIDS care. Figure 5.4 depicts HIV and AIDS social stigma and discrimination. Professional nurses reported that if this disease could be dealt with like any other condition, without strict confidentiality, this might minimize or prevent its stigmatization.

To this effect, one of the respondents said:

Uhm, okay, I know that there is a lot of policies on HIV and AIDS and uhm most of them protect the patients, especially the confidentiality of the status of the patient. I personally think that a policy should be developed upon, that does away with stigma. The stigma that is uhm linked to HIV and AIDS causes its own problems on itself so for us to uhm bypass that stigma will help us so there must be a policy where HIV and AIDS must be treated like any other chronic illness.

Chronic illnesses like diabetes uhm hypertension, asthma you name it uhm they don't get any special treatment like HIV. As the patient comes in and you have to write a special uhm consent forms for the tests to be done, it is done verbally so uhm the people if you ask them can we test you for it they more than willing to because there is no stigma linked to one of theses chronic disease they know if they uhm are tested for they can get treatment If you ask them: 'can we test you for it', they are more than willing to, because there is no stigma linked to one of these chronic disease they know if they uhm are tested for it they can be treated for it. So if we can get the stigma away from this HIV testing and results and everything it can be an open and a free thing a generalized vital uhm thing that the patients has to go through when he comes to health care facility then uhm the stigma will go away and also people will be more open and free about their status to the community and the community will not have sigma towards the patient so the community will be treated the same. That is how I feel that there must be a policy where this whole confidentiality and all of that uhm the standard must just lower a bit so that also in the health care facility where, where it can be discussed openly amongst health care workers so that uhm that we can be protected because we are having a hazardous job and if know the status of this patient and I cannot tell the colleagues that I am handing the report to over he might stand a risk of contracting the diseases if he is not double careful. So I think that type of policies they must maybe look into and change in a little bit.

Respondents in this study also cited the importance of local knowledge in the care of HIV and AIDS patients. Local knowledge should be understood by nurses as it facilitates care. Understanding the health beliefs of people enhances the provision of culturally congruent care. Such issues may also include gender stereotypes which impair certain genders to behave in particular ways. Knowledge that includes how rural women deal with sexual matters is important as is this might help nurses reaching out to the community which still regards HIV and AIDS as stigma bound. This is the reason that HIV and AIDS and gender forms an integral part of the conclusions drawn in this case.

According to Baylies and Bujra (2002:1) HIV and AIDS affects both men and women but women are more affected owing to their vulnerability regarding sexual relations. Given

how gender relations link to with sexual behaviour and economic security. Gender relations also inhibit women's attempts to protect themselves from the epidemic as some are economically unable to support themselves. Women's vulnerability to HIV and AIDS follows from social and economic factors. They have limited control to determine their lives and lesser ability to control the nature and timing of their sexual activity. Baylies and Bujra (2002:2) It is evident that women are the high risk population for contracting HIV and AIDS infection this is confirmed by Dominguez (1996:1) who state that 'Women are the fastest growing population of HIV infection.' He refers to the example of Hispanic women whose health status is complicated by significant psychosocial forces that impede access to health care. Dominguez's assertion is confirmed by HSRC (2012 : xxvi) by stating that Hispanic women follow more traditional sex roles that discourage assertive sexual behaviour by women. This is one of the aspects that result in a high rate of infection in these women. They may not even suggest condom use to their HIV positive husbands, even when sexual behaviour of their husbands exposes them to infection (Cameron, 2000:25).

The United Nation's Development Programme for Gender-Related Development states that 'women live longer than men' but the disadvantage to women includes their inability to participate freely in the public sphere, have time to themselves and enjoy dignity and self-esteem. The bias alluded to above is reflected in policy as well as legislation in different countries. This is the reason that the South African health care system has identified women as part of the vulnerable groups in the National Health Act (Act no. 101 of 1996).

Women's vulnerability is perpetrated by societal facilities like religion, education, family and the legal system. The above facilities socialized women to assume subservient positions in society. In many countries women are still legal minors and were in the past regarded as not assuming full adult status in the eyes of the law. The cultural conventions which guide the socialization of women reinforced by the religious ideologies may inhibit women from asserting themselves in public.

These problems also affect marital relations in the sense that women do not in general have a say in using protection in sexual intimacy as well as getting their voice heard in policy formulation as reported by Baylies and Bujra (2002:6-7). This is the reason that the emic perspective of the nurses regarding the issues relating to HIV and AIDS including stigma and problems caused by gender differences is important in this study. Baylies and Bujra, (2002:16) assert that some of the problems regarding gender differences outside marriage are that women are still worse off economically and depend on men for material things. This puts women at a risk as far as their sexual life is concerned as they have to

A model for HIV/AIDS care, research and policy interface

be submissive and yield to unsafe sex if the man so desires (also compare; Aggleton, Davies and Hart 2012; and Dominguez, 1996: 1). The above is a universal confirmation of the fact that women are at risk to contract the virus owing to many factors which range from biological, stereotypes, socialization, as well as economic factors.

Cameron (2000:24) reports that the AIDS epidemic in South Africa is a problem for black people and Hispanic women in particular who are affected in the same way that homosexuals were affected ten years ago. The incidence of HIV and AIDS is highest in black women in America. In 1996, new cases among black women in comparison to white women were three times more. This is an indication that black women even in South Africa may be more susceptible to HIV infection because of gender prescribed roles, and traditional beliefs.

A respondent said in this regard

If a woman has to choose a feeding method, because she is HIV positive, she is afraid of adhering to such a method exclusively, as the husband and the in laws will enforce mixed methods i.e. breastfeeding whilst bottle feeding on the other hand.

This is an indication that cultural roles play an important role in HIV and AIDS prevention and care.

The framework of HIV and AIDS is presented in Figure 5.4 in order to have a clearer understanding of how HIV and AIDS stigma affects individuals, families and groups. The first quadrant of the framework depicts that HIV and AIDS is life threatening, secondly people are scared of it, in the third quadrant HIV and AIDS is linked to the already stigmatized. Fourthly people with AIDS are seen as personally responsible and AIDS is caused by moral blemish.

Figure 5.4 presents the links between HIV and AIDS, social stigma and discrimination.

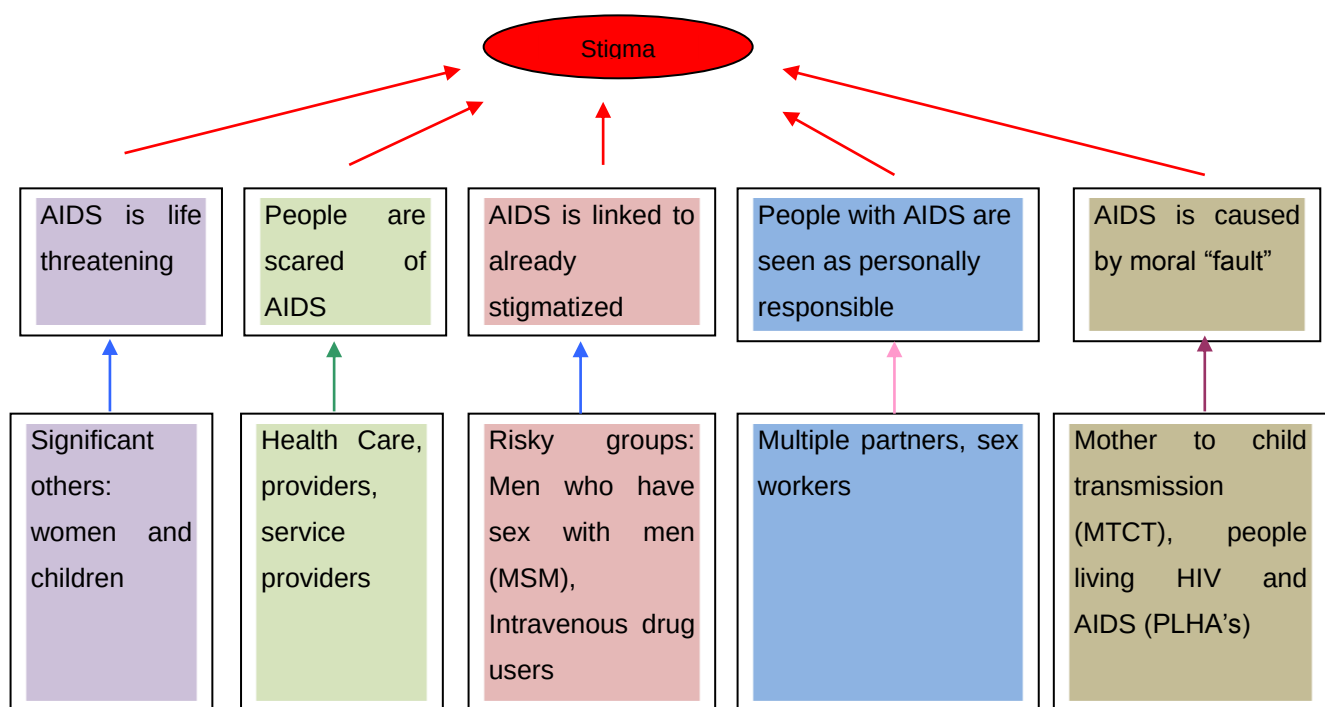


Figure 5-3: Conceptualizing stigma: key determinants of AIDS-related stigma (Pendit & Mahajan, 2005: 473)

The second row of the framework indicates that significant others are also threatened and health care providers and service providers are scared of the disease. It further indicates that men who sleep with other men and intravenous drug users are seen as the already stigmatized. In the fourth instance, multiple partners and sex workers are held responsible for the disease. Lastly, mother to child transmission and people living with HIV and AIDS are viewed as morally flawed. In this study, stigma came up strongly as a deterrent of HIV and AIDS care

Table 5-3: Concluding statements on HIV and AIDS care

HIV and AIDS stigma affects the care of patients, families and communities since a people living with this virus seek health care later in the disease's progress and thus increase the workload of nurses. Knowledge of HIV and AIDS prevention forms an integral part in the care of such patients. Stakeholder involvement is essential in the care of HIV and AIDS patients.

The last identified concept is staff outcomes and this will be discussed in the following section.

5.7 Staff outcomes

Nursing shortages will ultimately constrain health system reform and innovation, and contribute to escalating cost. This is evidenced by the fact that in most units of the hospital, especially in ICU's, agency staff are used to complement the staff levels, hence Pretorius (2012: 42) state that in units where there are correct ratios, this does not mean that there are the right nurses on the job.

Current human resources planning models in nursing are unreliable and ineffective as they consider volumes, but ignore effects on quality in patient care. This affects job satisfaction, which can lead to burnout as a result of people giving too much of their time, energy and effort to the job over a long period of time without adequate time to recover Sermeus, Aitken, Van den Heede and Rafferty, Griffiths, Moreno-Casbas & Zikos (2011: 231) Additionally, favourable practice environments and adequate patient to nurse workloads have been linked to lower rates of adverse patient outcomes, and higher patient satisfaction. In terms of nurse workforce outcomes, more favourable practice environments and lower patient to nurse workloads have been shown to be related to better nurse workforce outcomes, predominantly job satisfaction (Throsen, Tharp & Meguid, 2011:1)..

5.8 Staff outcomes due to increased workload in HIV and AIDS care

HIV and AIDS poses a more burden on the human resources available in our health care centres. Literature regarding the burden of HIV and AIDS was reviewed to support the effects of HIV and AIDS on staff outcomes. Burnout of health care workers including professional nurses was cited as one the effects of HIV and AIDS on the professional nurses.

5.8.1 Burnout syndrome

Huey (2008:7) cites Freudberg's (1974) definition that burnout syndrome is a state of fatigue and frustration, resulting from unrealistic and excessive demands on the personal resources of health and service workers. These result from a person attempting to achieve unrealistic expectations whether imposed socially or internally. This definition is appropriate for this study as caring for HIV and AIDS patients occurs as an internal drive for people who volunteer to care for HIV and AIDS patients e.g. home based carers or in the case of nurses as this is their work.

Van den Berg, van Rensburg, Janse van Rensburg, Bonthuyzen, Engelbrecht, Hlophe, Summerton, Smit and Du Plooy (2006:2) define burnout as 'a persistent, negative, work-

related state of mind found in normal individuals that is characterised by exhaustion and distress, sense of reduced effectiveness, decreased motivation and the development of dysfunctional attitudes and behaviours within the work environment. This psychological condition develops gradually and results from a misfit between intentions and realities within the work environment.'

Huey (2008:7) by indicating that such unrealistic expectations cause physical or mental exhaustion. Physical and emotional exhaustion results in the development of a negative self-concept, negative job attitudes as well as loss of concern and negative feelings towards clients. Van den Berg et al. (2006:20) claim that there are three components of burnout syndrome, namely emotional exhaustion, depersonalization and reduced personal accomplishment. Burnout in the first stage manifests itself as emotional exhaustion, which is followed by depersonalization which is regarded as a coping strategy utilized to deal with the unbearable situation. Feelings of reduced personal accomplishment are experienced probably because of hopelessness.

Burnout, has been identified as a significant problem in health care professionals who work with chronic illness individuals like HIV and AIDS, cancer as well as intensive care patients. Effects of HIV and AIDS burnout range from ineffective coping with occupational stress, chronic emotional stress of dealing with individuals with health problems, emotional exhaustion, dehumanized response to people receiving care from a burnt out person. Burnt out people also have reduced personal accomplishment (Heuy, 2008:8-11; Van Rensburg et al., 2006)

As mentioned in the previous paragraph, burnout may have serious mental, physical, psychological, social and occupational effects. Low morale, impaired work performance as well as reduced productivity. There are also incidences of high absenteeism in people who have the burnout syndrome. Health professionals also develop low job satisfaction and adverse interpersonal relations with clients (Heuy, 2008:11-12). Burnout is a combination of negative behavioural, attitudinal and physical changes in response to work-related stress Van Rensburg et al. (2006:2). Van Rensburg further indicates that the burnt out professional exhibits loss of concern for the client, fatalism about one's work, decline in motivation, effort and involvement at work, apathy, negativism, frequent irritability and anger with clients and colleagues. The professional further becomes preoccupied with his/her work comfort and welfare on the job. Other symptoms include a tendency to rationalise failure by blaming the clients or the facility /system. Resistance to change, rigidity, and loss of creativity may also occur in such professionals.

The assertions made by Heuy (2008:7) are an indication that there is a need to include impact of HIV and AIDS on the professionals caring for patients suffering from the illness. Lamendola (1998: 13-14) further state that development of cognitive, physical and behaviour terms associated with burnout as 'a syndrome characterized by progressive physical and emotional exhaustion involving the development of negative job attitudes and perceptions as well as loss of empathic concern towards patients'. It is caused by chronic emotional stress resulting from prolonged involvement with sick people. It occurs when value structure of the caregivers leads to expectations which cannot be met by work.

Van Dyk (2008: 407) states that burnout causes physical and emotional exhaustion, inability to offer psychological support to others, development of a negative self-concept, reduced sense of personal accomplishment, negative job attitudes and feeling of depersonalisation or loss of concern for patients, clients and colleagues. The above author further identifies the following manifestations of stress: A loss of interest in work, lack of job satisfaction, unpunctuality and neglect of duties. Development of a negative self-concept like feelings of inadequacy, helplessness and loss of confidence are other signs mentioned by this author.

Transforming education to meet the health systems' demands, is centred on providing an educated workforce to meet the demands for professionals to be equipped with skills to work in the health system. Transformative learning and interdependent learning are emphasized in this report as important to employees. This implies a health system that is meaningful and responding to the relevant needs of the communities we serve (Frank et al., 2010:1923-1924). Although there is a formal human resource plan to attract nurses into the public health care system, this still does not have a positive effect on the health care system as shortage of staff is still a challenge.

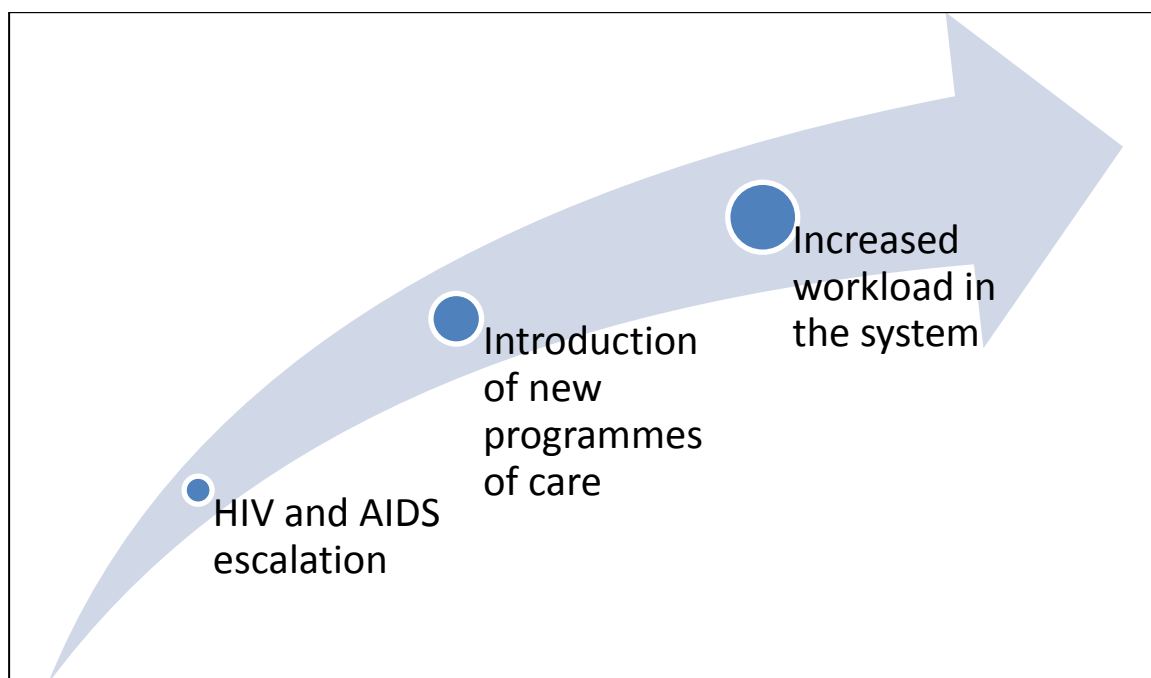


Figure 5-4: HIV and AIDS impact on the staff outcomes in the health system

5.9 HIV AND AIDS care, research and policy

Nursing research has to be evaluated in terms of its outcomes, and product which entails growth in scientific knowledge on which to base nursing care and education. This entails development of nursing theory. In this study a model will be developed to generate new knowledge in HIV and AIDS care, research and policy interface.

Development of nursing knowledge makes nursing a profession. One of the highest priorities in nursing is that of identifying, structuring and continuously advancing the knowledge that underlies the practices of professionals in the field. The baccalaureate preparation in nursing has as its goal identifying, organising and achieving a consensus concerning the specific body of knowledge that underlies nursing practices (Kenney, 2002:5-6). Nursing knowledge has been discovered through scientific enquiry to be valid, relevant and useful in nursing practice. Scientific nursing theories guide scientific investigation in the discipline.

Walker and Avant (2005:4) assert that the profession of nursing, like any other profession 'involves intellectual operations and derive their raw material from science and learning'. The notion of generation of knowledge through research is more clearly stated by Lo-Biondo-Wood and Haber (2006:114), who argue that the essence of science in nursing research is systematic collection, analysis and interpretation of data. This can be done through inductive (qualitative inquiry) or deductive reasoning (quantitative method).

5.10 Research and policy interface

Since this study intended to develop a model to enhance HIV and AIDS care, research and policy interface, it is necessary to review literature on this subject. Gilson and McIntyre (2008:749) indicate that there are few detailed analyses of the research policy interface in the health sector within the published literature. A review of literature in low and middle income countries' policy analysis for the period 1994-1997 identified very few papers presenting empirical material on the research policy interface. Even fewer examine the research policy interface with specific regard to the system level research, conducted by health policy and research unit as opposed to programmatic or service specific research.

The figure needs to illustrate the following – care informs research – which informs policy – leading to improved care

The interface amongst the three concepts is illustrated in Figure 5.5

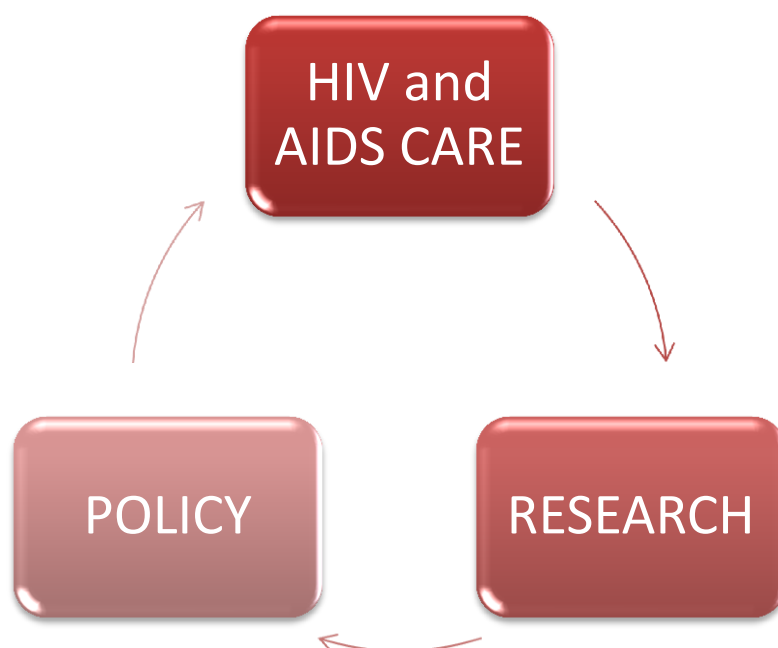


Figure 5-5: HIV and AIDS care, research and policy

The knowledge produced by research extends not only to findings, criticisms and arguments but also policy briefs and it also helps shape policy-makers' assumptions about problems and how to address them (McIntyre 2005:749). All nurses should be

groomed early in their career as potential future health policy entrepreneurs (Leavitt & Chaffee 2007:1400). In view of this Aroskar, Moldow and Good (2004:266) consider nurses who are involved in patient care as important in influencing public policy. This also applies to HIV and AIDS care, as research conducted in this field needs to be translated to policy.

Figure 5.7 presents the process of the development of the conceptual model.

Phase I: Empirical

Objective One

Clinical survey nurses and nurse managers

Quantitative

Objective Two

HRM rapid assessment tool HIV and AIDS environment

Quantitative and Qualitative

Objective Three

Interview guide institutional policies

Qualitative

Concluding statements on data collected

See Table 5-2:



CONCEPTS

- Policies
- Research
- HIV and AIDS care
 - Staff outcomes
 - Stigma

Phase II

Description of the Model

Figure 6 5: A model for HIV and AIDS care, research and policy interface

Figure 5-6: Process of the development of the conceptual framework

This framework has been developed from the objectives set and how these were achieved. The concepts that were derived from the results form part of the conceptual framework

5.11 Summary

A conceptual framework was discussed in this chapter. It is obvious that the model for HIV and AIDS care, research and policy can be developed from this conceptual framework. The scientific context of the development of the framework was discussed in line with the reality/practice order, theory research methodology order and metascience or philosophical perspective. Concepts were identified by reviewing the concluding statements to ensure consistency and congruency. Creative and critical thinking methods were employed to reduce the concluding statements into HIV and AIDS care, research and policy.

Literature search was done by identifying and defining key concepts that pertain to the search topic. Consequently, literary synthesis was done pragmatically to reduce the concluding statements to concepts.

The next chapter discusses model development.

CHAPTER 6: MODEL FOR HIV AND AIDS CARE, RESEARCH AND POLICY INTERFACE

6.1 Introduction

Chapter Five discussed the conceptual framework developed from the concluding statements in Chapter Three and Chapter Four. This chapter discusses the procedure followed in model development including description of the model, specific assumptions of the model, and a self-evaluation of the model to ensure all criteria was met.

Since the conceptual framework was developed in the previous chapter (i.e. Chapter 5) embarking on the development of the model will commence in this chapter. The chapter starts with the assumptions on which the model is based, the purpose of the model, its context, overview, structural form of the model concepts identified, process description and model evaluation.

6.2 Assumptions on which the model is based

Assumptions are important statements as they are accepted as the basis for theoretical reasoning (Chinn & Kramer, 2011:231), and are to be explicitly stated in research to enable the research community to understand the investigator's point of departure. Furthermore, Chinn and Kramer (2011) reiterate that if these have been stated the concepts, relational statements as well as definitions are used to form actual assertions, determine value positions and factual assertions.

The purpose of the model of HIV and AIDS care, research and policy interface is to ensure that the care experiences of professional nurses in their encounter with HIV and AIDS patients becomes a fertile soil for HIV and AIDS policy questions in this regard. This confirms the methodological-technical assumption of the model as it purports that knowledge is constructed through subjective and multiple, co-existing and contextual truth as perceived and created by the scientific community. This constitutes a move away from objective positivists' view as the only form of scientific knowledge, which exists. The researcher adopted multiple realities as the nature of good science. The research field was approached with openness of mind that allows for discourse, debate and dialogue. The experiences of nurses will be taken into consideration in exploring concepts relevant to HIV and AIDS care, research and policy interface. This proposes a postmodern and constructivist view towards knowledge construction.

Postmodernism allows for emerging themes during interviews to build a model to enhance HIV and AIDS care, research and policy interface. The data collected during the interviews was

complemented with quantitative findings. The use of both qualitative and quantitative research methods is a confirmation that in a postmodernist perspective, acceptance of multiple views in knowledge construction should be considered (Mouton & Marais, 1996:147)

The assumption of this study which state that a person i.e. the registered nurse and the person living with HIV and AIDS are bio-psycho-social beings, in interaction with each other. Their encounter contributes a pragmatic social milieu necessary to influence HIV and AIDS policy. The environment where HIV and AIDS care takes place is ambiguous, not pre-programmed, hence exposure of registered nurses to it forms a fertile ground for bridging the practice theory gap in caring for HIV and AIDS patients. Nurses learn the experiences and behaviours of patients and may be able to transform those into policy. Nursing is a science constituting a relationship between the nurse, patient/individual/family and community. It consists of quality care, research, competent practice, as well as maintenance and promotion of health, in the prevention and treatment of illness, and rehabilitation. Such care activities are carried out throughout a person's life.

Health is a dynamic phenomenon, constantly changing according to environmental and societal changes. It is a composite of emotional, social, physical and psychological wellbeing. The components mentioned above are unified wholes and are more than the sum of their parts.

Chinn and Kramer (2011:44) assert that 'a distinguishing feature of scientific observation is that the observer knows what is being sought, and to a certain extent what is likely to be found.' In this study, the investigator knows what is being sought. i.e. 'The model for HIV and AIDS care, research and policy interface', to put this more clearly, the study sought to identify the relational statements that could be used in the development of a model for HIV and AIDS care, research and policy interface. However, the investigator did not know what was likely to be found. This answered a question about 'what' because as Chinn and Kramer (2011:74) denote, science is both an approach to the generation of knowledge and how that knowledge could be utilized. In this study both qualitative and quantitative approaches have been used in order to generate knowledge about the phenomenon under study.

Having examined the nature of good science it is necessary to discuss the ontological dimension of this study as it relates to the researcher's beliefs.

As explained earlier on in Chapter One of this thesis, the notion of postmodernism is congruent with development of a model out of data collected from the people who nurse HIV and AIDS patients as their narratives are important in this regard. The use of both quantitative and qualitative approaches is a confirmation that in postmodernism different ways of attaining scientific knowledge are appreciated. The present-day nursing theory researchers ascribe to the

notion of putting into action principles that form the core of the self-corrective process of science. The idea of a scientific community is core to this notion, because scholars who work in independent research environments do come together at a certain point to critique each other's work. They therefore follow the principles of critique and replication (Walker & Avant 2005:9). This is also true with regard to this study as the existing policies and programs in HIV and AIDS care are reviewed, research is conducted in order that these should be modified, maintained or changed. This is the crux of postmodernism, being open to other ideas rather than the original standpoint of a researcher. Postmodernism is congruent with humanistic existentialism and constructivism because they both subscribe to the notion of making meaning out of what has been observed and interpreted. This notion also rejects value freedom, because in the development of social policy, values are taken into consideration.

6.3 Purpose of the model

The purpose of the model for HIV and AIDS research and policy interface is to provide the process of influencing HIV and AIDS policy. This model focuses on capacity building of registered nurses with regard to policy development. It also raises the awareness of nurses in political involvement. Surveying the nurses' experience with regard to access of HIV and AIDS patients, taking an audit of the policy in HIV and AIDS environments and exploring nurses' views with regard to policies enables nursing to formulate a model depicting the HIV and AIDS care, research and policy interface.

6.4 The context of the model

The context of this model is all healthcare facilities , and to put this in clear perspective these are the HIV and AIDS environments. The clinic, community health care centre CHC, district hospital and regional hospitals form the context for care of patients and the encounter with nurses. The context of the model further comprises a milieu in which family members, non-governmental organisations (NGOs) and other stakeholders ought to have input in policy, as this will encourage ownership of such policies. This is a context that is not pre-programmed as it resides human beings with values, beliefs and attitudes. These human beings have diversities and commonalities. Their diverse cultural orientations shape their health beliefs, lifeway's and social orientations. These determine peoples' outlook towards the world.

The examination of how HIV and AIDS stigma influences provision of prevention, care and treatment to patients and families, the exploration and description of the effects of HIV and AIDS on the workforce and the HIV and AIDS stigma, impact on the health workforce and policies and consequently provides the framework to develop a model for HIV and AIDS care, research and policy interface.

As mentioned in Chapter One the Free State occupies the third place in the occurrence of HIV and AIDS in the provinces. Therefore the context of this model was appropriate for this type of research.

6.5 The clinical area

The clinical nurse practitioner (PN) has to possess the following attributes as determined through concluding statements of the study:

- Knowledge of HIV and AIDS, prevention, care including culturally congruent care. Be aware of the diversity amongst HIV and AIDS affected and infected people.
- Develop the clinical research component.
- Be able to influence policy and increase their political awareness.
- Be able to involve stakeholders in HIV and AIDS care.
- Increase awareness on destigmatization of HIV and AIDS.

6.6 Overview of the model

An overview is a brief synopsis of the main attributes of the model. HIV and AIDS care, research and policy interface implies that the professional nurses have an important role to use evidence (research) to ensure quality care and influence policy when needed. The following aspects are important in the model and explain the process of the model:

6.7 Policy

Sclafani (2004:6) states that the ruling party seeks input from within its constituency and outside its constituent group. The people outside the party's political constituency give input through focus groups, public meetings or a formal public comment process. This allows departments to hear from those in the particular field who are directly responsible for implementation of the programmes. This allows policy developers to know how well the programmes are working at the state and local levels, what changes should be made to improve their effectiveness, what impediments or barriers exist that limit a programme's effectiveness, usefulness or what could be considered to improve the programme.

In South Africa public policy is often developed by means of conducting research on important issues e.g. poverty unemployment and health issues in order to determine the needs of the communities (Doyle, 2006:55). Policy is a social process. Although the major role player in

public policy is government, it is a social decision-making process. Public policy represents the collective wishes of society for social goods and services (Rosenthal & Strange, 2004:143-153).

It is therefore important for this study to be conducted as it aimed at eliciting the views of professional nurses on issues regarding HIV and AIDS care. Nurses, as explained in Chapter One of this thesis, are at the forefront of care for HIV and AIDS. It is therefore relevant that they should give input in this regard.

Porsche (2011:180) claims that nurses develop politically according to four stages. They move from stage one i.e buy in, secondly, self- interest, thirdly political sophistication and fourthly leadership stage

6.7.1 Policy-making process

During this stage research is conducted in order to determine the extent of the social issues in need of a solution. As explained in Chapter One the process of policy development is not linear but cyclical in nature. It is dynamic and on-going, consisting of several key components. Initiation, formulation, decision-making, budgeting, allocation of resources and publication are the key components in the public policy-making process. Policy implementation consists of planning, programme of action and evaluation of programme of action. The policy analysis phase consists of problem structuring, forecasting, recommendations, monitoring, control and evaluation. As discussed in Chapter One of this thesis the issues on HIV and AIDS policy that are elicited from professional nurses during interviews and questionnaire analysis will be utilized in influencing policy. This is done in the agenda-setting stage of public policy process.

6.7.2 Policy agenda setting

According to Fuo, (2013: 5) Policy development is viewed as a government instrument to allocate resources, to regulate people's behaviour and to communicate government's understanding of society's collective problems. Hence the first stage in which policy issues are identified and prioritized. This might be followed by lobbying of decision-makers to take appropriate action. This process starts with one or two members of the society who feel strongly that an issue needs the attention of the government. This is a stage that determines how stakeholders influence the government in policy development.

This stage also determines who influences or controls the policy-making process. The Proactive Public Service College Study Guide (2007:69) states that this stage comprises issue identification which involves understanding the issue, problem or concern necessitating government intervention.

Cloete & De Coning (2011:106) assert that not all the problems identified and even articulated in public actually reach the agenda setting stage. There is a pre- screening stage before policy issues reach the agenda-setting stage. Once an issue is identified as important it is considered to be included in the agenda setting phase. This is confirmed in the Pro Active Study Guide for Public Servants (2007:69) which contains discussions on agenda-setting as a stage in which issue identification is done. A further explanation regarding issue identification in agenda-setting is that issues can elevate to agenda-setting by having widespread public attention or awareness of the issue, having a shared concern by the public that action is required and having a shared perception that the matter requires government intervention.

- Continued existence of the problem leading to a crisis.
- The policy problem must achieve popularity.
- Problems should have an emotive aspect which attracts media attention e.g. issues of life and death like HIV and AIDS.
- Issues of wide impact like HIV and AIDS epidemic.
- Issues raising power relationships in society like those raised by constituencies belonging to the political party especially the elite members of the constituencies.
- Symbolic value issues, like sport e.g. major events like the 2010 FIFA world cup.

In South Africa according to Cloete (2011:112) policy is influenced by social and political life. Agenda-setting according to the above authors can therefore not be studied in isolation of the social and political milieu. This is confirmed by Leavitt (2008:159-160) who assert that it is important to meet legislators about any issue that needs to be transformed into policy.

Role-players in policy agenda-setting are elected political bearers who receive their mandate from the electorate to shape and give content to public policy. Appointed officials, who are also career public managers, receive and deal with policy problems. The courts of law contribute to the policy making process by identifying inherent policy weaknesses and draw the attention of both legislature and the executive to issues for public agenda. The interest groups mobilise their members as they have the desire to access the policy agenda. In South Africa interest groups play a major role in public agenda-setting, e.g. women's interests and the treatment action group for HIV and AIDS. The media also play a significant role in shaping the public opinion and hence the policy agenda (Cloete & De Coning 2011:114-115).

As mentioned earlier, professionals as experts in different fields should also shape policy. Leavitt (2008). The president of South Africa also reiterated this when addressing the academics at the University of Johannesburg on the 9th March 2009. He urged academics to be involved in policy issues.

6.7.3 Top-down policy implementation

Top down policy implementation is more dominant and it starts from the authoritative policy decision at the central top level of government and determines to what extent the actions of implementing officials and target groups were consistent with the policy decision. To what extent were the objectives attained over time? What were the principal factors affecting policy outputs and inputs? How was the policy reformulated over time on the basis of experience (Cloete & De Coning, 2011: 1870)

6.7.4 The bottom-up approach

The bottom-up approach is the reaction to the top-down approach and tries to address weaknesses in the latter approach. The proponents of this approach argue that stakeholders are charged with carrying out policy should be considered in policy analysis as it is necessary for policy to be re-invented so that it better fits local needs (Cloete & De Coning, 2011:187). This is also true in the case of this study as literature suggests that nurses participate in politics and policy development in order to develop health policy that is focused on patients' needs (Aroskar, Moldow & Good, 2004:266).

6.8 Research

The researcher in this study decided to use both methods in order to address research questions related to HIV and AIDS care, research and policy interface with inductive reasoning in qualitative research. On the other hand deductive reasoning was used in order to search for 'what is there' (Lo-Biondo-Wood & Haber 2006:114). Whilst in inductive reasoning the researcher endeavours to figure out what there is as he/she conducts research with an open mind without any preconceived ideas. The ideas that might exist before conducting research have been bracketed throughout the research process.

The above is an indication that in order for nursing science to develop and be dynamic there should be continuous generation, re-definition and validation of new knowledge. Therefore the interface between research and development of nursing knowledge may also contribute to utilization of such knowledge in policy development. The study HIV and AIDS care, research and policy interface is therefore consistent with development of nursing knowledge through theory development.

6.8.1 Research and policy interface

Gilson and McIntyre (2008:749) indicate that there are few detailed analyses of the research policy interface in the health sector within the published literature. A review of literature in low and middle income countries' policy analysis for the period 1994-1997 identified very few papers presenting empirical material on the research-policy interface. Even fewer examine the research-policy interface with specific regard to the system level research, conducted by health policy and research unit as opposed to programmatic or service specific research.

Considering the assertions by Gilson and McIntyre above, there is an apparent need to conduct research-policy interface investigations. This particular investigation would be conducted in HIV and AIDS care. The knowledge produced by research extends to policy briefs. Leavitt & Chaffee (2007:1400) assert that nurses should be groomed early in their career as potential future health policy entrepreneurs.

Leavitt (2008) state that nurses seem reluctant to become involved in public policy and political activities, as they think that nursing and policy are not related. In spite of this, Aroskar, Moldow and Good (2004:266) view nurses who are involved in patient care as important in influencing public policy.

6.9 HIV and AIDS care

In HIV and AIDS care the concluding statements used refer to HIV stigma and workload which affects staff outcomes. Escalation of this epidemic is not just due to stigma and failure to open up when infected but due to sexual behaviours which include non-use of condoms as well as failure to discuss sex openly. Zuma, in Nursing Update, March (2008:43) states that stigma could be addressed by a shift in mind set by those in leadership. Though managers still have a right to question absenteeism in cases of repeated illness, having a caring attitude may encourage a subordinate to open up and be able to seek help earlier. Jed and von Zinkernagel (2008: 415) claim that nurses who provide care to HIV and AIDS-infected individuals are also stigmatized by the communities. For this reason it is important for stigma to be properly managed as this would also enable nurses to care for HIV and AIDS patients without fear of stigmatization. Setswe, Peltzer, Banyini, Skinner, Seager, Maile, Sedumedi, Gomisand van der Linde (2007:640) emphasize that policy frameworks which are likely to succeed in combating HIV and AIDS need to be updated to cover issues of access, testing, disclosure and stigma. This is the reason that stigma is explored in depth in this study, utilizing both the recent and older publications. Gender relations also inhibit women`s attempts to protect themselves from the epidemic as some are economically unable to support themselves. Women`s vulnerability to

HIV and AIDS follows from social and economic factors. They have limited control to determine their lives and a lesser ability to control the nature and timing of their sexual activity.

In this study of HIV and AIDS care, research and policy interface some professional nurses stated that some HIV positive women couldn't make a decision on exclusive bottle or breastfeeding as this is determined by their in laws and significant others and failure to disclose their HIV status prevented them from proper care of their babies in terms of nutrition.

6.10 Staff outcomes

The researcher in this study of HIV and AIDS care, research and policy interface included Van Rensburg's (2006:101) study results in order to sensitize the reader about the level of burnout experienced by nurses caring for HIV and AIDS patients. The above study was reviewed with related literature such as that of Lamendola (1998:14), who identified stressors of working with the terminally ill patients as emotional involvement, lack of time to grieve for patients, identification with patients and reality of death. Contrary to the above, Lamendola (1998:66) further states that 'whilst a personal relationship with a dying person is a heavy burden, it is also very meaningful involving and rewarding'. This indicates that being involved in the care of a terminally ill patients and doing all one can to help the patients have dichotomous effects. A caregiver may be happy that she did all in her power to help the patient and grieve to let go and let the patients die in peace or be emotionally exhausted and angry that all his/her endeavours were in vain, if the patient finally dies.

In the study by van de Berg et al. (2006:15) the most frequently reported factor contributing to the dissatisfaction experienced by the participants is workload. All together 29% of the 1413 respondents referred to workload. Frustration due to excessive workloads and time pressures cause dissatisfaction, this is confirmed by Van Rensburg (2006:101) that the shortage staff in the Free State and in South Africa as a whole affects the health-care workers negatively. As this study was conducted in the Free State, it is necessary to consider the impact of HIV and AIDS on the already overburdened staff. The above information was obtained through research and this shows the importance of research in practice.

Van den Berg, van Rensburg, Janse van Rensburg, Bonthuyzen, Engelbrecht, Hlophe, Summerton, Smit and Du Plooy (2006:2) confirm that decreased motivation and the development of dysfunctional attitudes and behaviours within the work environment might be caused by work overload. This psychological condition develops gradually and results from a misfit between intentions and realities within the work environment this might eventually lead to burnout.

Huey (2008:7) confirms the above assertions et al. by Van den Berg *et al.*(2006:101) that physical and emotional exhaustion results in development of a negative self-concept, negative job attitudes as well as loss of concern and negative feelings towards clients. Figure 6.1 presents staff outcomes due to increased workload.

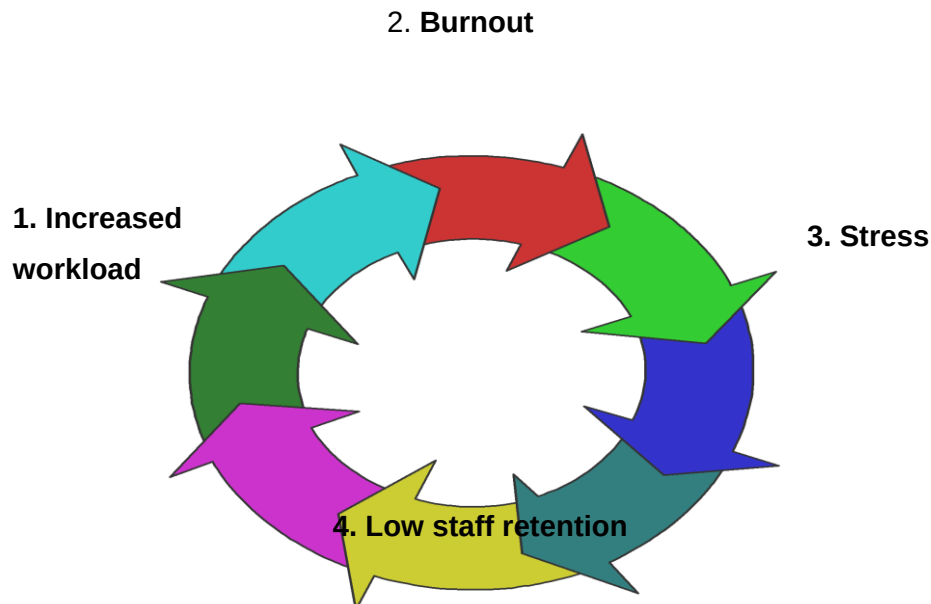


Figure 6-1: Effects of increased workload

One of the causes of the increased staff workload is the fact that HIV and AIDS patients seek medical help only when experiencing the complications of the disease. This is due to avoidance of stigma. Therefore stigma impacts negatively on the health care system. Figure 6.2 presents the impact of HIV and AIDS stigma on the health care system.

6.11 Description of the model

The HIV and AIDS care, research and policy interface is a middle range-oriented theory model. It depicts the multidimensional care aspects of HIV and AIDS care, research conducted at practice level and translation of such research into policy decisions (Renpenning, 2001:308). The model subscribes to the notion of emancipatory knowing (Chinn & Kramer, 2008: 9) as it involves development of nursing knowledge through practice and research, and combines these with political and cultural practices in HIV and AIDS care.

6.12 The three major concepts

As shown in Figure 6.2, the three main concepts in this model are depicted in circles. i.e. HIV and AIDS care, research and policy. These concepts were derived deductively from the

concluding statements in table 5.1. The circles are connected by arrows. HIV and AIDS care influences the conduct and utilization of research, which may in turn be utilized in policy briefs. Therefore there is an interface among HIV and AIDS care, research and policy development.

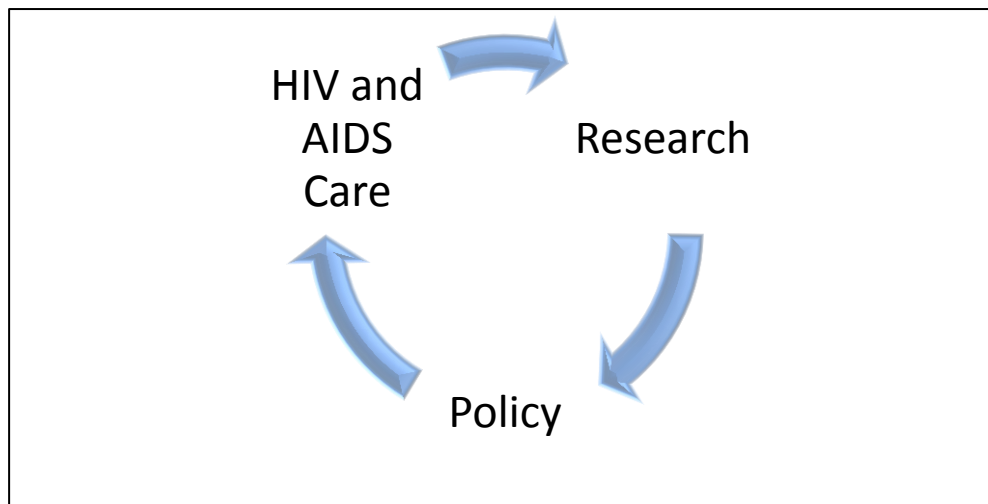


Figure 6-2: Interface between HIV and AIDS care, research and policy

- **Research and policy**

The relationship between nursing research and the systematic development of a body of knowledge is important. This body of knowledge is continuously tested and validated. Nicoll (2003:14) states that a baccalaureate curriculum in nursing theory should comprise nursing research. Nicoll (2003: 15) argues that the opinion of the patient is an important source of data in nursing research. It is therefore important to conduct nursing research at the practice level with professional nurses as they nurse and understand the patients' needs. Any applied research should contribute to theory, test theory in a specific situation and help clarify concepts and may lead to redefinition of a theory. Dempsey and Dempsey (2000:10) confirm this by stating that applied research is concerned with establishing new knowledge but it further involves deriving knowledge that can be immediately applied.

Nursing has to continually conduct research to contribute to a body of knowledge. Dempsey and Dempsey (2000:11). Nurses can contribute to a body of scientific knowledge by evaluating nursing literature critically, in order to discover gaps in the knowledge and evaluate the findings of the study and learn how valid research findings can be applied to nursing practice and ask questions that could form the basis for future research and become involved in research that could generate new knowledge.

Adam, Rottingen & Kieny (2015:1-3) state that health research is an important aspect of health and the promotion and conduct of research is a core element of WHO's constitution as an essential tool to provide evidence based policies and strategies to improve health service delivery. Stakeholders' research is valuable if it is relevant, and the research results are disseminated and implemented. Du Plessis (2006) asserts that nurses as stakeholders have the potential to make valuable contributions in health research as its main goal is to improve the health of the nation. This contributes to a body of empirical knowledge that is empirically-based and systematically organised (Jackson, Clement, Averill & Zimbro, 2009 :116)

The researcher decided to use both methods in order to address research questions related to HIV and AIDS care, research and policy interface with inductive reasoning in qualitative research. On the other hand deductive reasoning was used in order to search for 'what is there' (Lo-Biondo Wood & Haber, 2006:114). The ideas that might exist before conducting research have been bracketed right through the research process.

The above is an indication that in order for nursing science to develop and be dynamic there should be continuous generation, re-definition and validation of new knowledge. Therefore the interface between research and development of nursing knowledge may also contribute to utilization of such knowledge in policy development. The study HIV and AIDS care, research and policy interface is thus consistent with development of nursing knowledge through theory development.

- **Connections between care, research and policy**

Standards for practice, clinical guidelines and position statements that direct practice are based on research and best practices. The practice of nurses is regulated by law and therefore their best practices are policy best practices and this should enable nurses to influence policy from practice. This is true as the ability of the nurses to practice is protected by law and most areas of the nurses' practice are dependent on public policy (Leavitt, 2008: 159-160).

Leavitt and Chaffee (2009:1400) indicate that the nursing literature is critical of the fact that nurses and the nursing profession are not well represented in health policy. This leads to organisations formulating policy dictating to nurses. Health issues are known and mastered by nurses and yet they demonstrate impotency and political apathy.

The importance of conducting research and analysing its importance to policy development cannot be overemphasized as literature reviewed in this study points to the fact that research and practice are important to policy.

There is a relationship between HIV and AIDS care, research and policy. The practice environment is full of research questions which might be translated into policy.

6.13 The central part of the model (the practice setting)

The central part depicts the practice level in nursing and a fertile ground for research questions in HIV and AIDS care. Professional nurses encounter patients, families, and communities infected and affected by HIV and AIDS. It is in this area that nursing care is rendered. Professional nurses therefore have to understand the local knowledge of the communities they care for. This enables them to understand the reasons for stigmatization of HIV and AIDS patients. It is at this level of practice where professional nurses emphasize that destigmatization of HIV and AIDS enhances the understanding of local knowledge and improve patient outcomes.

Professional nurses manage HIV and AIDS like any other condition without stigmatizing the patients and are involved in HIV and AIDS education of patients and families to prevent HIV and AIDS transmission. Holzemer and Uys (2008:169) state that the person who is stigmatized may refuse to be tested for fear of stigmatisation, fail to use clinic services or health care services in general.

The authors above confirm that stigma affects the individual's willingness to utilize health services for fear of being labelled. Therefore eliciting the meaning attached to stigma and other factors affecting the care of HIV and AIDS patients will enable the researcher to describe and explore the behaviours associated with this disease, in order to develop a model to enhance HIV and AIDS care, research and policy interface.

There is therefore a need for specialised training of nurses for HIV and AIDS care.

Political orientation towards social determinants of health including HIV and AIDS elicit nurses' awareness of social issues necessitating their involvement in policy influence.

This model depicts that in the practice setting, patients' problems and questions emanate as important clues leading to nursing research. At other times nursing research yields further leads to on-going research as there should be construction and reconstruction of reality as mentioned in the paradigmatic perspective. Hence in this model arrows point from practice to research and research to practice. As the aim of research is to generate new knowledge in order to improve the nursing interventions. On executing care many questions crop up. Therefore the practice areas form a fertile ground for research questions.

In the second instance the model depicts a professional nurse in continuous interaction with the patient's family or community. The professional nurses therefore have to be able to include stakeholders in his/her function. She/he has to possess skills and competencies of his/her function as this forms an integral part in bridging the theory-practice gap. In his/her job description knowledge of applicable, policies and procedures regarding HIV and AIDS care is important. From his/her interaction with the patient, the professional nurse is able to have input into policy. This model shows that policy development should be a bottom-up process. Amongst the other most significant policy inputs, professional nurses could advise on HIV and AIDS prevention care and destigmatisation of the disease and programmes suitable for care.

6.14 The right broad arrow (conduct and utilization of research)

The right arrow represents research that should be conducted in order to contribute to improved patient outcomes in HIV and AIDS environments. It includes beliefs and practice of the community, their folk knowledge, socio-cultural behaviour in HIV AND AIDS care, social inequities, social determinants of health, race ethnicity, knowledge of HIV and AIDS, HIV and AIDS stigma, HIV and AIDS research and stakeholder inclusion in HIV and AIDS care,

Professional nurses should participate in research related to HIV and AIDS. It is evident that research and evidence based practice should be used for policy formulation. Hence research and policy interface should form an integral part of policy formulation.

Professional nurses in this study also confirm that training forms an integral part for HIV and AIDS care though this lacks the research component.

6.15 The outer left broad arrow (the ideal policy development process)

The outer left broad arrow represents the ideal HIV and AIDS policy development process. This includes stakeholder's involvement. Stakeholders include patient's families, community members and professional nurses. Since professional nurses are involved in facility al policy committees, they should be involved in HIV and AIDS public development.

Figure 6.3 presents an ideal policy development.

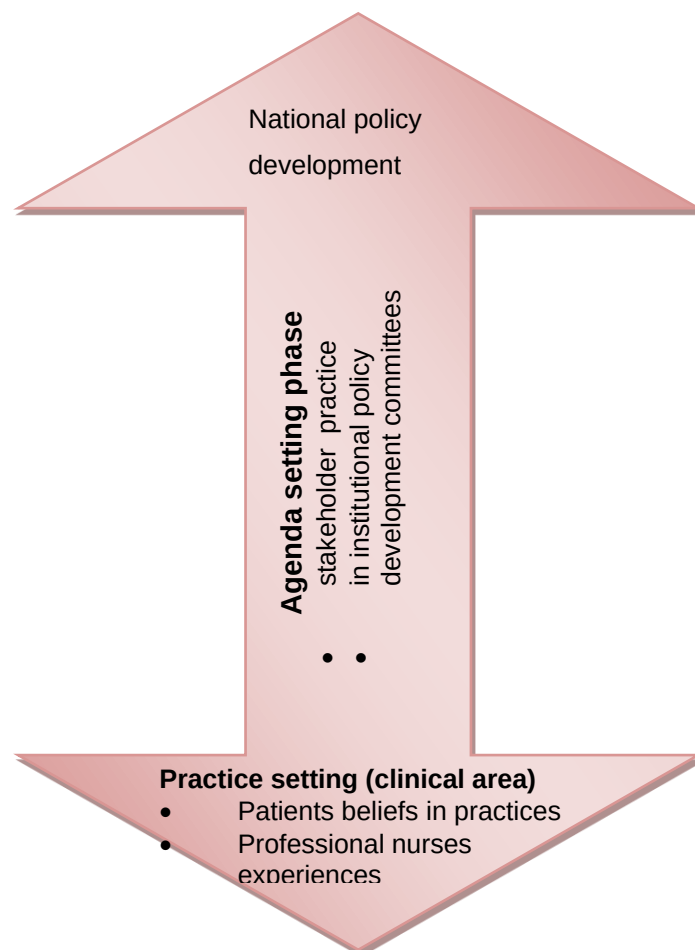


Figure 6-3: Ideal policy development proses

The bottom-up approach to policy development takes into consideration the professional nurses' experiences, stakeholder beliefs and practice as well as the political milieu.

Professional nurses are involved in facility al policy development committees but never participate in National policy development. Workplace policies on HIV and AIDS are available, yet these are not used to plan for staff absenteeism hence the high workload still exists in facilities . Stakeholder involvement is important in HIV and AIDS policy development including training of professional nurses in HIV and AIDS policy influence and pre-service.

HRM staff exists and perform basic functions but there is lack of capacity building regarding the development of HIV and AIDS policies. A top down approach is followed in HIV and AIDS policy development because nurses lack skills in the policy arena, locally, nationally and internationally.

- **Stakeholder inclusion in policy development**

Nurses' political awareness, policy process knowledge, research component and diversity awareness contribute to their influence to HIV and AIDS policy development. The above figure

as derived from the CNA model for policy development indicates stakeholder involvement in policy influence. This is significant as far as the model of HIV and AIDS care, research and policy interface is concerned. Non-inclusion of stakeholders leads to a lack of capacity in policy influence. Local knowledge of the community is important in HIV and AIDS policy influence. Figure 6.4 represents the importance of stakeholder inclusion in policy development.

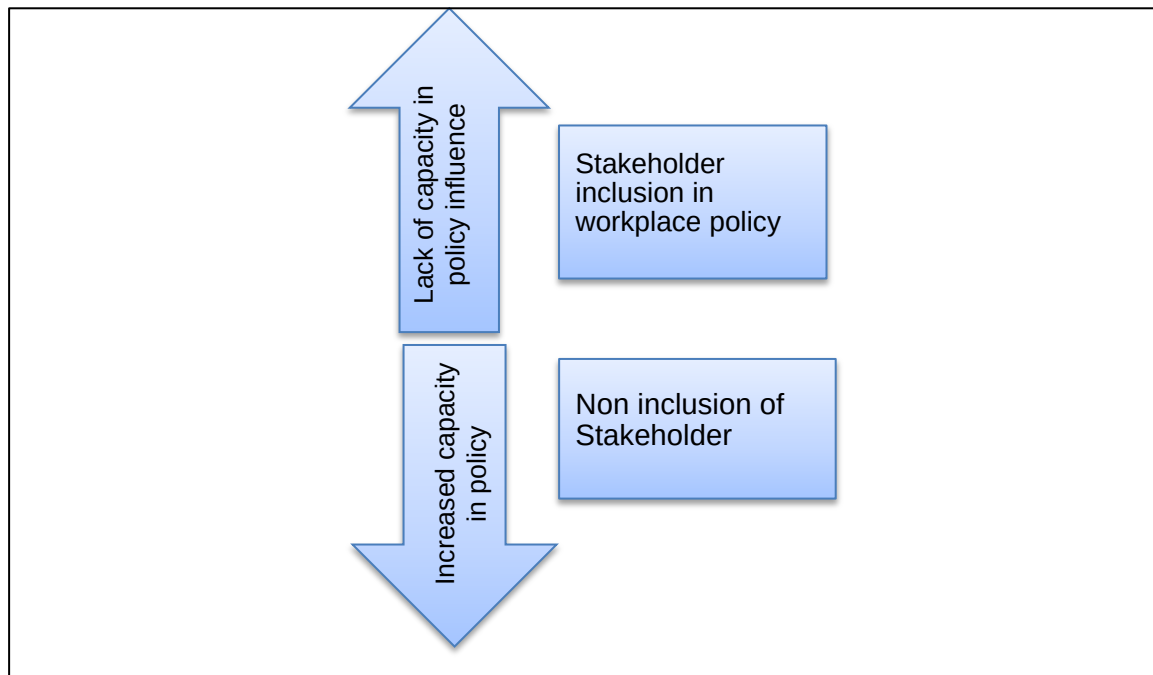


Figure 6-4: The importance of stakeholder inclusion in policy development

6.16 The upper outer part of the model: The staff outcomes due to increased workload in HV/AIDS care, environment.

Staff outcomes form the outer upper part of the model. This part signifies that HIV and AIDS care, research and policy interface might improve staff outcomes. This was confirmed by the professional nurses in chapter four as they indicated that if they could be allowed to influence HIV and AIDS policy, the staffing norms in this regard might improve as they (professional nurses) would also advise management in this regard.

HIV and AIDS causes a burden on the health care system due to its escalation. The programmes added to the care of patients' cross border migration and stigma increases the workload in HIV and AIDS. Professional nurses function within HIV and AIDS environments according to local policies, provincial and national policies. All these policies require involvement of staff.

6.17 The broad central bottom arrow

The broad central arrow represents the professional nurses' interaction with patients, families and groups in the community. Through the interaction with patients, nurses identify research questions emanating from patients problems. These are used in the conduct and utilization of research. Such research is used in policy briefs.

6.17.1 The structure of the model

The structure of the model is consists of the concept identified and the relationship between the concepts. In turn the relationships determine the strength and quality of the elements of the model (Chinn & Kramer, 2011). The structure provides overall form to the conceptual relationships within the model and emerges from the relationships within the model. It includes the central elements of the model and consists of concepts, and relationships between the concepts. The following concepts addressed in this model are: HIV and AIDS care, research, policy and staff outcomes displayed in Figure 6.6.

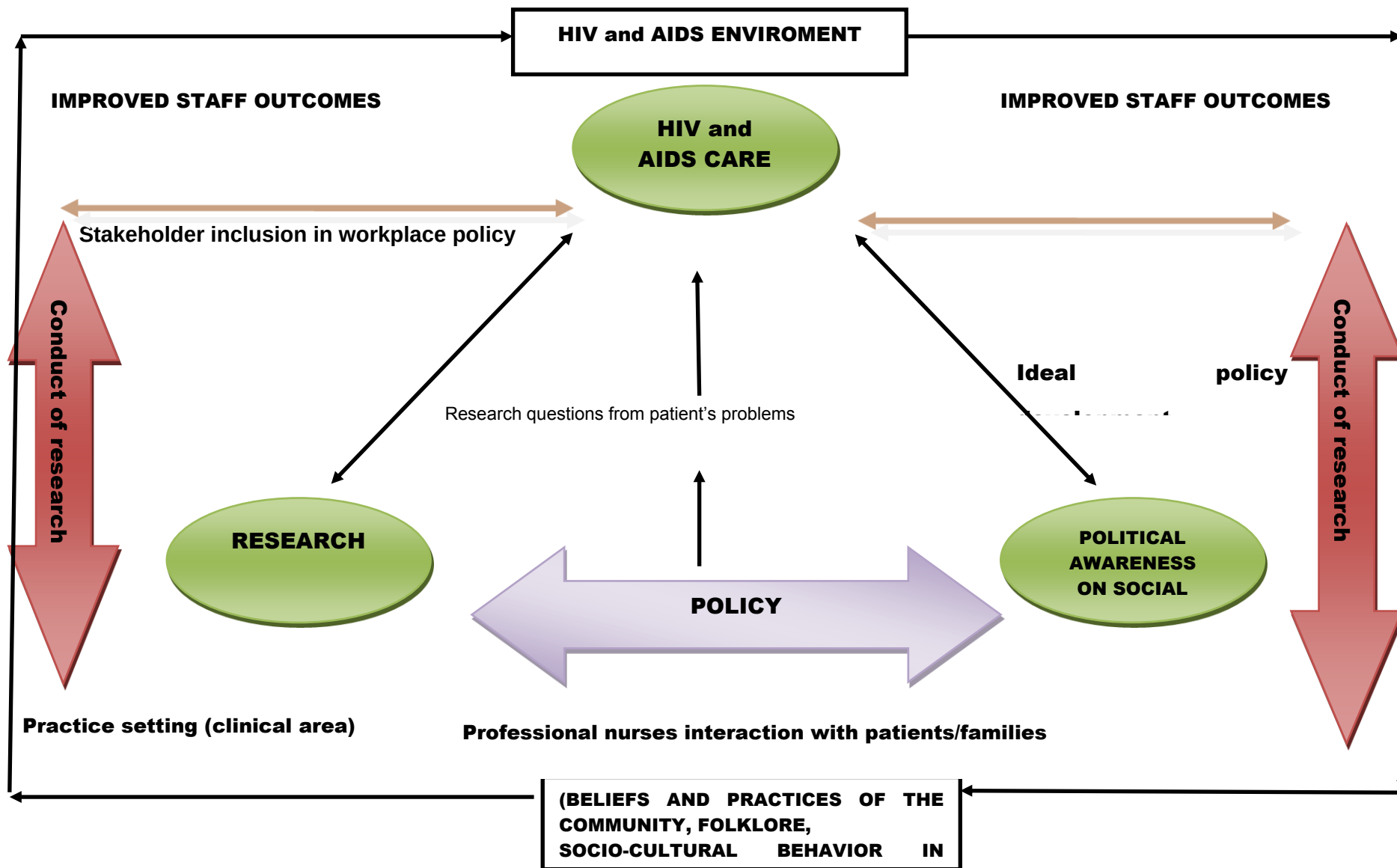


Figure 6-5: A model for HIV and AIDS care, research and policy interface

6.18 Definition of main concepts and related concepts

The main concepts and related concepts were described:

Professional Nurse: Nurse registered with the South African Nursing Council(SANC), executing preventive, promotive and curative care to patients/clients, families and groups. In carrying out their functions, professional nurses develop facility al policies. Their interactions with patients/clients, families and groups raises their political awareness on social determinants of health including HIV and AIDS. The care experiences of professional nurses enable them to conduct research on HIV and AIDS care and influence policy in this regard. Evidence based research therefore contributes to understanding of beliefs and practices of the community, folklore and socio-cultural behaviour in HIV and AIDS care.

Policy is the translation of Government's political priorities and principles into programmes and courses of action to deliver desired changes. In the case of this study policies developed by professional nurses may improve patients and staff outcomes. Whenever there is an issue that requires health care consideration this may be brought up to the agenda setting phase for policy discussion. Participation of stakeholders like professional nurses and community members alerts the policy makers about the real, practical challenges of people living with HIV and AIDS. Research from the care experiences of professional nurses contributes to participative approach to policy development.

Research It is an orderly process of inquiry that involves purposeful and systemic collection, analysis and interpretation of data in order to gain knew knowledge or to verify already existing knowledge (Dempsey& Dempsey 2000:4.This is a process that contributes to scientific knowledge development. Research therefore contributes to policy development as challenges experienced by the patients are an impetus for HIV and AIDS research, care and policy.

Interface – There is a positive interaction among HIV and AIDS care, research and policy. HIV and AIDS care requires continuous research in order to improve the known and existing patient interventions. Such research may be utilized to inform policy in HIV and AIDS.

HIV and AIDS Care. Specialized care is needed to nurse HIV and AIDS patients as there are programmes that have to be implemented in the care of these patients. Since these programmes are introduced to improve patient's outcomes, meticulous care has to be taken in their execution. Since HIV and AIDS is a chronic disease, it has to be viewed as such, rather than a stigmatized condition. This will enable easy disclosure of the condition which might lead to successful care Stigma prejudices people and prevents them from

seeking medical care, early in the disease progress. This leads to increased burden to the health care system and negative staff outcomes.

Professional nurse: The agent is the professional nurse who is continuously in interaction with the patient. Since the professional nurse spends most of the time caring for the patient/client, family or group affected or infected by HIV and AIDS, they are better positioned to understand the patients' needs regarding HIV and AIDS. Professional nurses as stakeholders in HIV and AIDS policy have to be involved in HIV and AIDS policy. Since HIV and AIDS is a social issue, professional nurses have to be involved in politics and policy briefs. These professional nurses have to be agents of change in health care policy.

Patients, families and clinic staff: Patients, families and groups (communities) are followers and potential policy influencers. Followers shape HIV and AIDS policy by narrating their stories about living with HIV and AIDS and being affected by the disease. They understand the behaviours of their folk and their beliefs regarding the disease. They understand the social determinants of health. The stigma levelled against the patients and their families also influence the views of the patients regarding treatment. Adherence or non-adherence to the comprehensive treatment regimen is influenced by these views.

The context: clinical area (HIV and AIDS environments): The clinical area is dynamic, not pre-programmed and ambiguous in nature. It forms a fertile soil for research questions. It is the first order of reality and practice where HIV and AIDS challenges are experienced. The nursing praxis occurs in the clinical area where the theory practice gap is narrowed. This is the reason that clinical specialists in nursing are encouraged to conduct research and input in policy.

HIV and AIDS policy influence: A bottom up approach to HIV and AIDS policy development should be followed as the care experiences of the professional nurses are important in influencing policy. Stakeholder involvement, understanding of the community's views and cultural care diversity should be considered in this regard. This is an important tool for HIV and AIDS policy influence as the people's lifeway's, and views regarding the causes of disease influence their health care behaviour. The conduct and utilization of clinical research cannot be overemphasized in this regard.

Continuous interaction with patients: Since nursing is a dynamic profession, which continuously develops a body of knowledge to improve to improve nursing interventions and to test the existing modalities of care, it is subjected to rigorous evolvement and change. The professional nurse (Agent), and the people affected and infected by HIV and AIDS continuously interact in an ever-changing clinical milieu. The HIV and AIDS programmes and

treatment introduced needs continuous adaptation by the professional nurse and the followers.

HIV and AIDS care, research and policy interface: The professional nurse needs to be empowered in policy influence political awareness, stakeholder inclusion in policy and conducting research are the important tools in empowering professional nurses about HIV AND AIDS care, research and policy interface.

6.19 Relational Nature of The Model

All the concluding statements of the model are derived from the empiric research and the conceptual framework by means of deductive reasoning. A summary of concluding statements is presented in table 6.1

Table 6-1: A summary of concluding statements of the study

Concluding statements on research	Concluding statements on policy	Concluding statements on HIV AND AIDS care
Professional nurses rarely participate in research related to HIV and AIDS. Research and evidence-based practice is not used for policy formulation. Professional nurses possess the knowledge of HIV and AIDS care, but lack the research component thereof. Research and policy interface should form part of policy formulation. Training forms an integral part for HIV and AIDS care although this lacks the research component.	Professional nurses are involved in facility al policy development committees but never participate in national policy development. Workplace policies on HIV and AIDS are available although these are not used to plan for staff absenteeism; hence the high workload still exists in facilities . Stakeholder involvement is important in HIV and AIDS policy development including training of professional nurses in HIV and AIDS policy influence and pre-service. HRM staff exists and perform basic functions but there is a lack of capacity building regarding the development of HIV and AIDS policies A top-down approach is followed in HIV and AIDS policy development	Destigmatization of HIV and AIDS enhances understanding of local knowledge regarding HIV and AIDS, improved patient outcomes and quality of life of HIV and AIDS patients. Professional nurses manage HIV and AIDS like any other condition without stigmatizing the patients. Job descriptions are available for all staff members and are adjusted according to additional staff functions. Changes in performance areas are taken into consideration. There is a formal human resource planning system to attract nurses into the healthcare system, i.e. the occupational specific dispensation that determines salary upon entry to the organisation. There is a policy of non-discrimination on the

	Nurses lack skills in the policy arena, locally, nationally and internationally.	basis of HIV and AIDS is available but there is doubt whether or not this is adhered to as HIV and AIDS is not disclosed. An HIV and AIDS programme is in place and focuses on using appropriate protocols to limit the risk of infection as well as education about HIV and AIDS. Training is a formal component of the organisation and is linked to staff and organisational needs, but it is not implemented in order to reduce staff absence from their posts during training. Professional nurses are involved in HIV and AIDS education of patients and families to prevent HIV and AIDS transmission. There is a need for specialized training of nurses for HIV and AIDS care. Increased workload on health system is caused by additional programmes, cross-border migration, stigma and burnout.

6.20 The concluding statements which form the basis for the relational nature of the model

A dynamic relationship exists among HIV and AIDS care, research and policy as the professional nurse uses their experience in this regard. The professional nurse, the patient/client or family function interdependently to build a dynamic body of knowledge regarding HIV and AIDS care. These stakeholders work towards attaining a bottom up approach to policy development.

As the professional nurse interacts with patients from diverse cultural backgrounds, it is important that the patients views about health and illness are understood. The importance of including significant others in the care of people living with HIV and AIDS is an impetus to conducting and utilizing evidence based research in policy development.

In order to influence policy, professional nurses should be aware of politics that affect health care delivery and form part of pressure groups to influence health care policy. Since professional nurses are able to develop policies that contribute to positive policy outcomes, they play a pivotal role in HIV and AIDS care, research and policy interface. As agents of change they are better positioned to drive health care policy. Their followers influence health care policy by narrating their experiences of living with / or caring for HIV and AIDS patients. Stigma levelled against HIV and AIDS patients poses a deterrent to care as such patients seek medical help very late in the disease process. This gives rise to increased workload leading to burnout. In order to improve staff outcomes, facility al policy development committees should participate in local and national policy development. It is also important for pre service (colleges/universities) to ensure rigorous evidence based research aimed at influencing health care policy.

HRM staff should be capacitated to develop HIV and AIDS policies at the workplace. This will lead to all training at the workplace planned in such a way that staff absenteeism is curbed to reduce workload. In caring for HIV and AIDS patients, policies regarding staff retention, promotion and incentives are adhered to in order to reduce increased workload which leads to burnout.

6.21 Critical reflections on the model

As the model was developed from empirical research, Dickoff, James and Wiedenbach (1968) states that the model is a true reflection of reality and does not need to be evaluated however, the researcher did a critical reflection based on the criteria used by Chin and Kramer (2011-246).

6.22 Clarity

The ideas and concepts used in the model for HIV and AIDS care, research and policy interface are clear and comprehensible with regard to HIV and AIDS care:

6.22.1 Semantic clarity

The empirical meaning of the concepts used in HIV and AIDS care, research and policy is clear. Over and above the operational definitions used, literature was used in explaining each concept and relational statement in the model. These definitions were an important aspect semantic clarity because they helped to establish the empirical meaning for concepts in this study were clearly defined too specifically but generally in the sense that they provided clear and accurate guidance for the intended empiric indicators for a concept. No words similar meaning were used to present the central concepts of the theory. Overly complex illustration discouraged comprehension. Diagrams were used to make the theory clearer.

6.22.2 Semantic consistency

Concepts are consistent with their meanings. The illustrations used show this consistency as it emanated from literature interviews the clinical survey and the HRM tool. See Figure 5.12-5.14. Consistency in this study was maintained so as to avoid confusion because concepts of a model have to be used in a way that is consistent with their definitions.

6.22.3 Structural clarity

This refers to the comprehensibility of the relationship within the model. Concepts were interrelated and connected by means of arrows. Arrows indicated the flow and direction of the model connectivity. Structural clarity refers to how understandable the connections and reasoning within the theory are. In this model concepts were interconnected are organised into a coherent whole. In other words, there are no structural elements that are related. All concepts are interrelated

6.22.4 Structural consistency

Different structural forms were used consistently in the model. This also was congruent with the semantic consistency and structural clarity in the model. Structural consistency is related to the use of different structural forms within the model. Consistency throughout the model concerning structure was reflected in the relationships. From the above and from the discussion the researcher concluded that this model was clear. Definitions in this model has been defined and linked in such a way that their relationships were understandable. Definitions and their structural forms were used consistency and there was a consistent evaluation semantic as well as structural clarity were preserved.

6.22.5 Simplicity

The model is simple to read and comprehensible; minimum elements have been used in each instance. The core concepts in the model are evident as they were derived from the relational statements which formed the conceptual framework of this study. Complexity implies many theoretical relationships between and among numerous concepts. The simplicity of the model becomes evident through the minimum elements in each category. The researcher comes to the conclusion from discussion that this model is not complex. The core concepts support the purpose of the model and are self-evident. The meanings of the concepts have been retained by not introducing new unimportant concepts.

6.22.6 Generality

The scope of the model determines its generality. As this model is consistent with middle range theory, it can be applied in all disciplines in nursing. This is used as guide and is heuristic in nature. The theory guides nursing in general on HIV and AIDS care, research and policy interface. The generality of a model refers to its breath of scope. A general model can be applied to a broad of situations. The scope of concepts and purpose within this model provided clues to its generality. The model was intended for the HIV and AIDS Care, research and policy interface. It has the capacity for the broader generalisation. The implication is that the model can be implemented in other situations and has a broader application value within a specific discipline in nursing practice. Since this model is a middle range type of a model, it can be applied in nursing in general, but may also fit a specific discipline in nursing.

6.22.7 Accessibility

Since this model forms part of the international project 'strengthening nurses' capacity in HIV and AIDS policy development'. This study is done in four countries which guarantees the broad usage of the model. This model can be used worldwide as HIV and AIDS is a widespread epidemic. Accessibility refers to how attainable the projected outcomes of the model are concepts can be made empirically accessible through generating and testing relationships, deliberative application of the model and clarifying conceptual meaning. This model is useful and should promote HIV and AIDS Care, Research and Policy interface.

6.23 Parsimony

The research theory praxis demonstrated in this model is meaningful, especially as it refers to the emancipatory knowledge development inherent in socio-cultural and political consciousness in nursing. The importance of this model is closely tied to the idea of its clinical significance or practical value. The importance of the model has to do with the applicability and the practical value

of the model generated in it. Research model and praxis should be related in a meaningful way. The model for HIV and AIDS care, research and policy interface is thus critical to nursing practice, education and research.

In order to evaluate this model a further question consistent with the development of the model were asked. Table 7.2 presents the questions asked.

Table 6-2: Critical questions asked in the development of this model

What are the barriers to policy influence in nursing?	Answer: • Hierarchical structure • Protocol • Politics • Alienation of nurses from the social realities • Non-involvement in political issues • Lack of research component in policy influence in the nursing arena in South Africa
What is hidden?	Lack of research capacity Lack of theory and practice • Integration i.e. nursing praxis in policy influence in nursing.
Who is not heard?	• Nurses in clinical practice
Who benefits	• If the model is successful nurses would be able to influence HIV and AIDS policy decisions in which case the society at large would benefit
What is wrong in not integrating HIV and AIDS care, research and policy?	• Policy decisions will be made in a vacuum, not from evidence that stems from research and thus ownership of such policies wouldn't be guaranteed.

Adapted from (Chinn & Kramer, 2011:14)

6.24 Summary

In this chapter model development was discussed. The chapter reflected on the conceptual framework and the assumptions of the study. A model consisted of the concluding statements and concepts derived deductively from the concluding statements. A thorough discussion of the process of development of the model was done. Relational statements were developed and critical appraisal of the model was discussed in relation to Chinn and Kramer's (2011) criteria.

CHAPTER 7: EVALUATION OF THE STUDY, LIMITATIONS OF THE STUDY, AND RECOMMENDATIONS FOR PRACTICE, RESEARCH AND POLICY

7.1 Introduction

This chapter presents the evaluation of the study, which is done according to the findings of the study and criteria used by Chinn and Kramer for model or theory evaluation HIV and AIDS care, research and policy interface.

7.2 Overview of the chapter

The chapter presents the following: Introduction, evaluation according to chapters, study limitations, and criteria used by Chinn and Kramer 2011:12.

7.3 Evaluation of the study

This is done according to different chapters and objectives of the study.

7.4 Chapter One: Conceptual phase and scientific grounding of the study

This phase comprised the conceptualization of the problem, and putting the problem into international, national and provincial perspective. The background of the problem, the problem statement, the aim and objectives. These were achieved by means of inductive and deductive logic.

- Objective One – Phase 1

To examine how HIV and AIDS stigma influences nurses provision of prevention, care and treatment to patients and families.

- Objective Two – Phase 1 objective

To explore and describe how HIV and AIDS affect the workforce. The human resource rapid assessment tool was used together with the clinical survey to answer the above objective.

- Objective Three – Phase 1 objectives

To examine the HIV and AIDS work place policies national HIV and AIDS strategy and nursing interventions.

Furthermore the protection of human rights was discussed by means of observing the ethical issues inherent in the study. Rigour, concept clarification, and outline of the study were discussed and the chapter concluded with a summary.

Though there is no separate chapter for literature review, in this study, scientific grounding of the problem, theoretical arguments as well as the whole thesis was embedded and supported by literature. The following instruments were used: The clinical survey, the HRM Rapid Assessment Tool and the Interview Guide on Examining HIV AND AIDS Policies

7.5 Chapter Two – the research design and methods

For Objective One phase the clinical surveys were used in 22 out of the 26 sampled facilities .

The themes which emerged from Objective 1 Phase One appear in data structure Table 4.2 which displays the themes and sub themes.

Standardisation of care for HIV and AIDS was mentioned as the respondents indicated that if care is not standardized, this leads to cross-border migration of patients which contributes to disparities in workload.

All other themes which appear in the table mentioned above have been discussed in Chapter Four.

7.6 Chapter Three – quantitative results

These results are presented in Chapter 3 Tables 3.1 to 3.15. The concluding statements of this chapter were reflected upon and are: Firstly a formal human resource planning system was suggested as a measure to attract nurses into the health care system i.e. the occupation-specific dispensation that determines salary upon entry to the organization. A policy of non-discrimination on the basis of HIV and AIDS is available but there is doubt whether or not this is adhered to as HIV and AIDS is not disclosed. Furthermore an HIV and AIDS programme is in place and focuses on using appropriate protocols to limit the risk of infection as well as education about HIV and AIDS. Job descriptions are available for all staff members and are adjusted according to functions added to each of them and changes in performance areas are taken into consideration.

Training forms a formal component of the organization and is linked to staff and organizational needs, but, it is not implemented in order to reduce staff absence from their posts during training. Management does not use this data to plan for HIV and AIDS programmes except the training data where staff trained in an aspect of HIV and AIDS are utilized to perform such

functions e.g. HIV and AIDS counselling. Salary history data is utilized, but as each personnel template is not updated, basing management decisions on the template is not beneficial.

A reflection of the above statements is done in order to evaluate the thesis rigour in construct validity. As mentioned in Chapter 5 deductive logic was used to identify main concepts of conceptual framework.

7.7 Chapter Four – qualitative results

The qualitative results are presented in Chapter 4 Table 4.1. These covered phase 1 Objective 3. The concluding statements of this chapter were reflected upon and are: Knowledge of HIV and AIDS forms an integral part in HIV and AIDS care and emphasis was placed on involvement of family members, knowledge standardisation of care of the programmes, and standardisation.

Another theme which emerged strongly was destigmatization of HIV and AIDS. The participants in this case reported that destigmatization enhances understanding of local knowledge as people living with HIV and AIDS would receive culturally congruent care. This in turn would improve patient outcomes, which contributes to increased quality of life.

Furthermore, the impact of HIV and AIDS emerged as a theme which included the additional programmes for HIV and AIDS care, cross-border migration and stigma because HIV and AIDS sufferers are admitted very late in the disease progress whilst the disease already includes complications. The complicated stage of the condition leads to increased workload.

Destigmatisation was also cited as a deterrent to culturally congruent care as in some South African cultures women are subservient to their husbands and are not free to choose protective sex.

Burnout was cited as a factor emanating from increased workload of the nurses.

Stakeholder participation emerged as a theme that would facilitate the policy development process.

7.8 Chapter Five – conceptual framework

This chapter consists of a conceptual framework developed from the concepts after data collection. A literature review was done to ground the existence of the problem of the phenomenon under study and embed the results of the study for authenticity.

Figure 7.1 shows the contextualisation of policy development in South Africa.

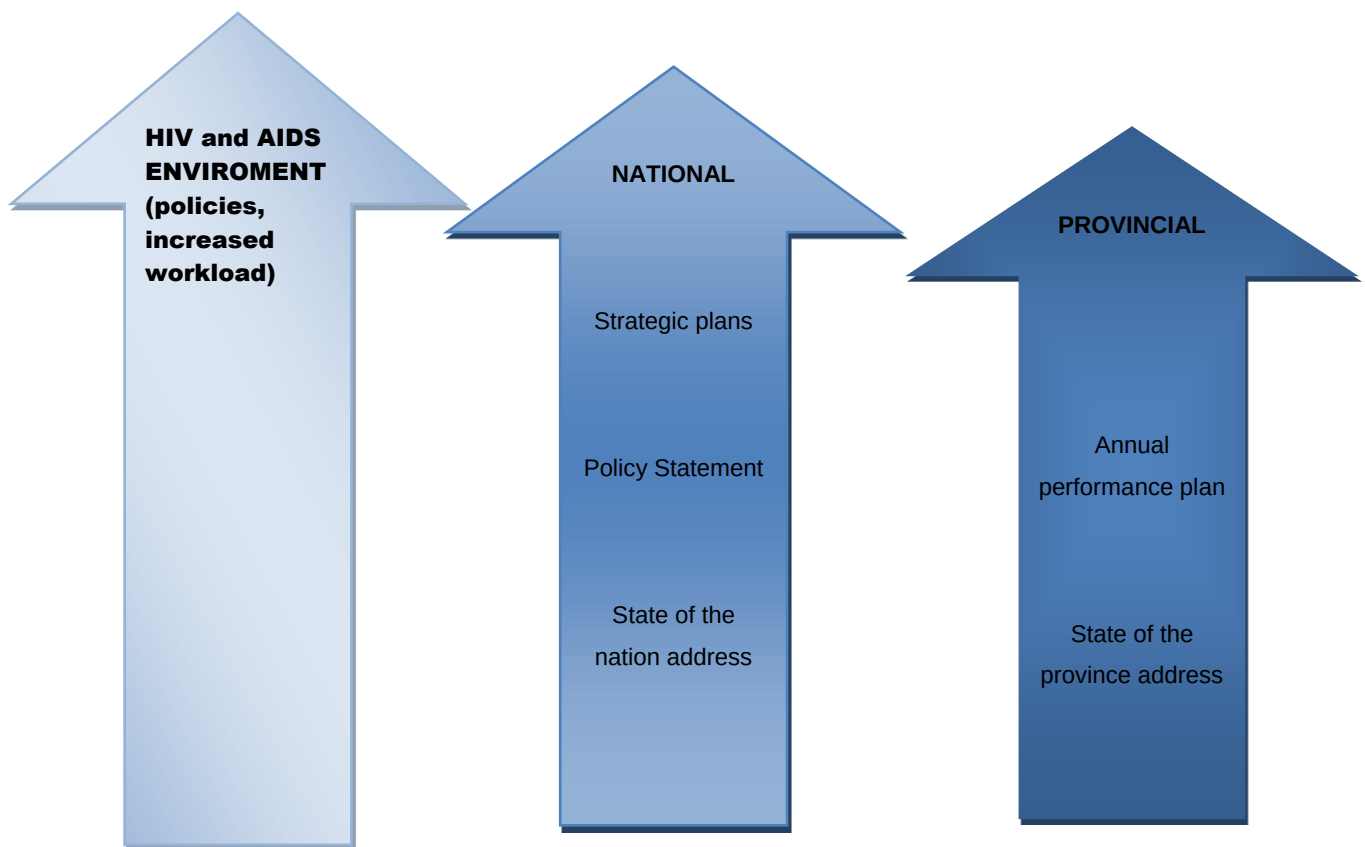


Table 7-1: HIV and AIDS policy development

Upon examining how the validity of the conceptual model was established, it is necessary to look at the evaluation of Chapter 6.

7.9 Chapter Six – model development

The model was developed out of the concluding statements embedded and supported by literature. See Figure 6.3.

7.10 The study limitations

The instruments used in this study were complex especially the HRM rapid assessment tool. This tool consisted of both qualitative and quantitative fields. Furthermore participants had to avail evidence of the policies referred to in the tool. This necessitated more time as was stipulated on the tool. Since there is shortage of staff in most of the facilities, this warranted the researcher to collect data after hours.

The instruments used in this study were three in number, The HRM rapid assessment tool was complex as it was both qualitative and quantitative. It's complexity was worsened by the fact

that evidence was needed to prove whatever the respondents answered e.g. if they alluded to the presence of any HIV and AIDS policy, this had to be availed. Data collection using this tool took longer than was anticipated. Therefore the subsequent interviews were done after hours to avoid disturbances in nursing care routine. In so far as policies are concerned staff may have different opinions regarding HIV/AIDS policies, because sometimes the phenomenon might be relative to people's perceptions. Experience of HIV/AIDS stigma might differ, especially in a question that expresses whether participant does discriminate against patients or not. This question might not be answered honestly, though participants were all told that their responses will be confidential and anonymous.

7.11 Recommendations

Recommendations for practice, research, education and policy are provided.

Recommendations for practice, research, education and policy are made below:

- (1) Increase awareness of the factors influencing HIV and AIDS stigma e.g. social determinants by means of conducting research on cultural care of people living with HIV and AIDS
- (2) Raise awareness on the research component in HIV and AIDS policies, interventions as well as community beliefs by encouraging clinical nurses to conduct research.
- (3) Encourage stakeholder involvement in HIV and AIDS care by educating them on HIV and AIDS care
- (4) Encourage clinical nurses' involvement in politics in order that they should be aware of matters involved in their practice including HIV and AIDS.

7.12 Recommendations for research

- (1) Roll out a clinical survey for strengthening nurses' capacity on HIV and AIDS policy development to other provinces in South Africa including other SADAC Countries.
- (2) Bridge the gap between theory, practice and policy development by introducing evidence based research in pre-service.
- (3) Utilize the model of HIV and AIDS care, research and policy development in research related to HIV and AIDS.

7.13 Recommendations for education

- (1) Include the policy development process and research project in this regard in the undergraduate curriculum in South Africa.
- (2) Establish a system of continuous professional development in all health facilities .
- (3) The South African curriculum for nurses should encourage their political engagement in healthcare matters.
- (4) Policy subcommittee in health and the ministerial advisory committee members should raise awareness on healthcare policy issues in South Africa especially on HIV and AIDS.
- (5) Labour should form part of the policy committees in all healthcare facilities .

7.14 Recommendations for policy

- (1) Involve nurses in the policy-making platform in South Africa
- (2) A culturally sensitive policy for HIV and AIDS has to be adhered to in order to render culturally congruent care in this regard.

A model for HIV and AIDS care, research and policy interface should be utilised by the Department of Health in order to ensure involvement of nurses in policy for HIV and AIDS.

7.15 Reflection on the academic journey

This journey was dichotomous as it brought me personal, professional and academic fulfilment, but yet it was challenging. The challenges encountered were sometimes unbearable. It is true that one's success in life is determined by her internal motivation, paradigmatic perspective and internal locus of control. If it was not the case, I could have given up along the way.

The strength of my determination comes from the Lord, my belief in Him pulled me through trials and tribulations. The commencement of this journey, the process and the outcome meandered from happiness, despair and hope, to visualization of the positive outcome of the journey.

People close to my heart added value to this journey. The death of my mother brought me sorrow and despair as her prayers anchored my thoughts and focus on this journey.

I grew, emotionally spiritually and socially and I learnt to keep up with the most daunting circumstances. This journey was indeed a continuum with two extremely different poles, but the overall process was fulfilling. It was not easy and yet on the other hand it strengthened me.

7.16 Summary

This chapter evaluates and models and presents the limitations and the recommendations. On embarking on this chapter it became obvious that there is congruency in the methods, background of the study as well as the purpose and the methods of data collection. It was found that this model was suitable to use in HIV and AIDS policy development.

BIBLIOGRAPHY

Aggleton, P., Davies P & Hart G. 2012. Families and communities responding to AIDS.

Available: <http://www.googlebooks.com>

Armstrong, K. 2010. *Governing Social Inclusion: Europeanization through Policy Coordination*. New York: Oxford University.

Aroskar, M.A., Moldow, D.G. & Good, C.M. 2004 Nurses' voices: policy, practice and ethics. *Nursing Ethics*. 11(3):266-76.

Ary, D. Jacobs P. & Razavieh, A. 2010. *Introduction to research in education* (4th ed.) Fort Worth, TX: Holt, Rinehart, & Winston

Babbie E. 2010. *The practice of social research. 2nd edition*. Belmont: Wadsworth. Cengage

Baylies, C, & Bujra J, eds. 2002 *AIDS sexuality and gender in Africa: Collective strategies and struggles in Tanzania and Zambia*. University of Tanzania: Routledge

Betancourt, T., Abrams, E., McBain, R. & Smith-Fawzi, M.C. 2010. Family centered approach to the prevention of mother to child transmission. *Journal of the International AIDS Society*. <http://www.jiasociety.org>. content 13/S2/S2.

Bodrick, M.M.E., 2011. The role of the patient liaison nurse in the ambulatory care context of a middle-eastern teaching hospital: a practice model. Johannesburg : Witwatersrand University.

Botes, A. 2006. The operationalisation of research model in a qualitative inquiry. University of Johannesburg. South Africa.

Buchan, J. & Calman, L. 2013. The global shortage of registered nurses: An overview. Geneva: ICN

Brink, H.I. Van der Walt, C. & Van Resnburg, G. 2010. *Fundamentals of research methodology for health care professionals*. 2nd ed. Cape Town: Juta.

Bruce, J.C. 2003. A model for restructuring specialist nurse education. Johannesburg: Witwatersrand.

Bruce, J.C. & Klopper H.C. 2010. into university context Part 1. Methodological Perspective. *Journal of interdisciplinary Health Sciences* (15) 1-6.

Burke, S.D. & Cornell, S.A. 2008. Medication management in type 2 diabetes. *Clinician Reviews* 18.3 (2008): 28-34.

Burns, N. & Grove, S.K. 2010. *The Practice of Nursing Research: Conduct, Critique, and Utilization*. 6th ed. St Louis: Elsevier.

Cameron, P.J. 2000. Quality of life and care providers of people living with HIV/AIDS. Canada:Alberta: Galgary

Canadian Institutes of Health Research, 2010. Health research roadmap: creating innovative research for better health and healthcare. <http://www.chri.irsc.gc.za> Date of access: 5 Feb. 2010.

Chinn, P. L., & Kramer, M. K. 2008 *Theory Development* . St. Louis: Mosby.

Chinn, P. L., & Kramer, M. K. (2011). *Integrated knowledge* Edn. St. Louis: Mosby.

Cloete, F. & De Coning, C. 2011. Improving public policy: Theory practice and results 3rd edition. Van Schaik. Pretoria

Coetzee, S. 2010 The Quality of doctoral education in South Africa. Potchestroom: North-West University (Thesis- Ph.D.)

Coetzee. S., Klopper, H.C. 2010. Compassion fatigue within nursing practice: A concept analysis. *Nurs Health Sei*

Edwards, N.C. & Roelofs, S. 2007. Teasdale-Corti handbook: strengthening capacity in HIV policy development in sub-Saharan Africa and the Caribbean: Ottawa International Development Research Centre.

Edwards, N.C. Webber, J. Mill, J. Kehwa, E. & Roloefs, M.A. 2009. Building Capacity for nurses-led research. *International nursing reviews*. 56 88-94

Evans, C. & E Ndirangu. 2009. The nursing implications of routine provider-initiated HIV testing and counselling in sub-Saharan Africa: a critical review of new policy guidance from WHO/UNAIDS. *International Journal of Nursing Studies* 46.5: 723-731.

Frenk, J. 2010. Health professionals for a new century: transforming education to strengthen health systems in an interdependent world. *The lancet*. 376. 9756 : 1923-1958.

Fyffe T. 2009. Nursing shaping and influencing health and social care policy. (6):698-706. United Kingdom

Field, D. 2005. Moving from novice to expert-the value of learning in clinical practice: a literature review. *Nurse Education Today*, 4. 560-565.

Field, PA & Morse J.M 2004. Nursing research: The application of qualitative approaches. London: Chapman & Hall

Gilson, L. & McIntyre, D. 2008. The Interface between research, theory and policy. *Social science and medicine*, 67(1):748-749.

Greeff, M., Uys, L.R., Holzemer, W.L., Makoe, L.N., Dlamini, P.S., Kohi, T, Chirwa, M., Naidoo, J.R. & Phethlu, R.D. 2008. Experiences of HIV/AIDS stigma of persons living with HIV/AIDS and nurses involved in their care from five African countries. *African Journal of Nursing and Midwifery* 10(1):78-108.

Glesne, C., & Peshkin, A. 1992. *Becoming qualitative researchers: An introduction* White Plains, New York: Longman.

Herek, G. M. 2000. The psychology of sexual prejudice. *Current directions in psychological science*, 9(1), 19-22.

Henney, S & Gonzalez-Block, M.A. 2014. Four countries on from bacon: Progress in building health research system to improve health system. *Journal of Health research policy and systems*: 12-56

Holzemer, W.L., Makoe, L.N., Greeff, M., Dlamini, P.S., Kohi, T.W., Chirwa, M.L., Naidoo, J.R., Durrheim, K., Cuca, Y. & Uys, L.R. 2009. Measuring HIV stigma for PLHAs and Nurses over time in five African countries. Vol 6 No 2. *Journal of Social Aspects of HIV/AIDS*

Holzemer, W.L. & Uys, L.R. 2008. Managing AIDS Stigma. *Journal of Social Aspects*. 165-174

Holloway & Wheeler. 2010. Qualitative research in nursing & health care 3rd edition.
John Wileys & sons

Human Sciences Research Council. 2004. South African national HIV prevalence, behaviour, risk. Mass Media Household Survey. Cape Town. South Africa

Jackson, P.J., Clement, P.T., Averill, J.B. & Zimbardo. 2009. Proposing a theory for nursing leadership. *Nursing Economics*. 27(3), 149-159

Jed, S.L. & Von Zinkernagel, D. 2008. Call to action the rights of nurses to Health and safety. *Journal of the Association of Nurses in AIDS Care*. 19 (6): 1415-1418

Kenney, J.W. 2002. Philosophical and theoretical perspectives for advanced nursing practice. 3rd ed. London: Jones & Bartlett.

Khadidiatou Ndiaye. 2008. When soutoura (dignity, respect and privacy) matters most: understanding and Assessing HIV/AIDS stigma in the family context in Senegal: Communication, ARTS and Science Department. Pennsylvania: Ann Arbor.

Klopper, H. 2008. The qualitative research proposal. *Curationis* 31(4):62-72.

Klopper H. & Williams, M.J. 2009. Health Science Education: Theoretical and philosophical Foundations. Study Guide for NSET311. North West University. Potchefstroom; ?

Krause, D.D. 2007. *Health related quality of life measures, in association with access to health care and services for persons living with HIV/AIDS in Mississippi*. Jackson Mississippi: University of Mississippi.

Krefting, L. 1990. Rigour in qualitative research: the assessment of trustworthiness. *The American Journal of Occupational Therapy* 45(3):1-15.

Kvale, S., & Brinkmann, S. (2009). Interviews: Learning the craft of qualitative research interviewing. Thousand Oaks, CA: Sage.

Lamendola, F.P. 1998. Patterns of the care giving experience of selected nurses in hospice HIV care: University of Minnesota.

- Leavitt, K.J. 2008. Making a difference: why perianaesthesia nurses must be involved in the policy and political process. *Journal of Perianaesthesia Nursing* 25(3): 157-162
- Leavitt, K.J. 2009. Leaders in health policy: a critical role for nursing outlook .Mosby Elsevier
- Liamputtong, P. (Ed.). (2013). *Researching sensitive topics*. CA: Sage
- Lincoln, Y.S. & Guba, E.G. 1985. *Naturalistic inquiry*. London: Sage.
- Lo-Biondo-Wood, G. & Haber, J. 2006. *Nursing research: methods, critical appraisal and utilization*. St Louis: Mosby.
- Makoroka L.2014.Health service utilization among men who have sex with men (MSM) who live in Toronto. Secondary analysis of a cross-section study. McMaster University: Hamilton, Ontario
- Marshall, C. & Rossman, G.B. 2011. *Designing qualitative research 3rd Edition*. London: Sage.
- Mason, D.J. and Leavitt, J.K. 1995. The revolution in health care: What's your readiness quotient? *The American Journal of Nursing* 95 (6) 50-54
- Mason, D.J.Leavitt J.K. &Chaffee 2006. Policy and politics: A framework for action. St Louis Elsevier.
- Milner FW, Estabrooks CA,Hampbery C.2005. Clinical nurse educators as agent for change: increasing research utilization *International Journal of Nursing*. Mosby: Elsevier
- Mkhize SW.2009.Transformational leadership model for nursing education leaders in nursing education institutions. Potchefstroom: North West University
- Mofokeng, M.A. 2006. Beliefs and practices of Sotho antenatal women. Pretoria: Unisa
- Mogengege, M.A. 2008. If Mama`s not happy, nobody`s: An exploration of the influence of stigma, disclosure, and family coping on the transmission of maternal depression to children in African-American families affected by HIV/AIDS. USA: Lexington, Kentucky
- Mohumba M. 2007: The relationship between HIV/AIDS-related stigma and the process of forgiveness with a special focus on the family context. USA: Lexington, Kentucky

Mouton, J. & Marais, H.C. 1992. *Basic concepts in the methodology of the social sciences*. Pretoria: Human Sciences Research Council.

Mouton, J. & Marais, H.C. 1996. *Basic concepts in the methodology of the social sciences*. Human Sciences Research Council. Pretoria.

Nicol, L.H. (2003). *Perspectives on nursing theory*. New York: Lippincott.

National Department of Health. 2011. *National Core standards for health establishments in South Africa*. Pretoria : Government Printers

Pasardh, A. & Van Dyk, G.A.J. 2005. Assessing Behavioural Intention of Small and Medium Enterprises in implementing an HIV/AIDS policy and programme. *South African Journal of Industrial Psychology*, 31(1):71-77.

Pawinski, R. A., & Laloo, U. G. (2006). Multisectoral responses to HIV/AIDS: applying research to policy and practice. *American journal of public health*, 96(7), 1189-1191.

Polit D, Hungler B. 2010. *Nursing Research: Principles and Methods*, ed 7th. Baltimore: J.B.Lippincott, .

Rosenthal, S. & Strange W. 2004. Evidence on the nature and sources of agglomeration economies. Realities of Canadian nursing: professional practice and power issues. 2nd edn. Philadelphia: Lippincott,

Rossouw D., 1995. *Intellectual tools : Skills for the human sciences*. 2nd edition. Pretoria: Van Schaik.

Roussell L., Swansburg, R.C., & Swansburg, R.J. 2006. *Management and Leadership for Nurse Administrators*. 4th edn.. Jones & Bartlett. London

SA FM News. 2009. 9 March. Speech of the ANC President to the Academics. Pretoria.

Sclafani, S. 2004. The administration and policy making process-An insider view inside act: 6-47

Sermeus, W., Aiken, L., Van den Heede, K., Rafferty, A. Griffiths, P., Moreno-Casbas, M. T., ... & Zikos, D. (2011). Nurse forecasting in Europe (RN4CAST): Rationale, design and methodology. *BMC nursing*, 10(1), 6.

- Setswe, G., Peltzer, K., Banyini, M., Sedumedi, S., Gomis, D. & Van der Linde, I. 2007
Reported and policy brief the 4th conference on social innovations in access to prevention
treatment and care in HIV/AIDS, Kisumu, Kenya. *Journal of Social Aspects of HIV/AIDS* 4 (2)
640-651.
- Shamian, J., Skelton-Green, J. & Villeneuve, M. 2006b. Policy is lever for effecting change .
2nd edn. Philadelphia: Lippincott, Williams & Wilkens. Pp. 83-104.
- SPSS Inc. 2010. SPSS* 16.0 for Windows. Release 16.0.0. Copyright by SPSS Inc., Chicago,
Illinois. <http://www.spss.com>.
- Streubert, H. J. Speziale R., & Carpenter, D. R. (2011). *Qualitative Research IN Nursing* 5th ed
St. Louise: Mosby
- Teasdale-Cort Handbook: see Edwards, N. & Roelofs, S. 2007. Canada
- The Concise Oxford English Dictionary. 2000. Oxford: Clarendon Press
- Thorsen, V. C., Tharp, A. L., & Meguid, T. (2011). High rates of burnout among maternal health
staff at a referral hospital in Malawi: A cross-sectional study. *BMC nursing*, 10(1), 9.
- Van der Berg, Bonthuyzen, Elenglebecht, Hlophe, Van Resburg&smit.2006. The world Health
Organization re-evaluation of human and management toxic equivalency factors for dioxins and
dioxin-like compounds. *Toxicological sciences* .93(2):223-241.
- Van Dyk, A. C. (2008). *HIVAIDS Care & Counselling*. Pearson South Africa.
- Walker, L.O. & Avant, K.C. 2005. *Strategies for Theory Construction in Nursing*. 4th edn. New
Jersey: Pearson Education Inc.
- World Health Organisation. World Health Report 2012. WHO: Geneva.
- World Health Organisation. World Health Report 2007. WHO: Geneva.
- Young, A., Taylor, S. G., & Renpenning, K. (2001). *Connections: Nursing research*,
- Zimbabwe, Human Sciences Research Council, Cape Town
- Zuma, S.M. 2008. Nursing leadership facing HIV/AIDS challenge. *Nursing update*. March 32(2)

Zungu-Ndirwayi, N., Shisana, O., Udjo, E., Mosala, T. & Seager, J. 2004. *An Audit of HIV/AIDS Policies*. Human Sciences Research Council: Cape Town.

ANNEXURE A: ETHICAL LETTER NORTH WEST UNIVERSITY



NORTH-WEST UNIVERSITY
YUNIBESITHI YA BOKONE-BOPHIRIMA
NOORDWES-UNIVERSITEIT

Private Bag X8001, Potchefstroom
South Africa 2520

Tel: (018) 299-2542
Faks: (018) 297-5308
Web: <http://www.nwu.ac.za>

Prof H Klopper

Ethics Committee
Tel: +27 18 299 2542
Fax: +27 18 297 5308
Email: Ethics@nwu.ac.za

5 February 2008

Dear Prof Klopper

ETHICS APPROVAL OF PROJECT

The North-West University Ethics Committee (NWU-EC) hereby approves your project as indicated below. This implies that the NWU-EC grants its permission that, provided the special conditions specified below are met and pending any other authorisation that may be necessary, the project may be initiated, using the ethics number below.

Project title: Programme of Research: Strengthening Nurses Capacity in HIV Policy Development in Sub-Saharan Africa and the Caribbean																
Ethics number:	<table border="1"><tr><td>N</td><td>W</td><td>U</td><td>-</td><td>0</td><td>0</td><td>0</td><td>4</td><td>4</td><td>-</td><td>0</td><td>7</td><td>-</td><td>S</td><td>2</td></tr></table>	N	W	U	-	0	0	0	4	4	-	0	7	-	S	2
N	W	U	-	0	0	0	4	4	-	0	7	-	S	2		
Approval date: 1 October 2007 Expiry date: 30 September 2012																

Special conditions of the approval (if any): None

General conditions:

While this ethics approval is subject to all declarations, undertakings and agreements incorporated and signed in the application form, please note the following:

- The project leader (principle investigator) must report in the prescribed format to the NWU-EC:
 - annually (or as otherwise requested) on the progress of the project,
 - without any delay in case of any adverse event (or any matter that interrupts sound ethical principles) during the course of the project.
- The approval applies strictly to the protocol as stipulated in the application form. Would any changes to the protocol be deemed necessary during the course of the project, the project leader must apply for approval of these changes at the NWU-EC. Would there be deviation from the project protocol without the necessary approval of such changes, the ethics approval is immediately and automatically forfeited.
- The date of approval indicates the first date that the project may be started. Would the project have to continue after the expiry date, a new application must be made to the NWU-EC and new approval received before or on the expiry date.
- In the interest of ethical responsibility the NWU-EC retains the right to:
 - request access to any information or data at any time during the course or after completion of the project;
 - withdraw or postpone approval if:
 - any unethical principles or practices of the project are revealed or suspected,
 - it becomes apparent that any relevant information was withheld from the NWU-EC or that information has been false or misrepresented,
 - the required annual report and reporting of adverse events was not done timely and accurately,
 - new institutional rules, national legislation or international conventions deem it necessary.

The Ethics Committee would like to remain at your service as scientist and researcher, and wishes you well with your project. Please do not hesitate to contact the Ethics Committee for any further enquiries or requests for assistance.

Yours sincerely

Prof M M J Lowes

(Chairman NWU Ethics Committee)
S : 54 2A: 21 21-1A-01

PERSON

Fax sent by : 0514448850

ANNEXURE B: EETHICAL FREE STATE DEPT. OF HEALTH

29/05/2009 09:27 051-4031950 HOD HEALTH

 **he**
Department
Health
FREE STATE

Chief Executive Officer
Thebe/Phumelela Hospital

Fax: 058-622 1017

Dear Me MA Mofokeng

**PERMISSION TO CONDUCT THE STUDY: DEVELOPMENT OF NURSES CAPACITY TO
INFLUENCE HIV AND AIDS POLICY FROM 6TH JUNE – 17TH JULY 2009**

The above-mentioned correspondence received on the 14 May 2009 bears reference.

Permission is hereby granted to conduct above-mentioned study at the facilities of the Free State
Department of Health provided that you comply with the following:

- ✓ Voluntary participation with informed consent.
- ✓ The study is conducted in a manner that does not impact negatively on services.
- ✓ That the Free State Department of Health receives a copy of the study results prior to
publication and consents to such publication.

Yours sincerely


PROF PL RAMELA
HEAD: HEALTH

DATE: 28/05/09

Head: Health
PO Box 227, Bloemfontein, 9000
4th Floor, Executive Suite, Staphen's House, off Nelsland and Harvey Road, Bloemfontein
Tel: (051) 408 1100 Fax: (051) 408 1990, e-mail: hoda@fshw.co.za

Fax sent by : 0514080000

ANNEXURE C: PERMISSION LETTER BY DIFFERENT FACILITIES : FREE STATE DEPT. OF HEALTH



NORTH-WEST UNIVERSITY
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School of Nursing Science
Tel: (018) 2991874
Fax: (018) 2991827
Email: francois.watson@nwu.ac.za

26 August 2010

Institutional Permission for Staff to Participate in the International Research Program: Strengthening Nurses' Capacity in HIV Policy Development in Sub-Saharan Africa and the Caribbean

Our organization, _____ (organization's name) agrees to participate in the project "Nursing Practice in HIV Prevention and AIDS Care in Sub-Saharan Africa and the Caribbean". The research led by Prof Hester Klopper, RN, RM, RPN, MBA, PhD (North-West University, South Africa) Judy Mill, RN, PhD (University of Alberta, Canada) and Ms. Mariam Waiusimbi, RN, RM, MScN (Mulago Hospital, Uganda) in collaboration with other investigators from Canada (Universities of Ottawa, Edmonton, Toronto, Lethbridge, and Dalhousie; and the Canadian Nurses Association); Kenya (Great Lakes University of Kisumu); Jamaica (University of the West Indies); Uganda (Mulago Hospital); and Barbados (Ministry of Health and Barbados Community College).

The purpose of this study is to describe and understand issues that affect the role of registered nurses and midwives and enrolled nurses in HIV prevention and AIDS care for individuals and families living with HIV and AIDS in five study countries (Uganda, Kenya, South Africa, Jamaica, and Barbados). This project is part of a larger research program to strengthen nurses' capacity in HIV policy development in Sub-Saharan Africa and the Caribbean. The Principal Investigators are: Dr. Nancy Edwards (Canada), Dr. Dan Kaseje (Kenya) and Dr. Eulalia Kahwa (Jamaica).

The specific objectives of this study are to:

1. Examine how multi-layered dimensions of AIDS stigma (institutional, personal, societal) influence nurses' provision of prevention, care and treatment to patients and families;
2. Understand how work place policies and their genesis (including gaps between institutional policies and national HIV and AIDS strategy recommendations) affect nurses in providing care for individuals and families living with HIV as well as obtaining treatment for themselves;
3. Understand gaps between current nursing practice and organizational supports for front-line nurses and managers caring for individuals and families living with HIV and AIDS;
4. Examine the impact of leadership hubs in improving nursing practices and workplace policies for individuals and families living with HIV and AIDS.

Our participation will consist of the following:

- Distributing letters to specific individuals asking if they will give permission for researchers to contact them about participating in interviews or focus groups about HIV and AIDS nursing care, stigma, and workplace policies
- Those willing to be contacted are asked to send their affirmative response and contact information directly to the research assistant.

09-01-12 09:47 Pg: 2

FSSON

Fax sent by : 0514486856

- Assemble a list of names of eligible nurses according to eligibility criteria provided by the researchers some of whom will receive letters asking if they will give permission to contact them about participating in interviews or focus groups about HIV and AIDS nursing care, stigma, and workplace policies.
- Distributing letters of information/consent and questionnaires about HIV and AIDS nursing practice to nurses involved with HIV and AIDS care. This questionnaire would be repeated at a later date in the study to assess changes;
- Participating in a Human Resource Management Assessment for HIV and AIDS Environments which would involve three staff members at our organization completing individual assessments and then a group assessment. This may be followed by individual interviews with three staff members. The researchers would like to repeat these activities at a later date in the study to assess changes.

Signature of Senior
Administrator:

Name of Senior
Administrator:

Organizational Name:

Contact Details:

Date:

ANNEXURE D: COUNTRY CODING FRAME WORK

Strengthening Nurses' Capacity in HIV Policy Development in Sub-Saharan Africa and the Caribbean Country Coding Framework - South Africa

Country Coding Framework

South Africa – Free State

INTERVIEWER CODES

Name of Interviewer	Codes
M.A Mofokeng	3
M.M Mokoena	4
NR Tshabalala	5
M. Rakhethla	6
M.M Mabolo	7
M.E Moloi	8

COUNTRY CODE

Country	Code
South Africa	4

DISTRICT CODES

Name of district	District Codes
Thabo Mofutsanyane	4
Motheo	5
Fezile Dabi	6

FACILITY CODES

Name of facility	Facility Codes
Elizabeth Ross Hospital	16
Namahadi Cline	17
Phuthadithjaba Clinic	18
Boiketlo Clinic	19
Mphohadi Clinic	20
Boitumelo Regional Hospital	21
Botshabelo Hospital	22
Thusanong Clinic	23
	24
	25
Seisoville Clinic	26
Metsimaholo District Hospital	27
Pax CHC	28

ANNEXURE E: • TOOL THREE



INFORMATION SHEET AND CONSENT FORM

HIV & AIDS Environments

Human Resource Management Rapid Assessment Tool (HRM Tool)

Invitation to participate: I am being invited to participate in the above-mentioned research study.

Study Purpose: The purpose of this study is to develop a model for HIV AND AIDS care, research and policy interface. This project is part of a larger research program to strengthen nurses' capacity in HIV policy development in Sub-Saharan Africa and the Caribbean.

This study is done in five study countries (Uganda, Kenya, **South Africa**, Jamaica, and Barbados).

The specific objectives of this study are to:

- 1. To examine how HIV AND AIDS stigma influence nurses provision of prevention, care and treatment to patients and families.**
2. To explore and describe how HIV AND AIDS affects the workforce.
3. To examine the HIV AND AIDS work place policies national HIV AND AIDS strategy as well as nursing interventions and identify gaps among them.

Which objective is relevant to the research I am asked to participate in: My participation will contribute Objective Two: Understanding how HIV AND AIDS affect nurses and midwives in

providing care for individuals and families living with HIV as well as obtaining treatment for themselves.

Participation: My participation will involve taking part in a human resource management rapid assessment exercise about my workplace. I will complete the assessment tool on my own, and then participate in a group activity with others in my workplace to complete the assessment tool together. A research assistant will work with me for both the individual and group assessments. The rapid assessment tool will examine human resource development and management processes for HIV and AIDS activities, workplace policies and practices. It will take me about an hour to complete the tool on my own, followed by 2-3 hours for group completion. I may be asked to participate in this rapid assessment exercise again in several years, as a follow up to look at changes in human resource policies. Data will also be used in comparative case studies across the five study countries about the impact of leadership hubs on nurses' engagement in HIV and AIDS policy development and collaborative action. The data may be used for secondary analysis at a future date following consent by all relevant research ethics boards. Secondary analysis means that the data would be used to examine issues other than the one being considered by this research team in this present study: for example, to test additional hypotheses or to apply mixed methods to look at emerging relationships in the data. Only researchers working with a member of the team for the current study will be permitted to access the data. Anyone conducting a secondary data analysis will only have access to anonymized data, or will be unaware of the identities of the participants.

Risks: Minimum risk is expected from my participation in this study. My decision as to whether or not to participate in the study will not have any positive or negative repercussions for me. I understand that I am requested not to disclose my HIV status in the study and I will not be asked to disclose my HIV status. I understand that my participation in this study will entail that I discuss topics that may cause me emotional distress or concern about work place issues. If I disclose HIV status or am emotionally distressed about my HIV status or that of a family member, a referral will be made to an appropriate individual or agency in the community. I have been assured that I can withdraw my comments and quotes, or refuse to be quoted. I have been advised to say only what I am comfortable saying, and I know that I may withdraw from the study at any time. I understand that the researchers will keep confidential and anonymous any responses I provide during the individual portion of the rapid assessment exercise. I understand that my responses during the group portion of the assessment will be heard by other members of my group, and although the researchers will ask all participants to respect confidentiality, this

cannot be guaranteed. I have been reassured by the researcher that every effort will be taken to minimize the risks, that my organization has given permission for me to participate in this research, and that only anonymized responses will be shared with my employers. I know that at the end of the interview, I will be asked if there are any portions of what I have said that I do not want to be quoted on, and that this will be recorded on tape and in a written note by the interviewer.

Benefits: My participation in this study will give me an opportunity to further understand human resource workplace issues relating to HIV and AIDS, and to reflect on weaknesses and strengths of policies at my workplace. The summary that will result from this study may be of benefit in helping me and my organization to identify areas for action to improve my workplace's human resources management policies.

Confidentiality and anonymity: I have received assurance from the researcher that any information I share in the individual assessment will remain strictly confidential, and that individual and group information will be summarized. I understand that the contents will be used only for the purpose of the study and that my confidentiality will be protected by the research team. I understand that while the researchers will protect my confidentiality and anonymity in how they use my responses, the nature of group activities means that other members of the group will know what my responses were. I understand that I am asked to maintain confidentiality of what is said by others during group activities and anonymity about who participated. The content will only be discussed within the research team. Anonymity will be protected by not recording my name or the name of my facility with the information from the tool. A unique code number will be assigned to the tool and to my facility. This information will be aggregated and will never be released individually; no one will be able to identify me or my facility. Aggregate results will be published so my identity or that of my facility will not be revealed in any reports or publications.

Dissemination of data: My organization will receive a copy of the group completion portion of the Assessment. Project leadership hubs will receive an executive summary of the results, and may request additional analysis.

Conservation of data: All information collected from me through the Human Resources Management Assessment will be kept in a locked filing system in the project office in North-West University: Potchefstroom Campus in South Africa. All computers on which study data will be stored will be password-protected. The data will be accessible only to the study's investigators, research staff, audiotape transcriber, graduate and post-doctoral students working with the project, and research interns. (Research interns are participants in an international research training program for nurses that will be held during the project.) Everyone who has access to the raw data will be asked to sign a confidentiality agreement. The study data will be stored for ten years following completion of the study, after which time the paper data will be destroyed.

Compensation: There will be no monetary compensation for my participation in the study. Refreshments will be provided during group assessment activities.

Voluntary Participation: I am under no obligation to participate and if I choose not to participate, I can choose to withdraw from the study at any time and /or refuse to complete the tool-

This study has received ethics approval from the University of Ottawa Research Ethics Board and the ethics boards of all Canadian partner universities. Furthermore within the South African context the research project have received full ethical approval from:

- North-West University Research Ethics Board
- Department of Health – North West Province and
- The relevant permissions letters from district level and facility al level.

For Ethical queries please contact,

Research Program Manager: Francois Watson

North-West University, Potchefstroom Campus

Tel (w): 018 299 1220

Email: francois.watson@nwu.ac.za

The Country Program Director: Professor Hester Klopper (Details below)

For further ethical inquiries please contact

Protocol Officer for Ethics in Research,

University of Ottawa, Tabaret Hall,

550 Cumberland Street, Room 159,

Ottawa, Ontario, Canada K1N 6N5

(613) 562-5841 or ethics@uottawa.ca

This study is funded by the Global Health Research Initiative, Canada.

CONSENT

I, _____ (print name) have understood to my satisfaction the information regarding my participation in the research project *“Nursing Practice in HIV Prevention and AIDS Care in Sub-Saharan Africa and the Caribbean”* and agree to participate. In no way does this waive my legal rights nor release the investigators, or involved facilities from their legal and professional responsibilities.

- a) I agree to participate in the study by completing individual and group responses to the Human Resource Management Tool,
_____ Yes _____ No

b) I agree to be quoted but all personally identifying information shall be removed or altered and contents of the quote shall not reveal my identity. _____

I do not wish to be quoted at all. _____

c) If I choose to withdraw, I agree that all data gathered from me during both the individual exercise portion may continue to be used in the study. _____

If I choose to withdraw, I request that data gathered from me during the individual portion of the assessment from me be destroyed. _____

d) I agree that data may be used for pedagogical purposes such as in classes by professors, workshops, presentations and case studies. All personally identifying information will be removed or altered and data shall not reveal my identity.

_____ Yes _____ No

There are two copies of this consent form, one of which is mine to keep.

Participant's Signature: _____ Date: _____

Hester Klopper, RN, RM, RPN, MBA, PhD, North-West University, South Africa, (018) 299 1830 or
Hester.Klopper@nwu.ac.za

Eulalia Kahwa, RN, PhD, University of the West Indies, Jamaica

Nancy Edwards, RN, PhD, University of Ottawa, Canada

Dan Kaseje, MD, PhD, Great Lakes University of Kisumu, Kenya

Judy Mill, RN, PhD, University of Alberta, Canada

Mariam Walusimbi, RN, RM, MScN, Mulago Hospital, Uganda

June Webber, RN, PhD, Canadian Nurses Association

Marion Francis-Howard, RN, RM, PhD, Barbados Community College

Angela Crawford, RN, RM, Ministry of Health, Barbados

Pamela Juma Atieno, RN, PhD(c), Great Lakes University of Kisumu, Kenya

Cerese Hepburn-Brown, RN, RM, MScEd, University of the West Indies, Jamaica

Greta Cummings, RN, PhD, University of Alberta, Canada

Frances Legault, RN, PhD, University of Ottawa, Canada

Susan Roelofs, BA, MA, University of Ottawa, Canada

Jean Harrowing, RN, MN, PhD(c), University of Lethbridge, Canada

Ann Tourangeau, RN, PhD, University of Toronto, Canada

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Human Resource Management Rapid Assessment Tool for HIV AND AIDS Environments

ID CODE	
Date of Completion	
Researcher	
Country	
District	
Facility	
Tool number	3
Type of tool	4
HRM Tool number	

**PLEASE READ THE INSTRUCTION CAREFULLY BEFORE
ANSWERING**

Instructions:

*For each of the HRM components in the matrix below, you will fill in the columns labeled “Current Stage” and “Evidence.” In the blank box under “Current Stage,” enter the number of the stage (1–4) with the statement **that best applies** to the current stage of your organization. If only part of the statement applies, enter the number for the previous stage. In the blank box under “Evidence,” **please record the reasons** that led you to select this box and any additional key information related to this component.*

Biographical Background

What is your current age (check box that apply)?

- ☐ 21 – 30 years
- ☐ 31 – 40 years
- ☐ 41 – 50 years
- ☐ Older than 50 years

What is your educational background (check all that apply)?

- ☐ diploma (specify specialty) _____
- ☐ baccalaureate degree (specify specialty) _____
- ☐ other specialty training (specify) _____
- ☐ medical degree (specify specialty) _____
- ☐ master's degree (specify specialty) _____
- ☐ doctoral degree (specify specialty) _____
- ☐ Other (please specify) _____

What is your present position in this facility:

How long have you worked in your present position? ____months ____years

How long have you worked in this organization? ____months ____years

Thank you for participating in this study. Your opinions and experiences are very valuable to us. When we finalize the research, we would like to be able to describe the facilities that participated in this study. This information will be aggregated and will never be released individually; no one will be able to identify you or your organization.

Facility description:

- Number of beds _____
- Number of in-patients in 2007: _____
- Number of out-patients in 2007: _____
- % of admitted patients with HIV AND AIDS _____
- Total number of staff _____
- Number of staff who are registered nurses _____
- Number of staff who are enrolled nurses _____
- Number of staff who are physicians _____

Level of facility:

- National
- Provincial
- District/parish
- Health centre
- Other _____

PLEASE READ THE QUESTIONS CAREFULLY BEFORE ANSWERING

HRM Capacity

Please circle the current stage of your organization.

HRM Component	Stages of HRM and Their Characteristics		Evidence	Other Comments
HRM Staff	1	There are no staff specifically charged with responsibility for HRM functions.		
	2	There are adequate HRM staff in the organization trained in maintaining basic procedures and record-keeping functions, but they do not have a leadership role in developing human resource plans or policies and are not trained to deal with HRM issues related to HIV AND AIDS.		
	3	There are adequate HRM staff in the organization who maintain basic functions and also develop HRM policy, but they do not address HIV AND AIDS issues.		
	4	There is an adequate number of experienced HRM staff in the organization who maintain HRM functions, develop policy, and participate in long-range strategic planning on the organization's response to the impact of HIV AND AIDS on human resources.		

HRM Budget	1	Outside of the personnel budget, there is no money allocated for addressing ongoing HRM activities (e.g., recruitment and training), including those needed to support HIV AND AIDS strategies.		
	2	There is a budget to support ongoing HRM activities (e.g., recruitment and training), but no additional funds for activities to support HIV/ AIDS strategies (e.g., a workplace prevention program, drugs, benefits).		
	3	Funds are allocated for ongoing HRM activities and also for HRM activities needed to support HIV/AIDS strategies, but the allocation is irregular and cannot be relied on for useful long-range planning.		
	4	Funds are allocated for ongoing HRM activities and also to sustain HRM activities needed to support HIV AND AIDS strategies. These funds represent a permanent budget item, reviewed annually and adjusted as needed.		

HRM	Stages of HRM and Their Characteristics		Evidence	Other Comments
Human Resource Planning	1	There is no capacity to develop human resource staffing plans for the organization		
	2	A formal system exists for determining the salary scale for each job category, but it is not routinely used.		

	3	A formal system exists, is understood by all employees and is consistently used to establish salary upon entry to the organization, so that qualified staff who are willing to work full days can be attracted.		
	4	A formal system exists and is used to establish starting salary, and also is fairly used to establish merit awards and salary upgrades.		

Personnel Policy and Practice

Please circle the current stage of your organization.

HRM Component	Stages of HRM and Their Characteristics		Evidence	Other Comments
Compensation System	1	No formal system exists for determining the salary scale for each job category.		
	2	A formal system exists for determining the salary scale for each job category, but it is not routinely used.		
	3	A formal system exists, is understood by all employees and is consistently used to establish salary upon entry to the organization, so that qualified staff who are willing to work full days can be attracted.		

	4	A formal system exists and is used to establish starting salary, and also is fairly used to establish merit awards and salary upgrades.		

Benefits Program	1	No benefits program is in place.		
	2	A standard benefits program is in place, but it is not assessed for its effectiveness in supporting the retention of HIV AND AIDS infected staff (e.g., expanded sick leave, funeral benefits, and free drugs).		
	3	A standard benefits program is in place. It is assessed for its effectiveness in supporting the retention of HIV-infected staff. No action is taken based on the assessment data.		
	4	A standard benefits program is in place and adjusted as appropriate to support the retention of HIV-infected staff. Its effectiveness in helping to retain staff is monitored regularly.		

HRM Component	Stages of HRM and Their Characteristics		Evidence	Other Comments
	1	There are no data available on staff retention rates and the factors contributing to declining rates (e.g., how much are declining rates due to HIV AND AIDS, and how much are due to out-migration, retirement, or other factors).		

Staff Retention	2	Data on staff retention rates are available, but no analysis has been done to determine the contributing factors.		
	3	Data on staff retention rates are available. An analysis has been done to determine the contributing factors, but no strategy has been developed to address these factors.		
	4	A strategy is in place to improve the staff retention rate. It is based on data and a realistic analysis of the available pool of qualified employees.		

Recruitment, Hiring, Transfer, and Promotion	1	No formal process exists for recruiting, hiring, transferring, and promoting staff.		
	2	There are formal procedures for recruiting, hiring, transferring, and promoting staff, but they are not followed consistently		
	3	Formal procedures for recruiting, hiring, transferring, and promoting staff are used consistently.		
	4	Formal procedures are consistently used for recruiting, hiring, transferring, and promoting staff. Adherence to these procedures is regularly monitored and evaluated.		

Policy of Nondiscrimination Based on HIV/ AIDS Status	1	There is no policy of non discrimination on the basis of HIV AND AIDS.		
	2	A policy exists for non discrimination on the basis of HIV AND AIDS, but it is ignored.		
	3	The policy of non discrimination on the basis of HIV AND AIDS is not consistently applied.		
	4	The policy of non discrimination on the basis of HIV AND AIDS is followed.		

HRM Component	Stages of HRM and Their Characteristics		Evidence	Other Comments
Orientation Program	1	No formal orientation program exists for new employees.		
	2	An orientation program exists, but it is not implemented on a regular basis and lacks a component about the organization's HIV AND AIDS policies.		
	3	Orientation is routinely offered but does not emphasize the mission, the goals, and the performance expected by the organization, especially as they relate to HIV AND AIDS.		

	4	Orientation is offered to all new employees. It emphasizes the mission, goals, and performance expected, and makes people feel welcomed and valued, as well protected from stigma if they are affected or infected by HIV AND AIDS.		

HIV AND AIDS Workplace Prevention Program	1	No HIV AND AIDS workplace prevention program is in place to develop awareness and protocols to prevent HIV/ AIDS infection (e.g., proper handling of needles, peer education program, distribution of condoms).		
	2	An HIV AND AIDS workplace program has been developed, but no resources are available to implement it.		
	3	An HIV AND AIDS program is in place. It focuses on using appropriate protocols to limit the risk of infection as well as education about HIV AND AIDS, but only some staff have participated in the program.		
	4	An HIV AND AIDS program is in place. It focuses on using appropriate protocols to limit the risk of infection, and provides HIV AND AIDS education. All staff participate, and it is monitored for effectiveness in increasing staff knowledge and use of protocols.		

HRM Component	Stages of HRM and Their Characteristics		Evidence	Other Comments
Employee Manual (e.g., organizational chart, work hours, health insurance, sick leave, grievances)	1	No overall employee manual exists.		
	2	An employee manual exists but is out of date.		
	3	A current employee manual exists and is up to date, but is not used for personnel decisions.		
	4	An updated employee manual exists and includes policies that refer to HIV AND AIDS. It is available to all employees and is used as a guide for all questions about employment in the organization. It is update		

Policy Regarding Treatment of People (Employees and Clients) Living with HIV/ AIDS	1	No policy is communicated about how people (staff and clients) living with HIV AND AIDS are to be treated.		
	2	There is a policy regarding how to treat people (employees and clients) living with HIV AND AIDS, but it does not include all the relevant information on HIV AND AIDS.		
	3	There are policies on how staff and clients living with HIV AND AIDS are to be treated, but they are is not available to all employees and is not always used as a basis for personnel decisions.		

	4	The policies on how staff and clients living with HIV AND AIDS are to be treated are up to date and available to all employees and are utilized systematically.		

Discipline, Grievance, and Termination Procedures	1	No formal procedures for discipline, grievances, or termination exist.		
	2	Formal procedures for discipline, grievances, and termination exist, but they are not practiced and do not include protection against discrimination on the basis of HIV status.		
	3	Formal procedures for discipline, grievances, and termination exist and are practiced. The procedures include protection against discrimination on the basis of HIV status, but these are not adhered to.		
	4	Formal procedures for discipline, grievances, and termination exist, including non discrimination on the basis of HIV status. These procedures are followed.		

HRM Component	Stages of HRM and Their Characteristics		Evidence	Other Comments
Relationship	1	There is no link between HRM, management, and the union(s).		

with Unions (if appropriate)	2	Links exist between HRM, management, and the union(s), but roles are not clear.		
	3	Management involves HRM in union issues, but not on a regular basis.		
	4	Management, HRM, and the union(s) work together to resolve issues and prevent problems, including those related to HIV AND AIDS.		

Labor Law Compliance (if appropriate)	1	No review of HRM policies occurs to ensure compliance with the letter and spirit of local and/or national labor law, including HIV AND AIDS regulations, if they exist.		
	2	There is some effort to review labor law, but it is not done regularly.		
	3	A review of labor law is done regularly as a formal part of the HRM function, but policy is not always adjusted to ensure compliance, including compliance with HIV AND AIDS regulations.		
	4	HRM policy and practice is adjusted to comply with local and/or national labor law, including any HIV AND AIDS regulations.		

Performance Management

Please circle the current stage of your organization.

HRM Component	Stages of HRM and Their Characteristics		Evidence	Other Comments
Job Descriptions (e.g., job title, qualifications, job responsibilities, supervisor)	1	No job descriptions are developed. Jobs are not reviewed in light of organizational strategies, or when tasks need to be redistributed		
	2	Some staff have job descriptions, but they are not always up-dated to include new responsibilities or to redistribute tasks, when needed.		
	3	All staff have job descriptions, but they are not adjusted or reviewed to take into account changes in responsibilities or redistribute tasks, when needed.		
	4	All staff have job descriptions which are reviewed and adjusted regularly to take into account changes in responsibilities or redistribute tasks, when necessary		

Organizational Strategies for HIV Infection Prevention, Care and/or Treatment of	1	There is no organizational strategy for HIV infection prevention or for care and support of clients.		
	2	There is an organizational strategy for HIV infection prevention or for care and support of clients but the responsibilities of individual employees are not specified		

Clients	3	There is an organizational strategy for HIV infection prevention or for care and support of clients and the responsibilities of employees are well-defined. The standards, however, are not always followed.		
	4	There is an organizational strategy for HIV infection prevention or for care and support of clients and the responsibilities of employees are well-defined. The standards are always followed.		

HRM Component	Stages of HRM and Their Characteristics		Evidence	Other Comments
Staff Supervision	1	There is no clear system of supervision. Lines of authority are unclear. Supervisors do not meet regularly with their staff, nor do they receive training on supervision skills.		
	2	There are established lines of supervision, but supervisors' roles and functions are not understood, and little supervision takes place. Supervisors do not receive training of any kind.		
	3	There are established lines of supervision, and supervisors understand their roles and functions. Supervisors are trained in general supervisory skills.		

	4	Supervision is well facility alized within the organization. Supervisors are trained in general supervisory skills as well as in HIV AND AIDS policies and sensitivity to HIV-related staff issues.		

Training of Supervisors with Regard to HIV/ AIDS	1	Supervisors do not receive any training on questions related to HIV AND AIDS issues related to staff		
	2	Some supervisors receive training on how to deal with employees in regard to HIV AND AIDS		
	3	Supervisors receive a general training on the issues and policies related to HIV AND AIDS, but there is no sensitivity training on how to respond to questions related to HIV AND AIDS from employees.		
	4	Supervisors receive a general training on the issues and policies related to HIV AND AIDS, along with sensitivity training on how to respond to questions related to HIV AND AIDS from employees.		

HRM Component	Stages of HRM and Their Characteristics		Evidence	Other Comments
Work Planning and	1	No individual work planning and performance review system is in place.		

Performance Review	2	A work planning and performance review system is in place for individuals, but it is informal and does not include individual work plans or performance criteria developed jointly by supervisors and supervisees.		
	3	A formal system for work planning and performance review is in place for individuals. Supervisors are required to develop individual work plans and performance criteria with each supervisee and to review past performance, but this is not done consistently.		
	4	Supervisors and supervisees jointly develop individual work plans and performance criteria. These are used to conduct reviews of past performance at least once a year.		

Training

Please circle the current stage of your organization.

HRM Component	Stages of HRM and Their Characteristics		Evidence	Other Comments
Staff Training	1	There is no organizational staff training plan or ongoing assessment of individual staff's development needs.		
	2	Training is offered on an ad hoc basis but is neither based on staff needs, nor linked to the organization's key priorities.		

	3	Training is a formal component of the organization and is linked to staff and organizational needs, however, it is not implemented to reduce staff absence from their posts during training.		
	4	Training is a valued part of the organization, and opportunities are developed for staff, based on their needs and on the needs of the organization, including HIV AND AIDS issues. It is implemented to reduce staff absence from their posts during training.		

Staff Training on HIV AND AIDS Protocols	1	There is no staff training plan on HIV AND AIDS protocols, reallocation of responsibilities, or HIV-related sensitivity.		
	2	Training on strategies in HIV AND AIDS is offered on an ad hoc basis. Training plans do not take into account problems related to absence of staff from their posts during training.		
	3	Training related to questions and strategies in dealing with HIV AND AIDS is provided as an official priority of the organization and addresses questions of absence of personnel from their post during training. However, not all employees receive the training.		
	4	Training related to questions and strategies in dealing with HIV AND AIDS is provided as an official priority of the organization and addresses questions of absence of personnel from their post during training. All employees receive the training.		

HRM Component	Stages of HRM and Their Characteristics		Evidence	Other Comments
Management and Leadership Development Programs	1	No programs have been developed to increase management and leadership capacity at all levels of the organization		
	2	An emphasis on developing management and leadership capacity exists, but development is done on an ad hoc basis and not linked to addressing the challenges facing the organization, such as focusing on HIV AND AIDS and helping to implement the national HIV AND AIDS strategy.		
	3	Management and leadership development opportunities are available on a regular basis, but they target senior-level staff and are not directly linked to addressing the challenges facing the organization, such as focusing on HIV AND AIDS and helping to implement the national HIV AND AIDS strategy.		
	4	A management and leadership development program is in place for staff at all levels, and everyone has an opportunity to participate based on performance and other established criteria. The program focuses on addressing challenges facing the organization, such as focusing on HIV AND AIDS and helping to implement the national HIV AND AIDS strategy.		

Links to External Pre- Service Training	1	No formal link exists with the pre-service training facilities that prepare employees for the health sector, or with the accreditation organizations that approve their curricula.		
	2	A loose relationship exists between the organization and pre-service training facilities , but they do not use the relationship to formally update their curricula to meet the growing need for management capacity within the health sector nor to prepare people to work in HIV/ AIDS prevention and/or treatment programs.		
	3	The organization and pre-service training facilities work together to ensure that their curricula focus on developing skills, knowledge, and attitudes required by the health sector, including management and other skills for working in HIV AND AIDS prevention, care, and/or treatment programs.		
	4	The organization and pre-service training facilities offer regular in-service training for staff in the workplace to upgrade staff skills and knowledge (e.g., management training, HIV AND AIDS issues, change management, and partnerships).		

HRM Data

Please circle the current stage of your organization.

HRM Component	Stages of HRM and Their Characteristics		Evidence	Other Comments
Employee Tracking System (e.g., data on the number of staff, position, location, gender, age, year of hire, salary level, projected HIV AND AIDS prevalence, rate of attrition, and absenteeism by cadre)	1	None of these data are collected in any kind of systematic way.		
	2	Although most of these data are collected, there is no system to maintain them or keep them up to date. They are not used to generate reports on attrition, absentee-ism, or staff turnover.		
	3	All of these data are available and up to date. They are used to generate reports on attrition, absenteeism, and staff turnover, but are not formally used in human resource planning.		
	4	All of these data are available and up to date. Data collection and reporting systems are in place. Data are formally used in human resource planning.		

Personnel Files (e.g., individual employee	1	No individual employee records exist.		
	2	Limited employee personnel files are maintained, but not regularly updated.		

records that track performance, promotion, and salary history)	3	Personnel files for all employees are maintained and kept up to date, but there is no policy for employee access to or use of these data.		
	4	Both updated personnel files for all employees and policies for appropriate use (e.g., confidentiality, employee access) exist.		

This is the last page, Thank you for your participation

ID Codes & Contact Details - Individual Participant

South Africa – Free State Province

Tool 3 – Human Resource Management Rapid Assessment Tool for HIV AND AIDS Environments

ID CODE (48 Participants in the Free State Province)							
Date	Inter-viewer	District	Facility	Interview / Focus Group #	Participant Name(s)	Department/ Ward/Unit	Contact Details

ANNEXURE F: TOOL FOUR



INFORMATION SHEET AND CONSENT FORM

WORK PLACE POLICIES – FOLLOW-UP TO HRM ASSESSMENT

Individual Interviews with Administrators, Nurse Managers, and Nurses

Invitation to participate: You are invited to participate in the above-mentioned research study. This study is funded by four Canadian organizations: International Development Research Centre, the Canadian Institutes of Health Research, the Canadian International Development Agency, and Health Canada.

Study Purpose: The purpose of this study is to develop a model for HIV AND AIDS care, research and policy interface. This project is part of a larger research program to strengthen nurses' capacity in HIV policy development in Sub-Saharan Africa and the Caribbean. This study is done in five study countries (Uganda, Kenya, **South Africa**, Jamaica, and Barbados).

The specific objectives of this study are to:

- 1. To examine how HIV AND AIDS stigma influence nurses provision of prevention, care and treatment to patients and families.
- 2. To explore and describe how HIV AND AIDS affects the workforce.
- 3. To examine the HIV AND AIDS work place policies national HIV AND AIDS strategy as well as nursing interventions and identify gaps among them.

Which objective is relevant to the research I am asked to participate in: My participation will contribute to Objective Three: Understanding how work place policies and their genesis (including gaps between facility al policies and national HIV and AIDS strategy recommendations) affect nurses in providing care for individuals and families living with HIV as well as obtaining treatment for themselves.

Participation: I am being asked to participate in an interview to discuss human resource management and policies for HIV and AIDS at my workplace. Topics will include existing policies, their development and genesis, and gaps in policies and implementation. The interview will take approximately 45-60 minutes. I may be asked to participate in a second interview on the same topic in 2-3 years time as follow up to examine any changes in policies. Data will also be used in comparative case studies across the five study countries about the impact of leadership hubs on nurses' engagement in HIV and AIDS policy development and collaborative action. The data may be used for secondary analysis at a future date following consent by all relevant research ethics boards. Secondary analysis means that the data would be used to examine issues other than the one being considered by this research team in this present study: for example, to test additional hypotheses or to apply mixed methods to look at emerging relationships in the data. Only researchers working with a member of the team for the current study will be permitted to access the data. Anyone conducting a secondary data analysis will only have access to anonymized data, or will be unaware of the identities of the participants.

Risks: Minimum risk is expected from my participation in this study. My decision as to whether or not to participate in the study will not have any positive or negative repercussions for me. I understand that I am requested not to disclose my HIV status in the study and I will not be asked to disclose my HIV status. I understand that my participation in this study will entail that I discuss topics that may cause me emotional distress or concern about human resource management at my workplace. I know that permission has been given by my facility for staff to participate in the study, but that my responses during this interview will not be shared with my employers

Benefits: My participation in this study will not have a direct benefit to me; however, it will give me an opportunity to identify the process of how policies were developed in my workplace. The information I share may help the investigators identify strategies for strengthening human resource management for HIV and AIDS, and nurses' involvement in decision making and policy development.

Confidentiality and anonymity: I have received assurance from the researcher that any information I share will remain strictly confidential. I understand that the contents will be used only for the purpose of the study and that my confidentiality will be protected. The content will only be discussed within the research team. Anonymity will be protected by not recording my name with my responses or identifying me in any way. A unique code number will be assigned to me to identify my taped interview and interview transcripts. My facility will also have a unique code and will not be named when presenting results. Aggregate results will be published so my identity will not be revealed in any reports or publications. Although my name was provided to the researchers by another contact person, the researchers will not reveal to that person whether or not I participated in this study.

Conservation of data: All information collected from me (audiotapes, interview transcripts, notes) will be kept in a locked filing system in the project office in North-West University.. All computers on which study data will be stored will be password-protected. The data will be accessible only to the study's investigators, research staff, audiotepe transcribers, graduate and post-doctoral students working with the project, and research interns. (Research interns are participants in an international research training program for nurses that will be held during the project.) Everyone who has access to the raw data will be asked to sign a confidentiality agreement. The study data will be stored for ten years following completion of the study or publication of related articles, after which time paper transcripts will be destroyed. Audiotapes will be destroyed five years after transcription.

Compensation: There will be no monetary compensation in this study.

Voluntary Participation: I am under no obligation to participate.

This study has received ethics approval from the University of Ottawa Research Ethics Board and the ethics boards of all Canadian partner universities. Furthermore within the South African context the research project have received full ethical approval from:

- The North-West University Research Ethics Board.
- Department of Health – North West Province and
- The relevant permissions letters from district level and facility al level.

For ethical queries please contact,

Research Program Manager: Francois Watson
North-West University, Potchefstroom Campus
Tel (w): 018 299 1220
Email: francois.watson@nwu.ac.za

The Country Program Director: Professor Hester Klopper (Details below)

For further ethical inquiries please contact

Protocol Officer for Ethics in Research,
University of Ottawa, Tabaret Hall,
550 Cumberland Street, Room 159,
Ottawa, Ontario, Canada K1N 6N5
(613) 562-5841 or ethics@uottawa.ca

This study is funded by the Global Health Research Initiative, Canada.

CONSENT

I, _____ (print name) have understood to my satisfaction the information regarding my participation in the research project “*Nursing Practice in HIV Prevention and AIDS Care in Sub-Saharan Africa and the Caribbean*” and agree to participate as a subject. In no way does this waive my legal rights nor release the investigators, or involved facilities from their legal and professional responsibilities.

a) I agree to allow my interview to be audio-taped: _____ Yes _____ No

b) I agree to be quoted but all personally identifying information shall be removed or altered and contents of the quote shall not reveal my identity. _____

I do not wish to be quoted at all. _____

c) If I choose to withdraw, I agree that all data gathered from me may continue to be used in the study. _____

If I choose to withdraw, I request that all data gathered from me be destroyed. _____

d) I agree that data may be used for pedagogical purposes such as in classes by professors, workshops, presentations and case studies. _____ Yes _____ No

All personally identifying information will be removed or altered and data shall not reveal my identity.

There are two copies of this consent form, one of which is mine to keep.

Participant's Signature: _____ Date: _____

Hester Klopper, RN, RM, RPN, MBA, PhD, North-West University, South Africa, (018) 299 1830 or Hester.Klopper@nwu.ac.za

Eulalia Kahwa, RN, PhD, University of the West Indies, Jamaica

Nancy Edwards, RN, PhD, University of Ottawa, Canada

Dan Kaseje, MD, PhD, Great Lakes University of Kisumu, Kenya

Judy Mill, RN, PhD, University of Alberta, Canada

Mariam Walusimbi, RN, RM, MScN, Mulago Hospital, Uganda

June Webber, RN, PhD, Canadian Nurses Association

Hester Klopper, RN, RM, RPN, MBA, PhD, North-West University, South Africa

Marion Francis-Howard, RN, RM, PhD, Barbados Community College

Angela Crawford, RN, RM, Ministry of Health, Barbados

Pamela Juma Atieno, RN, PhD(c), Great Lakes University of Kisumu, Kenya

Cerese Hepburn-Brown, RN, RM, MScEd, University of the West Indies, Jamaica

Greta Cummings, RN, PhD, University of Alberta, Canada

Frances Legault, RN, PhD, University of Ottawa, Canada

Susan Roelofs, BA, MA, University of Ottawa, Canada

Jean Harrowing, RN, MN, PhD(c), University of Lethbridge, Canada

Ann Tourangeau, RN, PhD, University of Toronto, Canada

Josephine Etowa, RN, RM, PhD, Dalhousie University, Canada

Colleen Davison, MPH, PhD(c), University of Calgary, Canada

Magdalena Richter, RN, RM, RPN, PhD, University of Alberta, Canada

Walter Kipp, MD, MPH, PhD, University of Alberta, Canada

**Interviews on Workplace Policies
Follow-up to Human Resource Management Assessment**

**Tool 4
Demographic Profile**

ID CODE	
Date of Completion	
Researcher	
Country	
District	
Facility	
Tool number	4
Type of tool	1
HRM Tool number	

What is your gender? __female __male

What is your current age (check box that apply)?

- ☐ 21 – 30 years
- ☐ 31 – 40 years
- ☐ 41 – 50 years
- ☐ Older than 50 years

What is your educational background (check all that apply)?

- ☐ diploma (specify specialty)_____
- ☐ baccalaureate degree (specify specialty) _____
- ☐ other specialty training (specify) _____
- ☐ medical degree (specify specialty) _____
- ☐ master's degree (specify specialty) _____
- ☐ doctoral degree (specify specialty) _____
- ☐ Other (please specify) _____

What is your present position in this organization: _____

How long have you worked in your present position? __years __months

How long have you worked in this organization? ____years ____months

- I Good afternoon.
- R Good afternoon mam.
- I I am Mrs. Mofokeng, Mantua. I am conducting research on strengthening nurses policy, uhm nurses capacity in HIV policy development in Sub Saharan, Africa and the Caribbean. The specific purpose of this, of this study that is conducted in the Free State is to develop a model for HIV and AIDS care, research and policy interface. The specific objectives of this study are to examine how HIV Aids stigma influence nurses provision of prevention, care and treatment to patients and families. The second one is to explore and describe how HIV and AIDS affect the workforce. Thirdly to examine the HIV Aids work policies, National HIV Aids strategy as well as nursing interventions that you do and Identify gaps amongst these. You are asked to participate in a interview to discuss Human Resource management and policies for HIV Aids at your workplace. Pages one to three of this package contains information that goes to you as a participant followed by the consent form, the demographic profile and the interview questions. The last page comprises of a second consent form which you will keep as a reference in participating in this study. Thank you very much. If you do not have any other questions can we proceed with the interview questions?
- R Yes we can proceed.
- I Okay thanks a lot. You are respondent number five, can you tell me what factors prompted your organization to develop policies about HIV in the workplace?
- R Factors that prompted the organization to develop policies regarding HIV and AIDS, are factors like empowering Health Care personnel on HIV how is it transmitted, how can it be prevented, how to manage patients with the disease and how can, how can the health care workers protect themselves against contracting the disease.
- I Tell me more about other factors, besides uhm knowledge to the health care workers. Is there any other factor that you can think about?
- R It's knowledge to the patients themselves so that they shouldn't, they shouldn't stigmatize one another. They should ah accept the status if they are infected or affected by the, the HIV.

ANNEXURE G: TOOL FIVE

*Strengthening Nurses' Capacity in HIV Policy Development
in Sub-Saharan Africa and the Caribbean*



NORTH-WEST UNIVERSITY
YUNIBESITHI YA BOKONE-BOPHIRIMA
NOORDWES-UNIVERSITEIT
POTCHEFSTROOM CAMPUS

INFORMATION SHEET AND CONSENT FORM

Survey Questionnaire – Nurses and Nurse Managers

Invitation to participate: I am being invited to participate in the above-mentioned research study.

Overarching Study Purpose: The purpose of this study is to describe and understand issues that affect the role of registered nurses and midwives and enrolled nurses in HIV prevention and AIDS care for individuals and families living with HIV and AIDS in four study countries (Uganda, Kenya, **South Africa** and Jamaica). This project is part of a larger research program to strengthen nurses' capacity in HIV policy development in Sub-Saharan Africa and the Caribbean.

This Specific Study Purpose: The purpose of this study is to develop a model for HIV/AIDS care, research and policy interface.

The specific objectives of this study are to:

1. To examine how HIV/AIDS stigma influence nurses provision of prevention, care and treatment to patients and families.
2. To explore and describe how HIV/AIDS affects the workforce.
3. To examine the HIV/AIDS work place policies national HIV/AIDS strategy as well as nursing interventions and identify gaps among them.

Which objective is relevant to the research I am asked to participate in: My participation will contribute to Objective One: To examine how HIV/AIDS stigma influence nurses provision of prevention, care and treatment to patients and families. +

Participation: I am being asked to participate in the study by completing a questionnaire about my nursing practices relating to HIV prevention and AIDS care. Topics will include prevention, assessment, and clinical management of HIV and AIDS; stigma; and policies and quality assurance initiatives at my workplace. My participation will take approximately 45 minutes. I may be asked to complete the questionnaire a second time in year four of the project as part of follow up to examine changes in nursing practice. Data will also be used in comparative case studies across the five study countries about the impact of leadership hubs on nurses' engagement in HIV and AIDS policy development and collaborative action. The data may be used for secondary analysis at a future date following consent by all relevant research ethics boards. Secondary analysis means that the data would be used to examine issues other than the one being considered by this research team in this present study: for example, to test additional hypotheses or to apply mixed methods to look at emerging relationships in the data. Only researchers working with a member of the team for the current study will be permitted to access the data. Anyone conducting a secondary data analysis will only have access to anonymized data, or will be unaware of the identities of the participants.

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Risks: Minimum risk is expected from my participation in this study. My decision as to whether or not to participate in the study will not have any positive or negative repercussions for me. I understand that I am requested not to disclose my HIV status in the study and I will not be asked to disclose my HIV status. I understand that my participation in this study will entail that I discuss topics that may cause me emotional distress or concern about human resource management at my workplace. I know that permission has been given by my facility for staff to participate in the study, but that my responses during this interview will not be shared with my employers

Benefits: My participation in this study will not have a direct benefit to me; however, it will give me an opportunity to identify the process of how policies were developed in my workplace. The information I share may help the investigators identify strategies for strengthening human resource management for HIV and AIDS, and nurses' involvement in decision making and policy development.

Confidentiality and anonymity: I have received assurance from the researcher that any information I share will remain strictly confidential. I understand that the contents will be used only for the purpose of the study and that my confidentiality will be protected. The content will only be discussed within the research team. Anonymity will be protected by not recording my name with my responses or identifying me in any way. A unique code number will be assigned to me to identify my taped interview and interview transcripts. My facility will also have a unique code and will not be named when presenting results. Aggregate results will be published so my identity will not be revealed in any reports or publications. Although my name was provided to the researchers by another contact person, the researchers will not reveal to that person whether or not I participated in this study.

Conservation of data: All information collected from me (audiotapes, interview transcripts, notes) will be kept in a locked filing system in the project office in North-West University.. All computers on which study data will be stored will be password-protected. The data will be accessible only to the study's investigators, research staff, audiotope transcribers, graduate and post-doctoral students working with the project, and research interns. (Research interns are participants in an international research training program for nurses that will be held during the project.) Everyone who has access to the raw data will be asked to sign a confidentiality agreement. The study data will be stored for ten years following completion of the study or publication of related articles, after which time paper transcripts will be destroyed. Audiotapes will be destroyed five years after transcription.

Compensation: There will be no monetary compensation in this study.

Voluntary Participation: I am under no obligation to participate.

This study has received ethics approval from the University of Ottawa Research Ethics Board and the ethics boards of all Canadian partner universities. Furthermore within the South African context the research project have received full ethical approval from:

- The North-West University Research Ethics Board.
- Department of Health – North West Province and
- The relevant permissions letters from district level and facility al level.

For ethical queries please contact,

Research Program Manager: Francois Watson
North-West University, Potchefstroom Campus
Tel (w): 018 299 1220
Email: francois.watson@nwu.ac.za

The Country Program Director: Professor Hester Klopper (Details below)

For further ethical inquiries please contact

Protocol Officer for Ethics in Research,
University of Ottawa, Tabaret Hall,
550 Cumberland Street, Room 159,
Ottawa, Ontario, Canada K1N 6N5
(613) 562-5841 or ethics@uottawa.ca

This study is funded by the Global Health Research Initiative, Canada.

***Strengthening Nurses' Capacity in HIV Policy Development
in Sub-Saharan Africa and the Caribbean***

CONSENT

I, _____ (print name), have understood to my satisfaction the information regarding my participation in the research project "*Nursing Practice in HIV Prevention and AIDS Care in Sub-Saharan Africa and the Caribbean*" and agree to participate as a subject. In no way does this waive my legal rights nor release the investigators, or involved institutions from their legal and professional responsibilities.

I agree that the researchers can re-contact me to request that I complete the questionnaire again at a later date:

- ☐ No
☐ Yes

If yes, please provide contact information:

Name: _____
Work place name: _____
Work telephone: _____
Work fax: _____
Email: _____

There are two copies of this consent form, one of which is mine to keep.

Participant's Signature: _____ Date: _____

Hester Klopper, RN, RM, RPN, MBA, PhD, North-West University, South Africa, (018) 299 1830 or
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Walter Kipp, MD, MPH, PhD, University of Alberta, Canada

ID Codes & Contact Details - Individual Participant

South Africa – Free State Province

Tool 5 – Clinical Practice Survey-Questionnaire for Nurse and Nurse Managers

ID CODE (158 Questionnaires in the Free State Province)					Participant Name(s)	Department/ Ward/Unit	Contact Details
Date	Inter- viewer	District	Facility	Interview / Focus Group #			

ANNEXURE H: TOOL THREE (3) & FIVE (5)

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Country Code	Participant ID:	Number of beds	Number of in-patients in 2007:	Number of out-patients in 2007:	% of admitted patients with HIV/AIDS	Total number of staff	Number of staff who are registered nurses	Number of staff who are enrolled nurses	Number of staff who are physicians	Level of facility:	Other level of facility	What is your age?	diploma (specify specialty)
PLEASE NOTE THAT THE FIRST 2 ROWS ARE ONLY EXAMPLES													
41101/10/5/4/4	110	9 836	12 395	52.20%	278	44	37	6	ct Hospital	District		4	General Nurs
41101/10/5/4/4	110	9 836	12 395	52.20%	278	44	37	6	ct Hospital	District		3	Diploma in G
41101/10/5/4/4	110	9 836	12 395	52.20%	278	44	37	6	ct Hospital	District		3	General Nurs
41101/10/5/4/4	110	9 836	12 395	52.20%	278	44	37	6	ct Hospital	District		4	General Nurs
41101/10/5/4/4	110	9 836	12 395	52.20%	278	44	37	6	ct Hospital	District		3	Mid midwifery
41101/10/5/4/4	110	9 836	12 395	52.20%	278	44	37	6	Hospital	District		3	General N
41101/10/5/4/4	110	9 836	12 395	52.20%	278	44	37	6	Hospital	District		2	Midwifery
41101/10/5/4/4	110	9 836	12 395	52.20%	278	44	37	6	Hospital	District		2	General N
41101/10/5/4/4	110	9 836	12 395	52.20%	278	44	37	6	Hospital	District		1	General N
41101/10/5/4/4	110	9 836	12 395	52.20%	278	44	37	6	Hospital	District		1	4 year cou
41101/10/5/4/4	110	9 836	12 395	52.20%	278	44	37	6	Hospital	District		1	Midwifery

Nr	Country	ID	aa aa. What is your age?	a1 A1. What is your gender?	a2.i A2. What type of health profession al are you currently - I. enrolled nurse	a2.ii II Registered nurse	a2.iii III Enrolled midwife	a2.iv IV Registered midwife
223	4	09/21/10/5/4/4/16/3/223	999	999	999	999	999	999
224	4	09/21/10/5/4/4/16/3/224	4	1	0	0	0	1
176	4	09/09/10/5/4/4/18/3/176	3	1	0	1	0	0
177	4	09/09/10/5/4/4/18/3/177	3	1	0	1	0	0
178	4	09/09/10/5/4/4/18/3/178	3	2	0	1	0	0
166	4	09/09/10/5/4/4/17/3/166	3	2	0	1	0	0
167	4	09/09/10/5/4/4/17/3/167	3	1	0	1	0	0
168	4	09/09/10/5/4/4/17/3/168	1	1	0	1	0	0
169	4	09/09/10/5/4/4/17/3/169	2	1	0	1	0	0
170	4	09/09/10/5/4/4/17/3/170	3	1	0	0	0	1
277	4	03/04/11/5/4/4/22/277	4	2	0	1	0	0
278	4	03/04/11/5/4/4/22/278	2	1	0	1	0	0
279	4	03/04/11/5/4/4/22/279	2	2	0	1	0	0
280	4	03/04/11/5/4/4/22/280	2	1	0	1	0	1
281	4	03/04/11/5/4/4/22/281	3	1	0	1	0	1
282	4	03/04/11/5/4/4/22/282	2	1	0	1	0	0