

Challenges and coping mechanisms of caregivers of people living with HIV and AIDS in healthcare facilities in Mahikeng

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Dissertation submitted in fulfilment of the requirements for the degree *Master of Social Work* at the North West University

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Year 2019

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DECLARATION

I, Tsholofelo Macinga declare that “**CHALLENGES AND COPING MECHANISMS OF PEOPLE LIVING WITH HIV AND AIDS IN HEALTHCARE FACILITIES IN MAHIKENG**” is my original work and has not been submitted before at this or any other university. Where the work of other researchers have been used, it has been duly acknowledged both in text and under the full references list.

.....

Signature

Ms T Macinga

.....

Date

DEDICATION

This study is dedicated to my late father, Mr Olehile William Macinga, and my mother, Mrs Kenyaditswe Florah Macinga. They both have always been my pillars of strength and source of motivation. They raised me in a family rooted in love, peace and respect. My mother got her Matric when she was 39 years old: she never gave up. That pushed me to apply for a Master's degree in Social Work and dream of becoming a PhD holder one day. She studied hard to become a Professional Nurse today, as just my father died a Professional Nurse too. I am proud to be their child and shall forever remain grateful.

ACKNOWLEDGEMENTS

I am grateful to the following important persons in my life:

- My Father, my Redeemer, my Lord, my daily consoler for having provided me with the strength to persevere and persist from the beginning until the end of my study. I felt like giving up at times, but he always whispered “it is possible” to my ears.
- My supervisor, Professor Ngenisiwe Henrietta Ntombela, for guiding me, having faith in me and always encouraging me to persevere, no matter how hard it was.
- My mother, Ms. K.F. Macinga. She has been both my parents for the last 13 years and made sure that all her children did not feel a void for the passing away of our father. She has been my source of strength and I am who I am because of her. I am blessed to have her.
- My other mentor, the late Ms. Twala. I thank her whole-heartedly for having persuaded me to do Social Work in the first place. I badly wanted to apply at other Universities, but she recommended NWU- Mahikeng Campus for fear of being far from home and external influences that could have hampered my progress in life. I wish she was alive to see my progress.
- My twin sister, Miss T Macinga. She has never given up on me. She always motivates me and says she want to call me a Dr one day.
- My fiance, Mr. I.C. Shophi. He has been there throughout. He was a shoulder to cry on during hard times and never stopped encouraging me.

ABSTRACT

The aim of this study was to explore the challenges and coping mechanisms of caregivers of people living with HIV and AIDS. The main objectives were to explore the overall challenges that caregivers of people living with HIV and AIDS face and the coping mechanisms that caregivers utilize in dealing with people living with HIV and AIDS.

This study adopted a qualitative research method, where semi-structured interviews were used to collect data. Twenty caregivers willingly participated in the study. All of them were above eighteen years old. The caregivers were strictly for people living with HIV and AIDS in the following five healthhealthcare facilities: Lifeline Mafikeng, Tsibogang Home-Based Care Centre, Karabo Home-Based Care Centre, Lomanyaneng Home-Based Care Centre and Isibindi Child and Youth Care Centre. All caregivers had worked in their facilities for at least three months to form a part of the study.

Following the interviews with the participants, the following themes emerged: Caregiver's understanding and knowledge of HIV and AIDS, Caregiver's experiences, Caregiver's challenges and Coping Mechanisms. The findings of the study have revealed that caregivers do face challenges when working with people living with HIV and AIDS. The three main findings that were discovered were social, emotional and the researcher discovered a new challenge, which is interaction challenge. These findings add to the theory of the Social Work profession and contribute to further research.

In order for the caregivers to carry out their work effectively and efficiently, the researcher recommends that caregivers should be provided with formal training for caregiving. Caregivers who do not have Matric must be sponsored and supported to attain this qualification, more male volunteers should be recruited as caregivers to promote diversity in gender in the caring facilities. Debriefing sessions for caregivers

should be conducted on a monthly basis so that they can offload the stress and pressure they get from caring for people living with HIV and AIDS.

LIST OF ACRONYMS

AIDS:	Acquired Immune Deficiency Syndrome
ART:	Antiretroviral Therapy
CYCC:	Child and Youth Care Centre
HBCC:	Home- based Care Centre
HIV:	Human Immune Deficiency Virus
NSP:	National Strategic Plan
STIs:	Sexually Transmitted Infections
TB:	Tuberculosis
UNAIDS:	United Nations on AIDS
WHO:	World Health Organization

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CHAPTER 1

1. GENERAL ORIENTATION AND BACKGROUND OF THE STUDY

1.1 Introduction

Caregivers across the globe play an important role in overseeing a diversity of patients while at the same time preparing themselves for unforeseen circumstances such as deterioration in the medical condition of their patients. On top of the high demand for their occupation, caregivers also have to face the greatest challenge of experiencing and witnessing the death of their patients. Tsheboeng (2015:1) states that the medical facilities globally carry a burden of the high demand to care for chronically ill patients such as those affected with Human Immune Deficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). In order to assist the chronically ill, caregivers are employed to help on a long-term basis. This implies that they should always be psychologically, emotionally and physically ready. It is their responsibility to provide a milieu that is healthy, supportive for people living with HIV and AIDS, so that the caregivers know that they are important and their health is of utmost importance.

Sullivan and Miller (2015:7) views a caregiver as an individual who provides physical and psychological care to a person. In relation to this study, they are seen as people working at general healthcare facilities such as Child and Youth Care Centres, Old Age Homes, hospitals and other healthcare facilities. Brannen, Mooney & Statham (2009:119) have demonstrated that caregiving is a demanding and stressful occupation. One of the reasons for such stress emanates from a lack of training, which was stated by Sullivan and Miller (2015: 11) to say that caregivers mostly come into the role of caregiving as a necessity and passion without having previous knowledge of skill. They mostly apply learn-as-you-go approach, which can create a lot of stress for them (Sullivan & Miller, 2015: 11)

Although the study's focus is on caregivers of people living with HIV and AIDS in healthcare facilities, Lundberg, Doan, Dinh, Zach and Le (2015:789) indicate that

caregivers who work at the households face tremendous psychosocial and economic challenges. The stress levels of caregivers of people living with HIV and AIDS has been found to increase (Abasibuong, Bassey, Oquensemi & Udobang, 2011). A study of Lentoor (2017:4) has revealed that caregivers reported to be facing fatigue for caring for HIV infected children, but some felt they have to prioritize the needs of their patients above their own. Furthermore, he discovered that caregivers of HIV infected children struggle with symptoms such as depression, which often leave them feeling emotionally stressed. This stress is due to guilt of having passed on the virus to their children (Lentoor, 2017: 4).

Caregivers face challenges such as isolation, psychosocial distress, social stigma and lack of basic training related to their caregiving (Nkosi, Kipp, Laing & Mill, 2006; Kipp & Nkosi, 2008). Although this study's focus is on those working at caring facilities, the researcher supports this estimation due to the reality that some family and community members who do not have sufficient knowledge about HIV and AIDS tend to subject the people living with the pandemic or their caregivers to discrimination. Such discrimination further marginalises the patients.

United Nations on AIDS ((UNAIDS) (2017)) estimated that 36,9 million persons globally were living with HIV by the end of 2017. Furthermore, this was made by an addition of 35.1 million adults, 18.2 million women who were above the age of 15 and lastly, 1.8 million of children were below 15 years (UNAIDS,2017:18). A United Nations Programme on HIV/AIDS forecast that African Nations which are exceedingly affected by HIV/AIDS would have a 115 million decrease in population due to the pandemic (UNAIDS, 2016:81).

The National Strategic Plan on Human Immune Deficiency Virus, Sexually Transmitted Infections and Tuberculosis (2017-2022: 26) has revealed that the rate of HIV,STI and TB is not reducing enough in South Africa as there are still about 270 000 new HIV infections annually (National Strategic Plan on HIV, STIs and TB, 2017-2022:26). Furthermore, the rate of infections remain high among young women and girls (National Strategic Plan on HIV, STIs and TB, 2017-2022:26).

This study intended to explore the challenges and coping mechanisms of caregivers of people living with HIV and AIDS in healthcare facilities in Mahikeng.

1.2 Problem Statement

The pandemic of HIV and AIDS takes a great toll on caregivers. Persons living with HIV/AIDS are prone to have a sense of giving up on their condition, due to the absence of any sign of improvement in their state. This is supported by Tsheboeng (2015:4) who mentions that some bedridden patients living with the pandemic wish to die instead of being taken to the clinic and hospital for management of their condition. This therefore gives evidence that caregivers instil hope in desperate situations where the patients have individually given up.

The study of MacKenzie (2017:6) has indicated that an increased demands on the health systems and cost related to health care have increased the need for caregivers. These caregivers cover a very wide spectrum of services which include assisting patients with basic activities of daily living, education, functional restoration, palliative care and social support (MacKenzie, 2017:6). Although caregivers cover a useful role in the healthcare systems, their service is inadequate due to the challenges they face.

One of the challenges manifest among terminally ill patients that has been identified by Lundberg et al (2015:789) is depression. This has been found out to be caused by the caregiver's demands to spend their entire day with persons living with HIV and AIDS which increases their dependency. Above all that, people living with HIV and AIDS are often forced to leave their jobs due to the intense need for care. Family caregivers are also prone to leave their own jobs in order to provide support to their ailing family member (Gaudine, Gien, Thuan & Dung, 2009).

The researcher observed that a significant number of healthcare facilities around Mahikeng lack sufficient support from the Government. Furthermore, these caregivers

lack resources as well as the capacity to facilitate the practice and process of caregiving (Uys & Cameroon as cited in Tsheboeng, 2015:4). Some of these resources include transport and even sufficient, sustaining stipends. This is supported by Boon, Ruter, James, Van der Borne, Williams & Reddy; Kang'ethe; Makoe & Jubber; Pallangyo & Mayers (2009 as cited in Bejane (2012:3) who all submit that caregivers work with inadequate resources, including severe financial limitations.

Earlier in 2017, the researcher attended a meeting of Non-Profit Organizations (NPOs) around Mahikeng area at Signal Hill Village. Before the meeting started, the researcher overheard one participant telling the other of how they struggled to get a person living with AIDS to a hospital due to lack of transport. The anecdotal and chance incident proves that although only one challenge was mentioned, there are still a lot more which are unforeseen and often overlooked. It was also learnt that although there are accessible health healthcare facilities within communities, caregivers, commonly known as volunteers, perpetually face challenges when caring for people living with HIV and AIDS.

Mahikeng area has numerous Non-Profit Organizations that focus on different social problems, particularly those in the vulnerable group, but due to HIV and AIDS being an issue that can be found in most NPOs, although not central to their mission and vision, the study focuses solely on the pandemic. The study only focussed on Tsibogang Home-based Care Centre (HBCC), Karabo HBCC, Isibindi Care Centre, Lifeline Mafikeng and Tsibogang HBCC. These healthcare facilities were chosen due to having been operational for more than five years. They also have caregivers of people living with HIV and AIDS, which is central to this study.

It is evident that there is much that needs to be researched about challenges that caregivers face in the different healthcare facilities they work in, as well as the coping mechanisms they apply to deal with their demanding occupation. Although caregivers are doing a good job, they are prone to suffer from emotional, physical, social and psychosocial problems. As far as challenges and coping mechanisms of the caregivers are concerned in this study, the challenges that they face were interrogated

in detail and coping mechanisms of how they deal with the challenges they face were categorised.

1.3 Research Questions

Research questions are the central questions that the study aims to address. The following were the research questions of this study.

- What are the overall challenges that caregivers face in healthcare facilities of people living with HIV and AIDS?
- What are the coping mechanisms that caregivers utilize in healthcare facilities in dealing with people living with HIV and AIDS?

1.4 Research Aims and Objectives

The following were the aim and objectives of the study:

Aim of the Study

- The aim of the study was to explore challenges and coping mechanisms of caregivers of people living with HIV and AIDS in healthcare facilities in Mahikeng.

Objectives of the study

In order to achieve the above mentioned aim, the study addressed the following objectives, set to:

- Explore the overall challenges that caregivers of people living with HIV and AIDS face?
- Identify and interrogate the coping mechanisms that caregivers utilize in dealing with people living with HIV and AIDS?

1.5 Significance of the Study

The study particularly increases the general knowledge that the community of Mahikeng have about what the caregivers face in handling people living with HIV/AIDS and the coping strategies they apply in their daily lives to be effective in their work. Additionally, this study eases the research process for subsequent researchers in understanding the challenges caregivers face particularly in this community, specifically in the development of better alternatives and projects in support of these caregivers.

This study is imperative due to the reality that it is often that the society ignores the needs and challenges that caregivers have, and expect too much from them. They are expected to perform at their level best at all times, forgetting that they are humans themselves. This study raises the awareness and knowledge that caregivers are humans and also face financial, social, physical and emotional problems while giving care to patients.

Since the caregivers are faced with multiple challenges, it is also imperative to learn about the ways they deal with the demands of their strenuous and stressful occupation. As a result, this study further identifies the coping mechanisms that different caregivers in healthcare facilities in Mahikeng apply and could apply in their lives to deal with people living with HIV and AIDS.

This study is relevant to the social work profession due to the reality that HIV and AIDS is a social problem and the profession on its own is concerned with resolving such problems. On the other hand, it is the key responsibility of social workers to ensure optimal social functioning of all people. Experiences and challenges are linked to the social functioning, that is what centrally makes this study related to this profession.

This study facilitates gaining a holistic understanding of the concept of caregiving. It interrogates and explains the concept, and it is anticipated that such explication could change the perceptions of some people in the society.

1.6 Scope and Demarcation of the Study

The study aimed to explore the challenges and coping mechanisms of caregivers of people living with HIV and AIDS in healthcare facilities in Mahikeng. The research was undertaken using a qualitative research approach which is concerned with gathering a few sample of participants. This study used twenty participants, where four were interviewed per facility. This number is a minimum that the researcher looked into. Data Saturation would have only occurred during data collection when the participants' information did not seem to add any value to the content. The issue of saturation was only introduced so as to avoid having a large number of participants who did not add any perspective to the study. However, all interviews added value.

In a qualitative study, the emphasis is on the depth as well as the quality of the information gathered from the interviewees and not on the breadth and scope (Creswell, 2014: 32). This allowed the researcher to have sufficient time to explore profoundly the caregiver's experiences and their coping mechanisms.

1.7 Limitations and Delimitations of the study

Limitations of a study are weaknesses that are out of the control of the researcher, whereas delimitations are factors that limit the scope and define the boundaries of the study (Simon, 2011: 2).

1.7.1 Limitations

The limitations of the study were as follows:

- Some people living with HIV/AIDS might require undivided attention from the caregiver. However, during the time of interviews, the researcher never got disturbed.
- Some caregivers might be unwilling to be interviewed. This may be due to the caregiver holding a misconception that the researcher means to expose people living with HIV/AIDS and disclose their profiles. Fortunately, the researcher never came across such.
- Since the researcher only interviewed twenty participants, results could not be generalized.

1.7.2 Delimitations

- First restriction of the study is that not every caregiver living in Mahikeng participated in the study. This was guided by the research method, being qualitative, which focused on having a few, only twenty participants, in order to interrogate deeply into the caregivers' experiences and identify the knowledge the community might not be aware of.
- The study only focused on caregivers working at different healthcare facilities in Mahikeng region.
- The researcher did not interview caregivers from all healthcare facilities in Mahikeng, but only focused on those that were selected for the study.

1.8 Definition of Concepts

1.8.1 Caregivers

A caregiver is an individual who habitually assists others who are limited by chronic disorders (National Centre on Elder Abuse, 2010). For the purpose of this study, the term caregivers refers to people working at general healthcare facilities such as Child and Youth Care Centers (CYCC), Old Age Homes, Hospitals, Disability Centers and other facilities specifically established for providing general care to people living with

HIV and AIDS. The caregivers are either formal or informal caregivers, that is community caregivers who may not possess any qualification of caregiving, health or social work caregivers, as long as they meet the inclusion criteria of the study.

1.8.2 HIV

HIV is an abbreviation of Human Immunodeficiency Virus (Van Dyk, 2010:237). It is a virus that enters a human body through ways such as intercourse with an infected person or alternatively using needles and syringes previously used by infected persons in open wounds. If left untreated, the virus develops into the syndrome called AIDS.

1.8.3 AIDS

AIDS refers to Acquired Immune Deficiency Syndrome. This implies that the syndrome is acquired and not inherited. What causes AIDS is an invasion of HI-Virus in the body, causing it to be weak to the extent of being unable to protect itself from various infections and pathogens (Van Dyk, 2010: 237).

1.8.4 Healthcare facilities

For the purpose of this study, “healthcare facilities” is a collective word for all the facilities established for the general care of people. These include Child and Youth Care Centres, Old Age Homes, Disability Centres, Clinics, Hospitals, Disability Centres and others.

1.9 Preliminary Literature Review and Theoretical Framework

1.9.1 Preliminary Literature Review

The preliminary literature review of this study encompassed aspects such as a general understanding of caregiving, what HIV and AIDS are and how one gets infected, the

overall challenges of caregivers of people living with HIV and AIDS and the general understanding of coping and coping mechanisms and ultimately the National Strategic Plan as the policy pertinent to the scourge of HIV and AIDS in South Africa. The theoretical framework of the study examines the Transactional Model of Stress and Coping and the Attachment Theory.

- Caregiving

Across different nations, caregivers are described differently. A caregiver is an individual who habitually assists others who are limited by chronic disorders (National Centre on Elder Abuse, 2010). For the purpose of this study, the term caregivers refers to people working at general healthcare facilities such as Child and Youth Care Centres (CYCC), Old Age Homes, Hospitals, Disability Centers and the other facilities designated for providing general care to people living with HIV and AIDS. There are two types of caregivers known as formal and informal caregivers. Formal caregivers are those that have undergone formal training and obtained a qualification as caregivers such as Social workers and Psychologists. On the other hand, informal caregivers do not necessarily have training, but are passionate about giving care to people. Informal caregivers are commonly known as volunteers.

- HIV and AIDS

HIV is an abbreviation Human Immunodeficiency Virus and is known for attacking the body's immune system (Van Dyk, 2010:237). The body's immune system protects the body from different viruses and bacteria, but does not have a specific way of protecting it against the virus. One way of contracting the virus is by engaging sexually with an individual who is infected with the virus without using protection. Antiretroviral Therapy (ART) is known not to cure the disease, but stops the virus from replicating itself in the body's immune system. When left unattended and untreated, the HIV develops into AIDS (Acquired Immune Deficiency Syndrome) which is known as the late stage of HIV (Van Dyk, 2010:237).

- Challenges experienced by caregivers

Caregiving affects caregivers mentally, physically and spiritually (Kang'ethe, 2010). They experience burnout which has a tendency of manifesting in ways such as insomnia and loss of confidence (Kang'ethe, 2010). The lack of transport of some caregivers to take people living with HIV and AIDS to healthcare facilities might be the core reason of this burnout. The challenges caregivers face are such that some people living with HIV and AIDS ask them for food, when they are hungry themselves. Kang'ethe (2010) further identifies that informal caregivers commonly known as volunteers do not receive psychosocial support to help them cope with the challenges they face and the coping mechanisms they employ (Akintola, 2010).

Caregivers experience anger, frustration, hopelessness and disillusionment in the work area. Having to deal with all the challenges lowers the performance of the caregiver, due to being subjected to emotional, physical, financial and social distress (MacKenzie, 2017:10). The persons living with HIV/AIDS pose behavioural, emotional and psychosocial difficulties. As a result, the level of care demanded from them increases. There is a lack of support and training services available for caregivers to deal with traumatized persons with HIV in the welfare system and it becomes difficult for caregivers to care for these patients and to provide accurate knowledge (McKenzie, 2017:10).

- Coping

Mabusela (2010:16) identifies coping as a construct that describes the manner in which people control their own emotions and behaviours when faced with a psychological stress. In the context of this study, coping mechanisms are strategies, ways, techniques or manners employed by caregivers to deal with the pressure and the burden they carry due to dealing with the demanding occupation of caring for people living with HIV and AIDS.

One professional and effective way that caregivers could be assisted to cope with the challenges they face when dealing with people living with HIV and AIDS is trauma debriefing sessions. This inhibits them from getting Posttraumatic Stress Disorder (PTSD). On this platform, caregivers are given an opportunity to state, express and describe their fears to either a social worker, psychologist or a trained counsellor who offers effective and relevant intervention.

It is imperative to conduct research on coping as overlooking the need for caregivers to know how to cope and relieve themselves from the stress they face when dealing with people living with HIV and AIDS might lead to becoming incompetent and impatient. Unattended stress leads to PTSD. As a result, caregivers ought to cope with the demands of their occupation so that their work is effective. Caregivers are faced with debilitating experiences such as fear of contagion and failure to contain themselves, surviving the onslaught of the pandemic becomes a difficult task (Van Dyk a cited in Tsheboeng, 2015: 37).

- National Strategic Plan

The National Strategic Plan (NSP) on HIV, Sexually Transmitted Infections (STIs) and Tuberculosis (2017-2022, XIII) is the strategic guide for National response to HIV, STIs and TB for a period of five years. The intention of the plan is to address drivers of the diseases and come up with its achievements of the previous periods. The interventions achieved earlier are evaluated as well as the service delivery. Furthermore, the interventions with potential are implemented (NSP on HIV, TB and STIs, 2017-2022: XIII). The NSP has a mission of making South Africa free from the burden of HIV, TB and STI and a vision of keeping it on track to eliminate these diseases by the year 2030 (NSP on HIV, TB and STIs, 2017: xiv).

One of the past successes of this policy is to have initiated approximately 1,4 million people on Anti-Retroviral Therapy (ARV) since the programme began in December 2003. Ever since its establishment, about 10 million of people voluntarily test for HIV and about 3,7 million people are on antiretroviral treatment (ART) (NSP, 2017-2022:

4). Furthermore, the Higher education and Training HIV/AIDS Programme (HEAIDS) drove HIV testing for students and the TB treatment success rate rose to 83% in 2016 (NSP, 2017-2022: 4).

Given the successes of the NDP in the past, it is evident that South Africa and particularly and contextually Mahikeng continues to benefit from the implementation of the NSP. People living with TB, STI have an access to ARVs and more and more people have an interest in knowing their statuses.

1.9.2 Theoretical Framework

The following include a model that aims to help caregivers cope with the challenges they face when dealing with difficult situations in the workplaces and in the context of this study, when dealing with people living with HIV and AIDS. These theories are relevant in the study. The transactional model of stress and coping provides a manner in which caregivers can cope with the daily stress they may face when dealing with people living with HIV and AIDS. On the other hand, the attachment theory indicates how the bond created between caregivers and their patients gets affected when circumstances such as death emerge. Finally, a strategy that is aimed at addressing the high rate of the HIV and AIDS in South Africa is discussed.

- **Transactional Model of Stress and Coping**

The Transactional Model of Stress and Coping constitutes the theoretical framework of this study. In developing this model, Lazarus and Folkman (1984) stresses that the best manner to understand the relationship between the caregiver and the care-receiver is by regarding and treating it as a transaction. That is a milieu of give and take, where an equilibrium should be reached when the caregiving process comes to termination. The model additionally advises caregivers to use the most appropriate coping strategies whenever they need to deal with a particular situation.

- Attachment Theory

This attachment theory is relevant to caregivers who, in many instances, grieve in anticipation for the fatally ill patients before and after death. In many cases, caregivers develop a very strong and secure bond with people living with HIV and AIDS and find it very hard to move on and cope after the death of those in their care (Tsheboeng, 2015: 40). Amongst the other three attachment styles, secure attachment is one of them, which in many cases applies to the type of bond or relationship that exists between caregivers and people in living with HIV and AIDS in the context of this study. This theory is thoroughly explained in Chapter 2 as well as the other attachment patterns.

1.10 Research Methodology

Research methodology constitutes steps and procedures for the research including detailed approaches of collecting data, analysing and interpreting it (Creswell, 2014:3). The research methodology of this study explores the challenges and coping mechanisms that caregivers apply.

1.10.1 Research approach

The approach used in this study is qualitative. Cooper and White (2012:7) define qualitative study approach as an approach that is concerned with understanding or description of a phenomena or event. This study meant that qualitative researchers study things in their natural setting, which in the context of this study is their workplace, trying to make sense of the phenomena in terms of their perceptions (Creswell, 2014). Therefore, for the purpose of this study, caregivers of people living with HIV and AIDS were studied in their working environment.

1.10.2 Research design

Research design is seen as a glue that holds the elements in a research project together, in short it is a plan of the proposed research work (Alchta,2016:68). This study used a phenomenology research design which attempts to comprehend people's perceptions, perspectives and understanding of a particular phenomenon (Pathak, 2017: 3960). Practically, during the interview, the participants were asked to state and express what it means to them to face the challenges and coping mechanisms in the healthcare facilities they work at, specifically relating to people living with HIV and AIDS.

Due to subjectivity, the researcher avoided it by using bracketing. During the period when the researcher went to the facilities to propose for the interviews, she left the places knowing which potential caregivers were going to be interviewed. During the introductory stage, the interviewees were asked about their expectations from the interviewer prior to the interview.

Interviews were conducted at the healthcare facilities in the anticipation that it was easier for caregivers to remember the challenges they face when they are in the environment where everything transpires. Ethical considerations were taken to ensure privacy and confidentiality. In a home environment where the caregivers live, the interview process was prone to be interrupted time and again and the issue of privacy and confidentiality threatened. At the workplace the manager of the centre was aware of the purpose of the interview and offered a room where there was no interruption.

1.10.3 Population target

According to the researcher, the population target of the study is the people that the study focuses on. Four participants were interviewed from each healthcare facilities to add up to twenty participants. For the purpose of this study, the inclusion criteria were caregivers of people living with HIV and AIDS from Tsibogang Home-based Care Centre (HBCC), Karabo HBCC, Isibindi Care Centre, Lifeline Mafikeng and

Lomanyaneng HBCC healthcare facilities around Mahikeng, who had more than three months of service at these healthcare facilities, who were above the age of 18 years and from any racial affiliation or ethnicity and of any gender.

The interview was semi-structured which allowed the researcher an opportunity to probe wherever there was a misunderstanding, which also made it easier for objectives of the study to be met. Although the study assumed a semi-structured interviewing, the communication and level of interaction between the interviewer and interviewee were different due to the different answers obtained from the interviews that created a dialogue and follow-up questions.

1.10.4 Sampling

Sampling is a process of extracting a sample from a population (Alvi,2016: 11). The study focused on twenty participants, where each set of four were sampled from Tsibogang Home-based care (HBC), Karabo HBC, Boikagong Child and Youth Care Centre, Lifeline and Feel at Home Disability Centre. An overall of twenty participants was used in the study and data saturation never took place because the participants provided information which added new and individual dimensions.

The sampling method used by this study is stratified purposive sampling. Alvi (2016: 20) sees this sampling technique as identifying participants according to preselected conditions pertinent to a particular research question. De Vos et al (2011: 392) maintains that this type of sampling method is based on the judgment of the researcher that the participants contain the most representative characteristics of population for the study. In simple terms, this sampling identified caregivers specifically of people living with HIV and AIDS. They care for people living with HIV and AIDS most of their time, get subjected to first-hand experience of how it feels like and get to apply their various coping mechanisms to deal with their care-receivers, that is all central to this study.

1.10.5 Process of Sample Recruitment

- The researcher approached the Department of Social Development, which makes the umbrella Department where all the healthcare facilities are registered under.
- After getting approval from the DSD, the researcher made copies of the letter and approached five identified healthcare facilities. The copies were given to the gatekeepers who served as a mediator between the researcher and the participants. The following was explained during the visit:
 - Purpose of the visit and study
 - Benefits of the study to the centre
 - The role of the independent person
 - Number of interviewees and the rationale
 - Estimated time for each interview
 - Refreshments/ token of appreciation

In order to ensure privacy and confidentiality, the researcher asked the manager to hold a meeting in a private office which has a lockable door, so that there was no disturbance. The researcher then made the Manager aware that the independent person of the study was the Social Worker responsible for providing trauma counselling to the participants.

The Social Worker was the researcher's colleague enrolled in the study for the purpose of providing trauma counselling. Lastly, the professional also built rapport with the participants in explaining the informed consent.

- Following the discussion when the manager agreed, the following transpired:
 - The researcher provided them with airtime to call all the four potential participants and tell them about the study.
 - The researcher then made arrangements to meet with the independent person and gave the independent informed consent.
 - The researcher gave the independent person a concise explanation of the study and clarified the informed consent to the caregivers.

- After that meeting caregivers were given 24 hours to decide on participation.
- After the caregivers's response, the independent person and the caregiver met to sign the informed consent..

After the caregivers signed the informed consent, the interview started.

1.10.6 Data collection

Data collection of the study was done through the unstructured or semi- structured interviews (Creswell, 2014:189). For the purpose of this study, a face-to-face semi-structured method of interviewing was used. This allowed the researcher to use predetermined set of questions (Maree, 2007: 87). The following techniques were used by the researcher to make the interview process effective:

- The first important technique that the reseacher applied to physically tune in to participants is the SOLER technique.
 - S- the researcher faced the caregiver squarely in order for them to feel attended to and for them to feel that they are actively listened to.
 - O- the researcher adopted an Open posture to show enthusiasm in what was transpiring.
 - L- in other interviews, the researcher Leaned towards the caregivers to make them feel listened to.
 - E- a good Eye-contact is what the researcher maintained throughout the interview process. This was also a good sign to show the caregivers that the interviewer has an interest in what was said.
 - R- lastly, the researcher was Relatively relaxed when applying this technique and it was definitely effective.
- The researcher applied active listening. Although the researcher took notes while the participants were answering questions, the researcher maintained eye-contact for them for feel tuned into.

- There was a use of prompts. In order to encourage the participants to be responsive, the researcher used both verbal and non-verbal prompts. Some of the verbal prompts that the researcher used is intentional responses such as, “okay” and I see” and one of the the nonverbal prompts that were using is nodding her head.
- Probing was mostly used. During the interview proces when the researcher did not understand the meaning the participant intended, she used different forms of probing such as questions to follow up on what the participat said, direct requests so that the caregiver clarified what they were saying further.

The questions were developed with reference to the literature that the researcher reviewed and based them on a phenomenological research design. In a phenomenological study, the researcher also referred back to the research questions of the study to guide her to develop questions relevant to the objectives of the study. In order to ensure relevance of the questions, the researcher asked an expert in the field of this study to look at the questions and deliberate on them. The researcher also developed the interview schedule and submitted it to one participant who reviewed the questions to ensure they were comprehensible.

Throghout the course of this study, the researcher prevented bias in the following ways:

- The researcher kept all detailed records. During the interviews, the researcher took all the notes of the participants’ responses and electronically recorded the session.
- All data was incorporated in the report. This is the other way that the researcher prevented bias.
- The researcher also guarded against confirmation bias. The researcher did so by avoiding to interpret data in a way that satisfied their expectation.

- During the interviewing process, the researcher collected all the data and evaluated it equally, because the data that is considered meaningful would otherwise skew the interpretation and conclusion.

The interviews were conducted in a private and confidential space at the centres, where there was no disturbance from anybody. The sample of the data collection tool that the researcher used is attached under Annexures.

1.10.7 Data analysis

Data analysis is a process where there is classification and interpretation of linguistic (or vocal) material to make statement about implicit and explicit dimensions and structures of meaning-making in the material and what is present (Flick,2013:6). The process of data analysis in this study was adopted from the work of Anderson (2007), Kelly(2006a), TerreBlance, Durrheim & Kelly (2006) and Kelly (2006b) as cited in Du Preez(2010:44). The analysis steps were applied as follows:

Step 1: Familiarization and Immersion

This is the first step of the data analysis process. In this step, the researcher read and re-read the textual data that was gathered during data collection in order to get an overall meaning of the texts. The researcher developed a precise understanding of the metaphors and language used by the interviewees.

Step 2: Thematising

In this stage of data analysis, the researcher explored the commonalities that underlie textual data. This was meticulous process of going through the data and while doing so the researcher highlighted and unpacked the different themes that emerged.

Step 3: Coding

In a qualitative approach, this process helps to organize raw data into categories. Furthermore, it ensures that data collected does not deviate from the original content, but allows categories to be generated and the researcher to have a sense and meaning from the data.

Since the researcher was familiar with the textual data, the researcher looked for themes in the data and noted them. Different themes were highlighted in different colours and similar ideas coded in the same colour. The researcher also listened to the audiotapes of the interviews, made transcripts out of those audiotapes, typed all interviews in Setswana and translated them to English.

Following the process of identifying themes and coding, the researcher only focused on coded data and identified themes. The researcher read through the colour coded information to check completeness of the information. The researcher continued to organize the information into useful segments by grouping common factors together, identifying and recreating new themes from the ones already developed.

Step 4: Elaboration

In this phase, the researcher explored the identified themes more closely in order to understand and capture the precise meaning. The themes that were finally selected were elucidated and scrutinized to answer the research questions of the study..

Step 5: Interpretation and checking

This made the final step of data analysis process. The researcher reported on the phenomenon that was explored. This was done in presenting themes and any derived sub-themes from the main ones.

1.11 Ethical Considerations

Ethics are the main moralities which research should take into consideration in undertaking a study. They guide the researchers in order to guard against using inappropriate or harmful words with the clients, mistreating them and avoiding cases where the privacy of the clients is not respected.

1.11.1 Informed Consent

Obtaining informed consent implies that all possible information on the goal of the investigations, the expected duration of the participants' involvement, the procedures followed during the investigation, the possible advantages and disadvantages and dangers to which participants were exposed as well as credibility of the study was rendered to potential subjects or their legal representatives (Royse, Williams, Tutty & Grinnell in De Vos et al., 2011: 117).

This study made a use of written informed consent. This form entailed all the details of the participant and the main purpose of this study.

Following the acceptance of the manager for the researcher to conduct the study at their care facility and after the caregivers' approval, the researcher and the independent person met so that the researcher explained the informed consent document. Ultimately, the independent person met with the caregivers on the day of the interview to explain the informed consent document to them.

1.11.2 Voluntary Participation

This ethical consideration requires that the participants, being the caregivers of people living with HIV and AIDS, take part in the study without any harassment and not coerced (Klenke, 2016:51). Hence the researcher developed a written informed consent which verified that the participants answered all the questions in a satisfactory

manner. The independent person ensured this by kindly asking them to sign the consent form as a way of agreeing to take part in the interview.

1.11.3 Avoidance of Harm

This is the basic ethical rule of research (Babbie, 2007 in De Vos et al., 2011: 114). The study may harm the participants whilst in the process of gathering information such as interviews (De Vos, Strydom, Fouche & Delport, 2011:114). Participants can be harmed in both emotional and physical ways by the researcher (De Vos et al., 2011: 114). An emotional manner may be teasing the interviewee about one or some of their weaknesses learnt during the interview and a physical manner may be pulling the interviewee by hand in order to pay attention to the researcher.

The interviews were conducted with no intention of harming the participants. Since the caregivers are also humans, this makes them prone to anguish. This study ensured professional communication during interviews and undivided attention. The researcher ensured this by not using any vulgar language and not dwelling much on sensitive topics to the participant. The above-mentioned examples and any other of emotional and physical harm were avoided at all phases of the interview.

Furthermore, in order to avoid causing harm and disclosing information, the researcher stored all the data in a safe locked cabinet.

1.11.4 Confidentiality

Confidentiality is simply not disclosing private information of the participant to anybody, unless if the information is harmful to the researcher and the people they interact with on a daily basis (Klenke, 2016:51).

This study adhered to the terms of this principle. The researcher assured confidentiality from the onset and so that building of rapport would be an easy process

for both the researcher and the caregiver. The following are the processes in which the researcher ensured confidentiality:

- The researcher never talks about what transpired during the interview with the caregivers themselves in public places.
- The researcher has never talked to the participants on the phone.
- Following the interviews, the researcher stored clients' data in a lockable cabinet where access is restricted to the researcher only.
- All the data that is stored on the computer are password protected, and can only be accessed by the researcher and will be kept for a period of five years.

1.11.5 Privacy

This principle was respected optimally in the following manners:

- The researcher collected data anonymously; the researcher did this by collecting data in a way that is no way connected to the information that identifies the participants. For instance, their identity numbers, addresses and cellphone numbers were never asked.
- Interviews were held in offices and rooms organized where there was nobody but the researcher and the participant only.

1.11.6 Anonymity

This ethical principle was respected optimally. It was protected by using pseudonyms by calling participants, "Participant 1, Participant 2...Participant 20." This also helped to differentiate participants.

1.11.7 Respect

Respect as an ethical principle is like a standing order that researchers throughout the research process should comply with. The researcher respected this principle throughout. In cases where participants were not willing to take part in the study, the researcher accepted and respected their decisions.

1.12 Chapter division

The chapters in the dissertation are presented as follows:

Chapter 1: General Orientation and Background of the study

Chapter 2: Literature Review and Theoretical Framework

Chapter 3: Research Methodology

Chapter 4: Data Presentation, Analysis and Interpretation.

Chapter 5: Research Findings, Conclusion and Recommendations.

1.13 Conclusion

This chapter introduced the study, problem statement, research questions, aims and objectives, significance of the study, scope and demarcation, limitations and delimitations, definition of concepts, preliminary literature review and theoretical framework, research methodology, ethical considerations and chapter division. The subsequent chapter provides an overview of the literature review and theoretical framework pertinent to this study.

CHAPTER 2

2. LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1 Introduction

With the increasing number of people contracting HIV and AIDS across different nations, caregivers are subjected to increased pressure. Caregiving is a stressful job, which explains why the overall estimation of caregivers across the globe can never be sufficient to cover all people living with HIV and AIDS. The social, economic, psychosocial, financial and other challenges that caregivers face when caring for people living with HIV and AIDS is a pure indication that there is an insufficient number of caregivers, as well as a large number of people living with HIV and AIDS making it a challenge for caregivers to provide care thoroughly and successfully.

Most health healthcare facilities in South Africa cannot cope with the increasing number of HIV and AIDS patients, and as a result, patients are discharged earlier from health healthcare facilities. This implies that the caregiving process becomes the responsibility of the Home-based Care Centers (Leake as cited in Tsheboeng, 2015: 30). As deteriorating as the matter of challenges that caregivers face is, some hospitals in South Africa have decreased the length of days of admission of HIV and AIDS patients from 14 to 3,5 days, which is quite disturbing (Tsheboeng, 2015: 30). With this decrease, patients are referred to Home-based Care Centers, where there are no professional caregivers employed, but only volunteers who merely depend on their intrinsic knowledge and judgment to give care to people living with HIV and AIDS.

This chapter focuses on literature review relating to caregiving as a whole, general information about HIV and AIDS, caregiving, coping, strategies and policies on the HIV and AIDS pandemic. It also examines the theoretical framework pertaining to the concept of caregiving and the HIV/AIDS pandemic.

2.2 Literature Review

The following provides an overview of caregiving, its different forms and the roles of caregivers, what HIV and AIDS pandemic is, various ways of contracting it, the treatment of the pandemic, overall challenges that caregivers face, what coping and the various coping mechanisms that caregivers could apply in dealing or rather working with people living with HIV and AIDS and ultimately the policy on HIV and AIDS in South Africa.

2.2.1 Overview of Caregiving

The following section defines a caregiver, the common types of caregivers and ultimately the roles of caregivers in South Africa.

2.2.1.1 What is a caregiver?

Caregiving around various spheres of life is described differently. The term “caregiver” is generally understood as an individual who gives care and support to another who is vulnerable and therefore not stable enough to take care of themselves. Tsheboeng (2015: 7) defines caregivers as people responsible for taking care of sick patients either in their place of abode or in caring facilities such as clinics. Caregiving therefore refers to the relationship between the caregiver who provides care to the client or patient, and patients to whom care is provided (Tsheboeng, 2015:7).

In this study, the term “caregiver” refers to an individual working at a general care facility such as Child and Youth Care Centre who are responsible for providing care to people living with HIV and AIDS. Across diverse nations, different names such as health workers, home- based caregivers, volunteers, carers, and community workers are used in this particular research. Although caregiving may be defined differently across different nations, or by different people and researchers it has two types.

2.2.1.2 Two kinds of caregivers

The following are two types of caregivers:

- Formal caregiving

This is the form of caregiving where the persons providing care are paid for services rendered (Jacobs, Van Tilburg, Groenewegen, Broese & Van Groenou ,2015: 120). These may include social workers, nursing staff, medical professionals and trained individuals working as caregivers.

- Informal caregiving

This is the form of caregiving where volunteers either do not get a constant stipend for volunteering or do not get paid at all (Jacobs et al, 2015:120). Informal caregivers do not hold any qualification about caregiving and some do not even have a Matric certificate. They give care to people living with HIV and AIDS for reasons which may include personal reasons such as having a family member living with either HIV or AIDS and having the willingness to help people whose health are at risk if not monitored.

2.2.1.3 The role of caregivers

Caregivers are privileged in experiencing the reality of HIV and AIDS pandemic due to working closely with people living with it. Amongst the many others, they strive to ensure that people infected with the pandemic as well as those affected by it are able to live a hopeful life. They face the reality of living with the pandemic from the time of diagnosis up until death by providing them with emotional, physical support and psychosocial support (France & Sardiwalla as cited by Mabusela, 201:25).

- Physical Care

Caregivers provide physical care to patients living with HIV and AIDS. This includes bathing, physical care, positioning and mobility, wound cleaning, skin care, oral hygiene, adequate ventilation and support for adequate nutrition (Mabusela, 2010:25).

- Palliative Care

Due to having experience in working with people living with HIV and AIDS and having knowledge on the difficulties that comes with the pandemic, caregivers are concerned with the holistic wellbeing of patients. Apart from the other important roles that the caregivers play, they provide palliative care to patients living with HIV and AIDS. In his study, Mabusela (2010:26) mentioned that this involves an arrangement of active and compassionate enduring therapies which serve the purpose of comforting both the people living with HIV as well as their families.

- Educational Role

Since caregiving is a broad occupation, Mabusela (2010:66) states that apart from the role of providing care and treatment to patients living with HIV and AIDS, they fulfil the role of implementing preventative services and education to those already living with the virus. These include campaigns, peer education, health promotion, as well as referring the clients to relevant service providers and in extreme cases moving the patients to hospitals (Mabusela, 2010: 66).

Due to the development of more enthusiasm in working with patients of HIV and AIDS, other caregivers perform counseling and offer health promotion through sex education. Campaigns through media such as radio provide caregivers time to attend forum meetings and also organize sporting activities for the youth enrolled in school and those who are not (Mabusela, 2010:67).

- Support Groups

Amongst the other roles, caregivers also form support groups, in the context of this study aimed at bringing together people living with HIV and AIDS. This creates a platform for sharing their experiences, feelings and thoughts, as well as communicating the impact that HIV and AIDS in their lives. These groups are voluntary and beneficial in helping people living with HIV and AIDS learn and acknowledge that there are many people out there who can relate to what they are going through being infected or affected by the pandemic.

2.2.2 HIV and AIDS

The following is general information ranging from what the HIV and AIDS pandemic is, how one contracts them and the treatment given to people living with the ailments.

2.2.2.1 What is HIV and AIDS?

Human Immunodeficiency Virus attacks the body's immune system. This is the very same that protects the body from infections and diseases, but does not have an exact way of protecting the body from the virus. Without treatment, most people who are infected become less able to fight off the germs that they are exposed to in their daily lives (Mitbawkar, 2010: 6). Many of the germs that people living with HIV have do not make a healthy person sick, but are prone to cause life- threatening infections and cancers in the immune system of an individual who has been weakened by the virus. The ART (Antiretroviral Therapy) also elongates the lives of people living with the disease (Mitbawkar, 2010: 6).

When left untreated or unattended, the HIV leads to AIDS (Acquired Immune Deficiency Syndrome). It is commonly known as the late stage of HIV. In this late stage, the CD4 cell count, which is a way of measuring the strength of the immune system, is below 200, where the normal counts 500 or even higher. Moreover, an

individual starts developing opportunistic diseases such as TB and Pneumonia due to the weak body (Mitbawkar, 2010: 6).

2.2.2.2 Who is at risk of contracting the disease?

Every living human being stands 100% chance of contracting the HI Virus provided they do not protect themselves and apply precautionary measures:

- Engaging sexually without using protection with a person living with the HI Virus. This includes vaginal, anal, as well as oral sexual engagement without protection.
- Using needles, syringes or other equipment to inject drugs, steroids or even medicine/ vitamins that have been used by a person living with HIV and AIDS.
- Babies could potentially get infected during their mother's pregnancy, delivery or after birth in immediate postpartum period. They can also become infected during breastfeeding.
- Health care and maintenance workers who may be exposed to blood and/or body fluids at work sometimes get infected through on-the-job exposures like needle-stick injuries (Mitbawkar, 2010: 7).

2.2.2.3 Treatment for HIV and AIDS

ART is a common acronym of the term Antiretroviral Therapy that is the treatment for both HIV and AIDS. It works by stopping the HI virus from replicating itself. Other terms for the treatment of HIV are HAART, referred to as Highly Active Antiretroviral Therapy and CART, which is Combination Antiretroviral Therapy. By stopping the replication of HIV, ART keeps the immune system from being damaged and allows it to be stronger to fight the virus and to recover (Gallant, 2016: 37).

ART has changed the outlook for people living with HIV. There are no time limits to the benefits of ART once an individual living with HIV starts taking it. Consistency in

taking the medication leads to the virus being controlled and opportunistic diseases prevented or given lower chances of entering the body of an individual living with HIV (Gallant, 2016: 37).

A study of Baggaley, Doherty, Ball, Ford and Hirnschall (2015:159) has revealed that globally there is an access of antiretroviral drugs largely on the life-saving benefits of treatment. There has been an increased use of antiretroviral treatment to prevent Human ImmuneDeficiency Virus and this was following a clear indication of reduced HIV transmission and acquisition when the treatment was given immediately to HIV-infected individuals in serodiscordant relationships or when taken by HIV-uninfected individuals as pre-exposure prophylaxis (PrEP) (Baggaley et al:2015: 159).

Furthermore,the abovementioned antiretroviral prevention interventions such as prevention-of-mother-to-child (PMTCT) and post-exposure prophylaxis (PEP) to prevent HIV infection following occupational or nonuccupationalexposure (Baggaley et al,2015:159).

- Treatment of HIV and AIDS in Africa

According to Statistics SA (2012:12), in the year 2012, there were 68% of people living with HIV and AIDS in Sub-Saharan Africa who had access to ART and about 10 countries within African had access to this treatment (WHO, 2010:13). Although a lot of Sub-Saharan countries have the privilege of access to ART, there are disparities in their receipt, just as studies have shown that in Botswana, about 98% of people living with HIV/ AIDS have access to ART and only 38% of the people from Democratic Republic of Congo (UNAIDS, 2013:16). The World Health Organization has introduced new entitlement conditions that people would get access to ART automatically when their CD 4 count is 500. In the case of children under the age of 15 years, it is automatic for them to receive ART immediately after diagnosis, irrespective of their CD 4 count (Tsheboeng, 2015:21).

According to Global AIDS Response Progress Report (2018:5) Zimbabwe had an estimation of 1,3 million people living with HIV in 2017. Furthermore, in 2017, about 84% of adults were receiving Antiretroviral treatment, when 89% were children. The report also revealed that 86,8% of adults and children were known to be on treatment 12 months after initiating of ART (Global AIDS Response Progress Report, 2018:7).

Despite a dramatic increase in the provision of anti-retroviral therapy in sub-Saharan Africa, there are disparities between regions as well as between individual countries. For example, ART coverage in Botswana is over 95%, but only 38% in the Democratic Republic of Congo (UNAIDS as cited by Tsheboeng,2015:21). Out the 21.2 million people living with HIV/ AIDS on the entire African continent (the vast majority in sub-Saharan Africa), only 7.6 million were reached by anti-retroviral treatment in 2012. (UNAIDS as cited by Tsheboeng,2015:21).

- Treatment of HIV and AIDS in South Africa

According to Marteens and Goemaere (2014:13), there are over two million South Africans who have been initiated in ART. As compared to other countries, the ART programme in South Africa is higher universally in terms of uptake. It has been estimated that its effectiveness is at 81%. It is significant to discuss the adherence of patients to ART, as well as their willingness to start the treatment when they have been diagnosed and not started. Patients should be told about the reality of what would happen if one fails to take the treatment accordingly and the benefits of taking the treatment (National ART Guidelines of the Department of Health, 2013:25 as cited in Tsheboeng, 2015:24).

South Africa has a range of health facilities which have solely been established to provide ARVs to HIV and AIDS patients and monitor their progress and adherence. There have been projects funded by various Departments and organizations which assisted a lot of people living with HIV and AIDS in clinics all across the nation and

the advantage is the feasibility and accessibility of these services (Rebe & McInlyne as cited by Tsheboeng, 2015:24).

- Treatment of HIV and AIDS in North West

The Department of Health (2013:1) made an estimation that in the years 2009 and 2010, about 88 288 people had already started ART treatment, whereas in 2011 it was 132 967 people in the North West region. An estimation of 323 488 in the year 2012 and 2013 were estimated as the targets. Furthermore, it is indicated that in 2007, about R547,3 million was spent by the North West Province for the treatment of HIV and AIDS and there was an increase in the budget of the treatment by 30% in 2008 and 2009. By 2010, the amount went up to 24% which ended up at R881,8 million (Department of Health as cited in Tsheboeng, 2015:25).

- Treatment of HIV and AIDS in Mafikeng

According to an unpublished report of the Ngaka Modiri Molema District Health, there are about 143 250 people who were initiated on the ART treatment since January 2015 until the end of August in Mafikeng (District Health Information System (DHIS) as cited in Tsheboeng, 2015: 25). The following was revealed by the report:

- A total of 1 980 adults initiated ART from January to August.
- A total of 138 021 adults continued ART by the end of August.
- About 76 children under the age of 15 years started on ART treatment.
- A total of 5 229 children under the age of 15 years persisted in ART treatment.
- A grand total of 2 056 patients started ART.
- Ultimately, 143 250 people persisted in ART (DHIS, 2015 as cited in Tsheboeng, 2015: 26).

2.2.3 Challenges of caregivers

In the different working settings and facilities, caregivers face different challenges which may otherwise threaten their ability to cope and give appropriate care to people living with HIV and AIDS. Some caregivers employ coping techniques to deal with these challenges and some do deal with these challenges but some do not at all. The following are some of the challenges which may be experienced by caregivers.

- Social challenges

Some challenges of caring for people living with HIV and AIDS have been identified as high levels of stress, anxiety and these can be draining physically, psychologically and emotionally, as well as socially (Homan, Searle, Esu-Williams, Aguirre, Mafata, Meidany as cited by Njau, Kariuku & Wambu, 2015:72). Caregivers are faced with physical and psychological deterioration, and have a fear of their own mortality as well as the fear of contagion and death of people living with HIV and AIDS. As a result, their ability to cope with the infection is challenged. If they do not know how to cope with these challenges, they are likely not to survive longer.

- Financial challenges

Long term caregiving has significant financial consequences for caregivers. They lose a lot of money when trying to care for people living with HIV and AIDS. A study of France (Njau et al, 2015:72) revealed that finances is one of the challenges, because sometimes, caregivers have to use their money to take patients to the Doctors and rarely get reimbursed for that. This challenges them in a way that it creates a shortage to cover for their financial responsibility at their households. Njau et al, (2015:72) further reports that some caregivers leave their jobs after receiving training because the stipends they get are either insufficient to meet their basic needs or they do not even get stipends at all.

- Fear of contagion

Amongst other challenges that caregivers face, they have a fear of contagion. Some caregivers fear that wearing gloves may not provide enough protection to prevent the infection of HIV (Njau et al, 2015:75). Although they have knowledge about HIV transmission, they still have fear of HIV contagion which then affects the quality of their work. Some even feel the need to use disinfectants when taking a bath after caring for persons living with HIV (Njau et al, 2015:75). There are still caregivers who harbour irrational fears of contagion taking place through a casual contact, changing the patient's bedding, using the same eating utensils or bathing facilities (Demmer as cited by Njau et al, 2015:75). The fear of contagion to some extent results in empathetic withdrawal of the caregiver to the patient living with HIV and results in the patients feeling emotionally and physically deprived, which are the most valued interventions or connections. Some may even feel contaminated, smelly and unwanted (Njau et al, 2015:75).

- Death

Caregivers face a lot of loss whenever HIV/AIDS patients die. This results in them having long-lasting anxiety about the families of those who have lost their loved ones, especially children (Nyapisi & Emeka, 2015:89). Due to some caregivers living with HIV themselves, they are exposed to first hand when caring for such people, that makes an inclusion of how they would also eventually get sick, therefore, they seldom allow themselves time to grieve for their patients when they die. In actual fact, they never get time to mourn the death of their patients because they have other critically sick patients to look after (Nyaphisi & Emeka, 2015:89). As a result of this, the researcher has deduced that it may lead to ineffectiveness of the coping mechanisms because instead of caregivers dealing with matters individually, they wait for much emotional and psychosocial damage to happen because they can get helped.

- Lack of skills/ training

Due to lack of training, some caregivers apply their own knowledge and judgement in caring for people living with HIV and AIDS. The study of Sullivan and Miller (2015:11) supports this statement by saying that most caregivers who do not have the skills normally depend on the learn-as-you-go approach which is a danger to them. This may otherwise result in a lot of stress and caregivers would not know how to handle a lot of workload and pressure (Sullivan & Miller, 2015:11).

In some cases, there is a non-compliance with treatment that occurs because caregivers do not know how or when to administer the medication they require. In application of their own judgement, it is appropriate as long as the patient takes medication. They may not be equipped with the knowledge of taking the medication in the same time everyday so that the viral load can decrease. This as a result creates resistance of the ART and does not boost the patient's immune system. This may stress the caregivers when they see their patients deteriorating under their care.

- Stigma and discrimination

Caregivers of people living with HIV and AIDS experience a lot of stigma and discrimination from the communities they live in (Tsheboeng, 2015:30). Communities' still lack knowledge about HIV and AIDS in general, as a result, they tend to attach stigma to the caregivers, discriminate against them and often maltreat or even fail to support them. This leaves caregivers with a social burden and failure to socialize even engage in community due to that. Although positive or not, caregivers end up preferring to keep their status a secret. In large communities where a lot of people are infected with HIV, members of the community may fear to get infected including the caregivers themselves. As a result, they have been rejected or even abandoned even by their own family members when they disclose their HIV status. Consequently, they receive little support from their communities (Amoateng et al as cited by Tsheboeng, 2015:32).

Caregivers in Mafikeng face a number of challenges and negative effects associated with providing care to people living with HIV/ AIDS on a daily basis. The physical and emotional demands of caring are overwhelming and as a result, they lead to daily challenges and burnout.

2.2.4 Coping

The following is general information about what coping is, the process of coping as discussed by Lazarus and Folkman and lastly the coping strategies that caregivers can apply when dealing with the challenges they get from caring for people living with HIV and AIDS.

- What is coping

It is seen as an organizational construct that describes how people regulate their own behavior, emotion and motivational orientation under conditions of psychological distress and contain people's struggle to maintain, restore and replenish and repair fulfillment of those needs (Aldwin as cited by Mabusela, 2010:16).

- Coping process

Coping is seen as a process that consists of four steps (Lazarus & Folkman as cited by Mabusela, 2010:12). The initial step to coping involves determining the meaning of an occurrence and the implication it has in an individual's life and wellbeing. The follow-up opting or choosing a coping strategy to apply and assessment of its effectiveness of the. The third step is implementation of the best chosen strategy and ultimately evaluating whether one can successfully deal with a stressful situation whenever subjected to it (Lazarus & Folkman as cited by Mabusela, 2010:13-14).

In relation to the study, given a situation of a relationship caregiver and patient/person living with HIV/AIDS. In a circumstance where the person living with HIV/AIDS dies, the incident has the likelihood of affecting the caregiver emotionally and even psychologically, as a result the incident may result in them questioning themselves what it means to them. For some it may mean they have failed the perished individual by not had provided adequate care or to some a period of sadness due to the emotional breakdown. With experience of working with similar cases in the past, the caregiver may apply the coping strategies such as going for debriefing sessions or even suggest other coping techniques to use and weigh down which one will be most effective. Finally, an evaluation of whether the best chosen strategy worked or will work, otherwise another strategy will be put forth for the caregiver to use in future.

- Coping strategies

According to Lazarus and Folkman (1984 as cited by Mabusela, 2010:13) there are two globally accepted models of coping, namely: Emotion- focused and Problem-focused forms of coping, they are elaborated as follows:

Emotion- focused forms of coping

This form of coping occurs when there has been a judgment and conclusion that nothing can be done to adapt to a harsh, threatening and/or challenging environment. Within this model are intellectual routes that are intended to lower the level of distress. This includes strategies such as distancing and avoidance of a threatening situation (Lazarus & Folkman, 2010).

Debriefing can be used as one effective way of dealing with emotions of caregivers. It is seen as an effective intervention to assist groups and individuals who have been exposed to some forms of trauma. The main goal of this strategy is to lessen the likelihood of Post-traumatic Stress Disorder. When given a chance, caregivers state their fears, describe their pain and narrate their problems to professionals such as

social workers who ultimately assist them to get the required treatment (Tsheboeng, 2015: 9).

Problem- focused forms of coping

This form of coping is prone to occur when conditions judged as impossible are responsive or easy to change. Folkman and Lazarus (1984 as cited by Mabusela, 2010:14) compared these strategies in the model to those in the problem solving process. These strategies are concerned with defining the problem, operating alternate solutions, weighing alternatives in terms of cost and benefit choosing the best probable alternate and finally implementing the chosen strategies (Lazarus & Folkman as cited by Mabusela, 2010:14).

2.2.5 Legislation pertaining to the HIV and AIDS pandemic in South Africa

The following is a policy developed by the government of South Africa that seeks to reduce the prevalence of HIV, TB and STIs in the country.

2.2.5.1 National Strategic Plan on TB, HIV and AIDS and STIs.

The National Strategic Plan (NDP) on HIV, TB and STIs (2017-2022:3) is the fourth plan in fighting for the diseases. This plan outlines the strategic framework for a multi-sectoral partnership to further accelerate progress in reducing the morbidity and mortality associated with HIV, TB and STIs. This plan's vision is to phase South Africa from the vision of these diseases and has a mission of keeping the country on track in order to eliminate HIV, TB and STIs as public threats by 2030 (National Strategic Plan on HIV, TB and STIs, 2017-2022: XIII). The following elaboration of goals of the NDP will only be focused on HIV, which is what the study relates to.

- Goals of the NDP

- In order for the NDP to meet its vision and mission, it has goals that it ought to achieve. The following are the eight goals that have been outlined by the National Strategic Plan: Goal 1: Accelerate, prevention to reduce new HIV, TB infections and STIs.

With this goal, the NDP aims to reduce new HIV infections by more than 60%. This is aimed at about 100 000 people living in South Africa by the year 2022. In order to achieve this goal, the NDP intends to do this by using the approach of combining prevention interventions. Some ways in which the NDP will do this is by providing Pre-exposure Prophylaxis (PEP) treatment to populations who have been identified as risk population and also provide targeted services to prevent mother-to-child transmission of HIV and Syphilis in the Prenatal and Postnatal Period (NDP on HIV, TB and STIs, 2017-2022:XIV).

- Goal 2: Reduce Morbidity and Mortality by providing HIV, TB and STI treatment, care and adherence support for all.

The NDP intends on achieving this goal by providing about 90% pf people living with HIV and AIDS with Antiretroviral Treatment and ensure that that 90% achieve HIV suppression. The NDP aims to achieve this goal by ensuring that 90% of all people living with HIV know their status, they receive sustained ART and all those receiving it are virally suppressed (NDP on HIV,TB and STIs, 2017-2022: XV).

- Goal 3: Reach all key and vulnerable populations with customized and targeted Intervention.

With this goal, the NDP intends to ensure that no one is left behind. It promotes accessibility and feasibility of the services by ensuring that only high quality services especially for key populations which has been identified as transgendered people, sex

workers, inmates, as well as people who use drugs. In order for this goal to be achieved, the NDP will apply a key strategy of involving key populations, increasing their engagement, as well as advocating for them and the vulnerable populations regarding the development and implementation of social and health support activities (NDP on HIV, TB and STIs, 2017-2022: XV).

- Goal 4: Address the social and structural drivers of HIV, TB and STIs and link those efforts to the NDP.

The NDP hereby aims to reduce all environmental factors that leads to the spread of HIV and is committed to doing that by establishing and implementing social and behavioral change programmes that seeks to help communities to change their attitudes, beliefs and lifestyles in order to save themselves from contracting the HI Virus (NDP on HIV, TB and STIs, 2017-2022: XVII).

- Goal 5: Ground the response of HIV, TB and STIs in human rights principles and approaches.

With this goal, the NDP aims to intensify the efforts which will close the gaps that hinder full implementation of rights-related legal and policy commitments, gaps in the care of service providers and gaps in access to legal redress for people who experience stigma and discrimination by at least 50%. Some of the practical ways in achieving this goal is by reducing stigma through community education (NDP on HIV, TB and STIs, 2017-2022: XVII).

- Goal 6: Promote leadership and shared accountability for a sustainable response to HIV, TB and STIs.

The NDP aims to ensure collaboration of AIDS structures at National, Provincial, District and Local levels to contribute and bring on board ways in which they can work together to ensure that there will be mutual accountability in responding to the HI Virus

and that a team or collective effort is applied to fight the disease (NDP on HIV, TB and STIs, 2017-2022: XVI).

- Goal 7: Mobilize resources to support the achievement of the NDP goals and ensure a sustainable response.

The Government of South Africa has provided R78,2 billion for 2017/18 to 2019/20 for HIV, TB and STIs programmes and a total of R82,6 billion over 3 years period. In order to achieve this goal, the NDP will maximize the funds available for implementation of the NDP and the impact of these funds (NDP on HIV, TB and STIs, 2017-2022: XVII).

- Goal 8: Strengthen strategic information to drive progress towards achievement of the NDP goals.

The NDP aims to achieve this goal by mainly optimizing routinely collected strategic health information for data utilization. Specifically, it will increase data utilization, link clinical, laboratory and pharmacy data and implement master patient index for use in all service delivery settings (NDP on HIV, TB and STIs, 2017-2022:XIX).

- Principles of the NDP

Without the fundamental rules or values that represent what is planned and visional, the NDP will not be able to meet all the outlined goals, vision as well as its mission. The following is a concise elaboration of the six principles of the NDP on HIV, TB and STIs. For the sake of relevance to this study, these principles will only be focused on HIV.

- Principle 1: A person- centred approach (NDP on HIV, TB and STIs, 2017-2022:3).

The NDP has its main focus and interest on the people. The establishment of the NDP is for the mere benefit of the citizens of South Africa. All the efforts and strategies of the NDP are meant to help achieve the vision of seeing South Africa as a country free from HIV.

- Principle 2: A response that is inclusive and participatory (NDP on HIV, TB and STIs, 2017-2022:3).

The NDP intends to ensure that all the citizens and specifically key populations such as sex workers and AIDS councils at different levels are brought on board to discuss the strategies and plans that can be implemented in reducing the prevalence of HIV in South Africa.

In relation to this study, the NSP should not limit their invitation to all the stakeholders and people working closely to people living with HIV and AIDS. This is because they get first hand information about the challenges, experiences, fears, hopes and factors which led to those people to be living with HIV and AIDS. This could lead to a lot of discoveries or new information about what factors leads to HIV other than the common ones. The discoveries would therefore be incorporated in the NSP and new interventions may emerge.

- Principle 3: Ensuring that no one is left behind (NDP on HIV, TB and STIs, 2017-2022:3).

The NDP will ensure that all the key and vulnerable populations that have been identified by the NDP are reached with all the interventions established.

- Principle 4: A reliance on sound evidence (NDP on HIV, TB and STIs, 2017-2022:3).

The NDP will not quote or give data or information from unreliable or unverified sources, but will depend purely on evidence that is valid and verifiable.

In relation to the abovementioned view of the researcher under Principle 2, caregivers would be relevant and reliable sources as they work closely with people living with HIV and AIDS, which makes them understand them holistically.

- Principle 5: Commitment to protecting and promoting human rights (NDP on HIV, TB and STIs, 2017- 2022:3).

The NDP will ensure that all the key and vulnerable populations have equal access to the services relating to HIV, they are treatment with the utmost respect when seeking these services and provided with much, fair and equal information as possible regarding HIV, irrespective of their language, age, gender, race and other diversity factors.

- Principle 6: A multi- sectoral approach

With the social and structural drivers of HIV evolving, the NDP will establish plans and strategies of preventing or reducing them from developing in order to reduce the prevalence of HIV in South Africa. The NDP will thereafter link the efforts to the vision, mission and goals of the National Strategic Plan.

Although the NDP is not pertinent in directly addressing the challenges that caregivers of people living with HIV and AIDS face, which is the focal point of this study. It provides for an indirect approach or strategy that gives hope that with the adherence of the Government of South Africa to the goals and principles of the NDP, South Africa

will be a better country tomorrow. The NDP provides a response to some of the challenges that the caregivers face such as burnout in a way that with the reduction of environmental drivers of HIV, which NDP is committed to doing, the HIV prevalence will be reduced and caregivers will not be subjected to much strain of caring for people living with HIV and AIDS, which leads to burnout.

2.3 Theoretical Framework

In this part of Chapter two, the focal point is on the model that is pertinent and applicable to the challenges that the caregivers face when dealing with people living with HIV and AIDS.

2.3.2 Transactional Model of Stress and Coping

According to this transactional model, there are two key concepts known as appraisal and coping. Appraisal is described to be an individual's assessment of what a certain incident means to their wellbeing. On the other hand, coping is seen as the efforts that an individual puts in order to deal with specific demands or stressors (Lazarus as cited by Du Preez, 2010:13).

Lazarus further states that stress is a condition that is caused by relationships and not commonly viewed stimuli such as the environment, behaviour and psychological influences (Lazarus as cited by Du Preez, 2010: 13). According to Folkman and Lazarus (as cited by Du Preez, 2010: 13), psychological stress is the relationship with the environment that an individual appraises as important to his or her wellbeing and in which the strains go beyond the available coping resources.

The result of a stressful occurrence therefore depends on an individual's expectations to their appraisal regarding the significance of the event (Khrono as cited by Du Preez, 2010: 13). In turn, appraisals depend on an individual's particular personal and situational factors. Lazarus identified two forms of appraisal, which are Primary and

Secondary appraisals. Primary appraisal is concerned with an occurrence that is important to the wellbeing of an individual and secondary is concerned about the coping strategies applied when stress is experienced.

This model suggests that coping intervenes to stall the effects of stress on an individual's wellbeing. Folkman, Schaefer and Lazarus (as cited by Du Preez, 2010: 14) identified five groupings of coping strategies, namely: problem-solving skills, social networks, specific and general beliefs, health and ultimately functional resources. They further maintain that the appraisal aspect of the occurrence is the most influential element to the coping process, therefore, the principal feature of this model is that individuals differ in their appraisals of similar circumstances, which leads to different stress outcomes (Du Preez, 2010: 14).

In relation to the study, it is learned that these theorists view stress as an occurrence or rather condition that will only exist due to the outcome of the relationship between the caregiver and the person living with HIV and AIDS. As a result, the meaning that caregivers attach to what is happening in the relationship they have with the person living with HIV and AIDS is what determines whether they will end up having stress or not.

2.3.3 Attachment Theory

This theory is a psychological, evolutionary and ecological theory that is concerned with the relationships that exist between human beings. It postulates that the bond that develop and exist between the child and the caregiver has an outcome for the child's self-concept and developing a view of the social world (Mino, Guendelman, Castilo-Carniglia, Sandana and Quitana, 2018: 1). Within the concept of this theory, the behaviour of an infant that is associated with attachment is mainly seeking a proximity attachment figure being the caregiver in a stressful situation (Mino et al, 2018: 1). In relation to the study, the person living with HIV and AIDS seeks the proximity associated with attachment from the caregiver both in a stressful situation and to give general care to them.

Generally the concept “attachment” means an affectionate bond between an individual and an attachment figure. For the relevance of this study, that is the people living with HIV and AIDS and their caregivers. In most cases, these bonds are reciprocal in that the people living with HIV and AIDS wish or rather expect to get care, protection and safety from their caregivers and in return, apart from the financial boost, they get emotional satisfaction to learn that the people they are giving care feel secure and are well taken care of. It is real and possible for people living with HIV and AIDS to direct their proximity seeking to more than one caregiver as soon as they start discriminating between them. With this affectionate bond they have developed with their caregivers, people living with HIV and AIDS may go through some disruptions in the bond they have with their caregivers, which may leave them feeling insecure and confused (Mino et al, 2018: 1)

During times when people living with HIV and AIDS have a fear of danger, they use “alarm” to activate attachment behavioral system. This may be caused by a fear that the caregiver is incompetent in caring for them and lack the basic skills, such as communication, as a result they start seeking a different caregiver. People living with HIV and AIDS also experience “anxiety”, and this is during times when their relationship with the caregiver is going to be cut due to reasons such as change of work. This leaves the individual hard to cope and have a fear that the subsequent caregiver may not be as competent and caring as the previous one. In times when the caregiver is unresponsive or absent, the people living with HIV and AIDS will feel separation anxiety. This may be with the reason that they may feel that they are not fit enough to care for themselves as their caregivers do, or even how to approach a crisis shall it emerge (Kobak, 2008:27).

The following is various attachment styles/ patterns that exists between people living with HIV and AIDS and their caregivers that shows their level of bond:

a. Secure Attachment Pattern

In this type of attachment style, the person living with HIV and AIDS gets worried when the caregiver has to go somewhere and feels safe in their return. They may feel better when the other caregiver is available but prefers the other one more than the available one. The kind of caregiver in this attachment pattern responds approximately and consistently to the basic needs of people living with HIV and AIDS (Mino et al, 2018:2).

b. Avoidant Attachment Pattern

This is the one where the people living with HIV and AIDS will not feel distressed when the caregiver leaves. The individual will not really get excited when the caregiver returns. The caregiver here encourages the independence of the people living with HIV and AIDS and will rarely pay attention to the distressed individual (Mino et al, 2018:2).

c. Ambivalent Resistant Pattern

Under this category, people living with HIV and AIDS do not depend on the caregivers as a secure base. They are likely to feel preoccupied when the caregiver is available. The caregiver is in return inconsistent, swinging between appropriate and neglect responses (Mino et al, 2018:2).

d. Disorganized Attachment Style

The person living with HIV and AIDS could show actions such as being uncomfortable when the caregiver returns and the behavior is normally negative, which implies that they mistreat patients (Mino et al, 2018:2).

The type of attachment style that exist between the caregiver and people living with HIV and AIDS have a great influence on the way in which the caregiver will react shall the people living with HIV and AIDS parish. A pattern full of securing is recommended between the caregiver and people living with HIV and AIDS as it makes it easy for both parties to play their parts and have a reciprocal relationship. This theory is relevant to the study in a sense that it proves that although some caregivers may be passionate about their work, others will only do it for a financial boost or any other reasons apart from the needs and benefits of the people living with HIV and AIDS.

2.4 Summary

The literature review of this study revealed that caregivers are faced with challenges which may be overlooked by the society. The challenges cannot be addressed overnight due to the reality that the society at large have impossible expectations from caregivers and yet do not give them support in their work of caring for people living with HIV and AIDS. The literature review further provided detailed information the process of caregiving, HIV and AIDS, coping. This makes it easy to understand what caregiving is due to understanding the elements that makes this study. A policy pertaining to the HIV and AIDS pandemic settled the literature review compartment of this chapter.

The theoretical framework encompassed a model and a theory which to some extent pertains to the issue of caregiving. The model described how the relationship between the caregiver and the person living with HIV and AIDS is the main factor that may subject the caregiver to stress, whereas the theory explained how the bond that exist between them may have an effect or an influence in their future.

CHAPTER 3

3. RESEARCH METHODOLOGY

3.1 Introduction

Research method is a systematic manner to solve a problem under study. In it, various steps are usually assumed by a researcher in studying a research problem along with the rationality behind them (Kothari, 2004: 8). Creswell (2014: 3) describes it as the plans and procedures for the research that span the general assumptions to detailed methods of collecting data, analysing it and ultimately interpreting it. This study aimed at exploring the challenges faced by caregivers of people living with HIV and AIDS in different caring facilities.

This chapter presents the research methodology that this study followed. This encompasses the research type and design, sampling method and techniques, instrumentation and the way in which data was collected and analysed.

3.2 Research Approach

This study followed a qualitative research design. Concisely, this research approach is concerned with understanding or description of a phenomena or event (Cooper and White (2012:7). It is based on discovering the underlying motives and desires using in-depth interviews. The researcher conducted face-to-face interviews at the identified caring facilities. The interviews were comprehensive in order to gain fecund understanding of the underlying factors of the caregivers' experiences on caring for people living with HIV and AIDS and what facing those experiences mean to them.

3.3 Research Design

The design is an arrangement of conditions for collection and analysis of data in a manner that combines relevance to the study. In other words, it is a process where linguistic and vocal material is classified and interpreted to make a meaning(Flick,2013:6). According to the researcher, the research design is a guideline that outlines how the researcher selects the sample, collects data, deciding upon the method of collecting the data and ultimately how the data collected is analysed.

3.3.1 Phenomenological Research Design

The design in this study is a phenomenological research design. This type of qualitative design is concerned with understanding people's perceptions, perspectives and understanding of a particular study (Pathak,2017:3960). In relation to this study, the experiences that the caregivers of people living with HIV and AIDS were studied. These experiences are therefore known as their lived experiences (Pathak,2017:3960). The participants were asked questions outlined in the interview schedule by the researcher in order to understand how they observe them.

The other central aspect of this qualitative research design is for the researcher to take into consideration their own beliefs and feelings in conducting the interviews. This made it easier for the researcher to understand the experiences from the vantage point of the caregivers and not what the researcher wanted to hear. One way the researcher did this is by bracketing. This was done by identifying the expectations from the interviews before the interviews started so as to avoid being subjective.

3.4 Population and Sampling

- Population

According to Hanlon and Larget (2011:3), a population is all the individuals or units of interest. The population of this study caregivers of people living with HIV and AIDS.

- Sampling

Sampling is the process of extracting a sample from the population (Alvi,2016:11). The sample of this study was five caring facilities, namely Tsibogang Home-based care (HBC), Karabo HBC, Isibindi Child and Youth Care Centre, Lifeline Mafikeng and Lomanyaneng HBC. A sampling unit is a geographical unit such as a Village, District or Suburb (Alvi,2016:11). The sampling units for the identified facilities are: Signal Hill Village, Golfview, Lomanyaneng and Magogoe. A sample size is the number of participants selected from the entire population to constitute a sample (Alvi,2016:11). The sample size of the study was twenty participants. This was influenced by the research approach being qualitative that assumes that a smaller sample size makes it easy for the researcher to probe, go deeper and even understand all the underlying factors regarding the topic under study.

The following were the inclusion and exclusion criteria of the study:

Inclusion criteria

- All caregivers of people living with HIV and AIDS from Tsibogang Home-Based Care Centre (HBCC), Lifeline Mafikeng, Karabo HBCC, Lomanyaneng HBCC and Isibindi Child and Youth Care Centre.
- All caregivers were of any gender, race and ethnicity.

Exclusion criteria

- All Caregivers who have worked less than 3 months at the five mentioned centres.
- All caregivers who under the age of 18 years.
- All other caregivers of people living with HIV and AIDS at other healthcare centres other than the listed five.

3.5 Data collection methods

According to Creswell (2014:189), data collection in a qualitative approach is the steps which include the restrictions of the study and whether the information gathered is done through unstructured, semi-structured or structured interview. This procedure made it easy for the researcher to collect as much information and spend time at the setting (Creswell, 2014:0190). An interview is the sole data collection method that this study assumed. Its elaboration is as follows:

➤ Interviews

It is a way of collecting data by a way of either verbal stimuli or reply in terms of oral responses. Kvale (as cited by Alshenqeeti, 2014: 40) has defined an interview as a natural and socially acceptable way of collecting data as it can be used in various situations covering a variety of topics. In an interview there is two-way conversation in which the interviewer asks the participant questions in order to collect data and to learn about the ideas, beliefs, views, opinions and the behaviour of the participant.

When interviewing a participant, the researcher has freedom to decide the format as well as the content of questions, select the type of wording of questions, decide upon the way of asking questions and even choose the order. The procedure of asking questions can either be flexible, which allows the interviewer to ask any questions that

comes to mind in relation to what the study is about or fixed, where an interview has to follow a certain order.

This study used specifically personal interviews where there was a face-to-face conversation between the researcher and the caregivers of people living with HIV and AIDS. The personal interview followed a structured manner where the researcher asked a predetermined set of questions using the same wording and order of questions as specified in the interview schedule to the participants of the study.

For the purpose of this study, using an interview was an advantage due to the following reasons:

- Its appropriateness in complex situations

An interview is useful in that a participant can be prepared about the expectations and procedure of the interview before it can transpire. This helped the researcher to otherwise avoid asking the participants sensitive questions and also explain complex questions prior the interview.

- Its usefulness for collecting in-depth information

Through probing as one of the skills of interviewing, the researcher was able to go deeper into understanding the phenomenon under study.

- Questions can be explained

It is less likely that the participant understood all the questions asked because the independent person explained the informed consent document in a familiar language and the researcher repeated the question(s) that were misunderstood.

3.6 Data Analysis

The following is an analysis approach that was followed by the researcher:

3.6.1 Thematic Analysis

The data was analysed by themes, as a result, thematic analysis is an analysis approach that was followed. According to Mohammed Ibrahim (2012:40) this type of approach is used to analyse classifications and present themes that relate to the data. This type of analysis approach allows the researcher to determine precisely the relationship between concepts and compare them with the replicated data (Mohammed Ibrahim, 2012:40).

The goal of thematic analysis is to identify themes from the collected data and use them to address the research, particularly to answer the researcher questions of the study (Delahunt & Maguire, 2017: 3353). The following are the analysis steps that the researcher followed using thematic analysis approach as a guideline. These analysis steps that are developed by De Vos, Strydom, Fouche & Delport (2011). The data analysis steps were applied as follows:

- Managing data

This phase came immediately after the researcher conducted the interviews and when all the necessary data was gathered. The researcher changed all the collected data into file folders that were sorted according to different questions that were gathered on one-on-one interviews with the caregivers of people living with HIV and AIDS (De Vos et al, 2011: 408).

- Reading and writing memos

In order to write memos, the researcher firstly got acquainted with the data collected, in order to develop a better understanding of it. Where necessary, editing was done so that the data made sense. One other thing that the researcher did was listening to the recordings of the interviews to assure that what is written is a true reflection of what transpired during the interviews.

- Describing, classifying and interpreting data

The first thing that the researcher did in this step is analysing all the data collected through the interviews and classifying them into themes. These themes summarize and better describe the data collected. A thorough reading of the memos written and listening to the recordings lead to the emergence of themes which in some way answer to the research questions that were earlier developed by the researcher.

- Representing and visualising

This makes the concluding step of this procedure. The data collected through the interviews were presented in themes. Since this study has an interview schedule that has questions relating to the research questions of the study, the themes developed are narratives presented to answer those questions.

3.7 Ethical Considerations

Ethics are the main moralities which the research should take into consideration whenever they undertake a study. They guide researchers in order to guard against using inappropriate or rather harmful words with the clients, mistreating them and avoiding cases where the privacy of the clients is not respected. The ethical steps applied are discussed below:

- Informed Consent

Obtaining informed consent implies that all possible information on the goal of the investigations, the expected duration of the participants' involvement, the procedures followed during the investigation, the possible advantages and disadvantages and dangers to which participants may be exposed as well as credibility of the study, be rendered to potential subjects or their legal representatives (Royse; Williams, Tutty & Grinnell in De Vos et al., 2011: 117).

For the purpose of this study, this study made a use of written informed consent. This form explained all the details of the participant and the main purpose of this study. The written consent was typed in English and was explained in Setswana, a local language that the participants are familiar with.

Following the acceptance of the manager for the researcher to conduct the study at their care facility and after the caregivers' approval, the researcher and the independent person met so that the researcher could explain the informed consent document to the independent person. Ultimately, the independent person met with the caregivers on the day of the interview to explain the informed consent document to them.

- Voluntary Participation

This ethical consideration fully requires that the participant, being the caregivers of people living with HIV and AIDS, take part in the study without any harassment and not coerced (Klenke, 2016:51). Hence the researcher developed a written informed consent which verified that the participants answered all the questions in a satisfactory manner.

- Avoidance of Harm

This is the basic ethical rule of research (Babbie, 2007 in De Vos et al., 2011: 114). The study may harm the participants in the process of gathering information such as through the interviews (De Vos, Strydom, Fouche & Delpont, 2011:114). Participants could be harmed in both emotional and physical ways by the researcher (De Vos et al., 2011: 114). An emotional manner may be teasing the interviewee about one or some of their weaknesses learnt during the interview and a physical manner may be pulling the interviewee by hand in order to pay attention to the researcher.

The interviews were conducted with no intention of harming the participants since the caregivers are also humans, which makes them prone to anguish. This study ensured professional communication during interviews and undivided attention. The researcher ensured this by not using any vulgar language and not dwelling much on sensitive topics. The emotional and physical harm were avoided at all phases of the interview.

Furthermore, in order to avoid causing harm and disclosing information, the researcher stored all the data in a safe locked cabinet.

- Confidentiality

It is simply not disclosing private information of the participant to anybody (Klenke, 2016:51). This study adhered to the terms of this principle. The researcher assured confidentiality from the onset and established rapports for both the researcher and the caregiver. The following ensured confidentiality:

- The researcher never talked about what transpired during the interview with the caregivers themselves in public places
- The researcher never talked to the participants on the phone.
- Following the interviews, the researcher stored clients' data in a lockable cabinet where access is restricted to the researcher only.

- All the data that was stored on the computer are password protected, and could only be accessed by the researcher.

- Privacy

This principle was respected optimally in the following manner:

- The researcher collected data anonymously in a way that is no way connected to the identities of the participants. For instance, their identity numbers, addresses and cellphone numbers were never asked.
- Interviews were held in offices and rooms organized where there was nobody but the researcher and the participant only.

- Anonymity

This ethical principle was respected optimally. It was protected by using pseudonyms by calling participants, "Participant 1, Participant 2...Participant 20 " This also helped to differentiate participants.

- Respect

Respect as an ethical principle is like a standing order that researchers throughout the research process should comply with. The researcher respected this principle throughout. In cases where participants were not willing to take part in the study, the researcher accepted and respected their decisions and never asked the gatekeepers who they were to go after them.

3.8 Trustworthiness

The following are the components that relate to trustworthiness that were applied in the study:

- Credibility

According to Anney (2014: 276) it is the confidence in how well the data and processes of analysis address the intended focus. The qualitative analysis of the research does highlight and proves that the study has measures what it was set to measure in the beginning.

- Transferability

Anney (2014: 277) sees this component as the extent to which the findings can be transferred to other settings. This is to check whether the same results could be confirmed should the interview schedule be used on the same population at different time intervals. The researcher ensured applicability of the tool by asking and elaborating questions in the same way to all participants and not making any edits on the questions after the interviews were conducted.

- Dependability

This component refers to the ability of the researcher to account for the constant changing conditions of the phenomenon studies, for the interaction with study participants and the entire research process carried out with an emergent design (Anney, 2014: 278). The researcher is confident that similar findings would be obtained if the study was to be repeated with the same people in the same context. There is consistency in the data collection tool as well as the researcher.

- Confirmability

This refers to neutrality of the researcher rather than that of the research (Anney, 2014:279). The researcher maintained a neutral stance at all aspects of the research and ensured this principle by avoiding being subjective during the process of the interview. This is due to the fact that subjectivity would have led the researcher to ask the caregivers questions and persuaded them to answer in a way that satisfied the feelings, thoughts and opinions of the researcher in relation to the question.

3.9 Conclusion

This chapter focused on research methodology which are the overall steps and techniques used to make the research successful. These included research design being phenomenological due to the study being based on the feelings, thoughts and experiences of the participants in Mafikeng and sampling five identified caring facilities. This chapter further discussed the interview schedule used to gather data and analysis techniques.

CHAPTER 4

4. DATA PRESENTATION, ANALYSIS AND INTERPRETATION

4.1 Introduction

This chapter is based on the presentation of qualitative data, its analysis and interpretation from the participants of the study. Maree (2015: 49) explains qualitative data analysis as an informative viewpoint that is intended to explore and scrutinize the meaning behind the content or feedback obtained from the data collected from the participants of the study.

The findings that were gathered through one-on-one interviews with caregivers of people living with HIV and AIDS are discussed in this chapter. Twenty participants willingly took place in this study. Before the interviews went on, the independent person explained the informed consent document to the participants to ensure that they understood what was expected from them and why they were relevant for the study. Pseudonyms were used to maintain anonymity and instead of their real names, they were referred to as, "Participant 1, Participant 2, until Participant 20". Themes that emerged from the interviews and ultimately a summary of the findings are discussed below.

4.2 Demographic Information of the participants

The following presents the profiles of all 20 participants that were interviewed in this study. Information such as their age, gender and their background is given. This information was derived from the interview schedule. The profiles of the participants helped the researcher to identify the needs, loopholes as well as the dominating gender in order for the researcher to make recommendations to the subsequent researchers with the same field of study. The demographic information of the study is important as it relates to the inclusion and exclusion criteria of the study. This study

included caregivers of all genders, which is shown below and excluded all caregivers below the age of 18 years, hence, the researcher never interviewed any.

- Participant 1

Participant 1 is a single man aged 42 years, who does not have any dependants. The highest qualification he has obtained is Grade 11. He has received basic training for caregiving, which he referred to as, “HIV Awareness”.

- Participant 2

Participant 2 is a single mother of one, aged 40 years and has Grade 11 as her highest qualification obtained. She has received two training sessions for caregiving which are Home-Based Care training and Family Support Intervention.

- Participant 3

Participant 3 is a single mother of three, aged 29 years and her highest qualification obtained is Grade 10. She has never received any training in caregiving.

- Participant 4

Participant 4 is a single mother of three and aged 25 years. She has Grade 12 as her highest qualification and has never received any training in caregiving.

- Participant 5

Participant 5 is a married mother of two aged 43 years. She resides in Lonely Park and her highest qualification received is First Aid. She has never received training in caregiving.

- Participant 6

Participant 6 is a single mother of two who is 36 years old. Her highest qualification is Grade 11 and has never received training in caregiving.

- Participant 7

Participant 7 is a married mother of three and aged 46 years old. She has Grade 12 as her highest qualification and has an Auxiliary Health Care training.

- Participant 8

Participant 8 is a single mother of one who is aged 30 years. Her highest qualification is Grade 11 and has no trainings of HIV and AIDS and Caregiving.

- Participant 9

Participant 9 is a single mother of two and aged 49 years. She has Grade 12 as her highest and further received two training sessions on caregiving known as, " Mary Mount training and Tsibogang training".

- Participant 10

Participant 10 is a married mother of three who is 53 years old. She has Standard 9 as her highest qualification and has further received training in Home-Based Care and Counselling.

- Participant 11

Participant 11 is a widowed mother of three aged 46 years. She has Standard 10 as her highest qualification and has never received any training on caregiving.

- Participant 12

Participant 12 is a single man aged 44 years with three dependants. He has Standard 10 as his highest qualification and has further trainings for HIV and AIDS and Basic Counselling.

- Participant 13

Participant 13 is a single mother of one aged 27 years. She has obtained a Diploma in Human Resource Management as her highest qualification and have obtained Grade 12. She has received training in HIV and AIDS empowerment.

- Participant 14

Participant 14 is a married woman with one dependant and aged 42 years. She has received Grade 12 as a highest qualification and has further trainings in psychosocial support, trauma debriefing and HIV and AIDS empowerment.

- Participant 15

Participant 15 is a single man with two dependants and aged 42 years. He has obtained Grade 12 as his highest qualification and has never received any training on caregiving.

- Participant 16

Participant 16 is a single mother of five aged 31 years. She has Grade 12 as her highest qualification and further trainings in Child and Youth Care Work and HIV and AIDS.

- Participant 17

Participant 17 is a single mother of one who is 32 years. She has Grade 12 as her highest qualification and have received training in Child and Youth Care Work and HIV training.

- Participant 18

Participant 18 is a single mother of two aged 46 years. She has Grade 12 as her highest qualification and has never received any training for caregiving.

- Participant 19

Participant 19 is a married man aged 36 years with two dependants. He has Grade 12 as his highest qualification and has further certificate in Social Auxiliary Work as well as trainings in Thogomelo and Families Matter Programme.

- Participant 20

Participant 20 is a single mother of three aged 49 years. She has obtained Standard 10 as her highest qualification and has training for CYCW and HIV and AIDS.

The analysis of the demographic information is as follows:

In this study, twenty participants were interviewed, where the majority of sixteen were women and men four. The domination of female in the caring profession relates to the finding of Mabusela (2010:61) where he found whilst conducting his research that in an area where he was conducting his study, there were 35 female caregivers and only one male. There was also dominance of female in the study of Mabusela (2010: 53), where he interviewed a total of twenty participants, where five were male and sixteen were female. The majority (eleven) of the participants were in the 40-49 age category, five in the 30-39, three in the 30-39 and only one in the 50-59.

The majority of the participants have obtained Grade 12, five Grade 11 and only two have finished school at Grade 10. Out of 20 participants, 14 has received certificates either in HIV and AIDS, Counselling or Caregiving and 6 never. The majority (12) of the participants are single, seven are married and only one is widowed.

Lastly, the majority (7) of the participants have three dependants, six with two dependants, three has one dependant and only one do not have any.

To some degree, the profiles of the participants helped the researcher to identify a loophole of lack of training. The profiles revealed that six caregivers have never received any form of training which is a serious need.

4.3 Themes that emerged from the interviews

The following themes emerged from the interviews that were conducted with the twenty participants and substantiated with the information gathered from the literature review:

4.3.1 Theme 1: Caregiver's understanding and knowledge of HIV and AIDS

The overall findings of this study established that all caregivers do have knowledge and an understanding of the HIV and AIDS pandemic. However, it is easy to tell that some do not have training as caregivers for people living with HIV and AIDS. The researcher deduced that the experience that caregivers have of working with people living with HIV and AIDS had taught them the little that they know.

4.3.1.1 Sub-theme 1: Understanding

The findings of this study identified that all participants of the study expressed their knowledge of the pandemic in different ways, but with the same meaning behind them. The caregivers do have an understanding of the HIV and AIDS pandemic; however, some provided an understanding that was very basic. The caregivers' responses to the questions made it easy for the researcher to conclude that the caregiver has never received any training in both HIV and AIDS caregiving. The understanding that they gave was very brief and not as comprehensive as the researcher had expected from a person who works with people living with HIV and AIDS on a daily basis.

When asked about their understanding of the pandemic, Participant 7 said, *"I understand that the virus does not mean witchcraft and does not enter into a person's body due to their economic status, like being poor or unfortunate, it affects anybody who engage in sex that is unprotected.* Participant 14 said, *"I understand that It is a virus that most people say is a disease, but they explain to them that it is not a virus and when you know you have it, take your treatment properly, lower on drugs usage, lower on unprotected sex and know how to protect yourself". Your status or physical characteristics do not count".* This point reflects back to the literature that was reviewed in Chapter 2 of this study under the discussion of, "Who is at risk of contracting the disease?" The discussion gave the following highlights:

Every living human being stands 100% chance of contracting the HI Virus provided they do not protect themselves and apply the precautionary measures:

- Engaging sexually without using protection with a person who is living with the HI Virus. This includes vaginal, anal, as well as oral sexual engagement without usage of protection.
- Using needles, syringes or other equipment to inject drugs, steroids or even medicine/ vitamins that have been used by a person living with HIV and AIDS.
- Babies can potentially get infected during their mother's pregnancy, delivery or after birth in immediate postpartum period. They can also become infected during breastfeeding.
- Health care and maintenance workers who may be exposed to blood and/or body fluids at work sometimes get infected through on-the-job exposures like needle-stick injuries (Mitbawkar, 2010: 7).

From what Participant 7 said, the researcher learnt that working with people living with HIV and AIDS makes it very easy for the caregivers to understand the pandemic. Most caregivers do not really have any training on HIV and AIDS or caregiving, but they are keen to understand it because this is what they do on a daily basis. As a result, it makes it easy for caregivers to know which coping mechanisms works for them.

This study derived its understanding of HIV from Van Dyk (2010: 423) who says it is a virus that enters a human body through ways such as using needles and syringes previously used by an infected person. If left untreated the virus develops into the syndrome called AIDS. This syndrome is not inherited, but acquired. It is caused by the invasion of the HI Virus in the body, causing it to be weak to the extent of being unable to protect itself from various infections and pathogens (Van Dyk, 2010:423).

4.3.1.2 Sub-theme 2: Knowledge

The outcome of this study has found that all twenty participants have pertinent and significant knowledge about the pandemic, although too brief and made it easy for the researcher to pick that no training had been received. Furthermore, the researcher realized that some participants did not have confidence in what they were saying. This statement has been supported by Mackenzie (2017:26) who discovered that caregivers had limited knowledge on the health conditions and the information they provided to the patients was not always accurate. The researcher had to ask more follow-up questions in order to make an investigation of whether the caregivers are knowledgeable about HIV and AIDS. The researcher expected that the caregivers would start from explaining the acronyms, go to the manner in which an individual can contract the disease, the stages of the HIV, the difference between the HIV and AIDS, opportunistic diseases and the treatment available for the Virus. Instead, the researcher got very brief responses.

When asked about their knowledge of the pandemic, a few participants responded in the following ways:

Participant 1 said, *"It is a virus you get from sleeping with multiple partners without protection"*.

Participant 2 said, *"HIV is a virus that lives in the blood and one can live for a long time when they have the virus, but if one does not take the treatment properly it can lead to AIDS. When it is AIDS, most opportunistic diseases attack you, such as sugar diabetes and you cannot do anything for yourself"*.

Participant 4 said, *"The HI Virus is the virus that weakens the soldiers of the body and it can be suppressed by ARV's, they only suppress and does not heal"*.

Participant 13 went on to say, *"HI Virus suppress the soldiers of the immune system and AIDS is the last stage of HIV"*.

The knowledge of the HIV and AIDS pandemic of the abovementioned participants reflects back to the literature that was reviewed in Chapter 2 of this study under the

discussion of, “what is HIV and AIDS?” The discussion highlighted that, Human Immunodeficiency Virus attacks the body’s immune system. This is the very same that protects the body from infections and diseases, but does not have an exact way of protecting the body from the virus. Without treatment, most people who are infected with the virus become less able to fight off the germs that they are exposed to in their daily lives (Mitbawkar, 2010: 6). Many of the germs that people living with HIV do not make a healthy person sick, but are prone to cause life- threatening infections and cancers in the immune system of an individual who has been weakened by the virus. The ART (Antiretroviral Therapy) also prolongs the lives of people living with the disease (Mitbawkar, 2010: 6).

When left untreated or unattended, the HIV leads to AIDS (Acquired Immune Deficiency Syndrome). It is commonly known as the late stage of HIV. In this late stage, the CD4 cell count, which is a way of measuring the strength of the immune system, is below 200, where the normal counts 500 or even higher. Moreover, an individual starts developing opportunistic diseases such as TB and Pneumonia due to the weak body (Mitbawkar, 2010: 6).

Just as Tsheboeng (2015: 77) mentions, a lack of clarity in the career combined with inexperience and lack of training can result in an ad hoc approach that undermines the quality of services. She further adds “Voluntary caregivers need continuous support i.e. debriefing and training” (Tsheboeng, 2015: 77). Not having comprehensive knowledge about the pandemic is a risk because dealing with people living with HIV and ADS is a sensitive issue and a risk. Irrespective of the many years of experience in the field, caregivers need training that can validate and approve that what they are doing is correct. Depending on their judgment and knowledge is risky for oneself and people taken care of.

The issue of lack of training of caregivers, which result in inadequate knowledge and skills is not only a danger their patients, but to them as well. Sullivan and Miller (2015:11) have revealed that most caregivers who lack skills usually depend on the

learn-as-you-go approach. This pose a psychological risk such as stress as this can be considered as cheating their wellbeing. That is convincing themselves that they are strong to handle such situations when in reality they cannot.

On the other hand, lack of training affects their work effectiveness and the quality of work they render to their patients (MackenZie,2017:26). This is in a sense that people living with HIV and AIDS spend most of their caregivers and depend on caregivers to provide them with a holistic guidance. That encompass emotional, psychosocial, as well as educationally. Lack of training may lead caregivers to miseducation towards their patients.

4.3.2 Theme 2: Caregiver's experiences

The findings of the study indicated that caregivers' experiences are different in the diverse situations. Some caregivers totally enjoy giving care to people living with HIV and AIDS because they learn a lot of the things that make them grow and develop in future. It becomes easy to help other people living with the same virus, and to even apply the same knowledge of caregiving to patients who are living with different conditions, diseases or viruses. The researcher realized that the way that caregivers feel about their job is strictly determined by how their patients progress under their care. Seeing their patients getting better and accepting their status boosts their morale and mostly their spirits gets uplifted to see bedridden patients regain their strength when hope had been lost.

4.3.2.1 Sub-theme 1: Caregivers involvement

When asked about their experiences, the caregivers responded in the following ways:

Participant 2 said," *I like giving care to people living with HIV and AIDS because sometimes one of your family members will contract the disease, now you have the experience to work with them, even when they wanted to get bathed, you do not fear*

like before, cringe and wonder where to hold them, you know what to do before you hold them”.

Participant 7 said, *“Although it is painful to work with people living with HIV and AIDS, sometimes it is fun because the main intention is to see a patient out of bed and walking, so I enjoy to help such person. I enjoy to encourage that patient and I love them anyway”.*

Participant 9 said, *“my experience in caregiving changes as time goes on, sometimes you do not know how to accept a certain situation, like when you enter into the first family, it will not be the same as the second one. The situations are not the same, but I have learnt that when you find a patient who is down, automatically your mind and emotions get affected, but when you remember that there are those patients who accepted their status, you wonder what it is that the others need to accept their status. She further went on to say, “The patient is the ultimate determiner of how it is to work with them”.*

Participant 10 explained that, *“learned have learnt a lot from working with people living with HIV and AIDS and how to treat them, whether they are HIV positive or diabetic, they give you enough experience for you to grow in life”.*

Participant 19 said, *“[sigh!] I have started seeing someone die through this job, sometimes you work with an individual, connect with them and as time goes on, when you expect them to get better, and they pass on. When you told yourself that the other one is going to die, they recover and it feels good to see that you have made a difference in someone’s life”.*

Participant 15 said, *“Working with a person living with HIV is painful, it is a bit painful, it is like you Feel pain, you put yourself in their shoes and wonder what if it was you with the virus”.*

A study of Mabusela (2010: 65) clarified that there are various reasons that make caregivers enjoy their work or rather remain as caregivers. These reasons range from financial considerations to expressing enjoyment and love for the work (Mabusela, 2010: 65). But in this study, it is mostly the desire and the need to change another person’s life. Some caregivers have a strong desire to help people living with HIV and

AIDS as some caregivers fear to even come near them. They realized that some patients would not survive this battle without their assistance. Akintola (as cited by Mabusela, 2010: 30) reported that some caregivers have experienced the pandemic in their own household, as a result they required knowledge and skills to care for their family members.

4.3.3 Theme 3: Caregiver's challenges

The findings of the study revealed that caregivers face a lot of challenges such as tremendous psychosocial and economic challenges. This theme confirmed findings of the study on the challenges experienced by the caregivers. From the observation, interpretation and the interviews, the researcher deduced that most caregivers enjoy their work but face a lot of challenges. The following are the dominant challenges that most caregivers face:

4.3.3.1 Sub-theme 1: Interaction and anxiety challenges

The findings of this study on this theme show that caregivers come across different characters amongst patients whilst in the field, conducting home visits. Sometimes, they come across friendly patients who are welcoming and easy to build rapport with. On the other hand, some patients are either very rude, reluctant to get assisted, never welcome the caregivers and do not even want to hear what caregivers advise. As a result of this, some caregivers are left anxious and wonder what kind of treatment they are going to encounter the following time they conduct home visits.

Some participants mentioned that they sometimes get mistreated by their patients and sometimes never get welcomed warmly into their homes when conducting home visits.

Participant 7 said, *"They are not the same, there are those who are humble and the ones who are either too strict or rude, or I do not know if I should say naughty. They*

are not the same. So it is a challenge to a caregiver when you enter into one's house and find a patient who is strict and does not want to speak to anybody".

The researcher has discovered interaction challenge as new. Some of the caregivers face interaction as a challenge whilst in the field. The literature review does not have interaction challenge as one. However, a study of Homau, Searle, Esu-Williams, Aguirre, Mafate & Melday (as cited by Njau, Kariuku & Wambu, 2015:72) said some challenges of caregivers of people living with HIV and AIDS has been identified as anxiety. In the context of this challenge, it is anxiety about what kind of treatment caregivers are going to recommend the following time they are in the field.

4.3.3.2 Sub-theme 2: Stigma and discrimination.

The findings of the study identified that caregivers are subjected to some form of social prejudice, mainly stigma and discrimination from their community members. Their commitment to caring for people living with HIV and AIDS is also often questioned. Instead of getting support from their community members, they get treated as if they are HIV positive and that they have certain bad behaviours. The findings of this study also confirmed that there are some community members who are on ART but do not take their treatment properly, mixing their treatment with alcohol and their behaviour is also very bad.

When asked about the challenges, Participant 12 said, *"I was once faced with this challenge and that person pointed me out in a taxi. It was a man who saw me walking a patient and he said I also take treatment and even when they see me like this, I also queue at Ward 6. I never opposed what he was saying because I was avoiding a dialogue and unnecessary noise because he was drunk. I just said yes and you see that I am taking care of myself, I take my treatment accordingly that is why I am beautiful. Take your treatment as well to be like me. After he heard me saying that to him, he started spreading rumours about me at the taverns in the village".*

Participant 20 said, *“Some of them say that I also have HIV because I care a lot about people who have the virus and I never speak of other diseases but HIV. I end up saying to them if I take treatment then I take my treatment so they must also take it in order to look like me”*.

Akintola (2010: 78) has observed that stigma is still very rife in South Africa and has negative implications for both caregivers and people living with HIV and AIDS who have experienced discrimination and hostility from members of the community (Tsheboeng, 2015: 78). Amoateng, Kalule-Sabiti and Oladipo (as cited by Tsheboeng, 2015:33) established that whether caregivers are HIV positive or not, they suffer from discrimination, and as a result, families may keep the sick person's HIV and AIDS status secret. Furthermore, they alluded that in areas where there are a significant number of people infected with HIV or AIDS, community members often fear contracting the virus. Some caregivers who often sought help have been rejected or abandoned even by their own family members (Zimba and McInerney as cited by Tsheboeng, 2015: 33).

A study of Kemble (2010: 49) has revealed that being HIV positive in some communities can be a highly lonely experience for people living with HIV and AIDS and even their caregivers due to stigma. Community members still think that they have become HIV by being sexually promiscuous. Additionally, many people in the community still believe that HIV is a death sentence, thus adding to the stigma of people living with HIV and AIDS and their caregivers.

Van Dyk & Friedland, Rencack and McColl (as cited by Mabusela, 2010:35) mentioned that both infected and uninfected Home-Based caregivers working in the HIV/AIDS arena are stigmatised. Furthermore, they stated that for people living with HIV and their family members, the stigma, fear and discrimination often associated with the illness can create barriers to effective care.

The stigma and discrimination about people living with HIV and AIDS is rife to the extent of affecting even children whose parents died due to AIDS. Just as a study of Alliance (as cited by Motaung, 2010: 30) mentioned that experiences of children living with HIV and AIDS has revealed that children in the process of grieving for dying or dead parents are mostly stigmatised by the society by associating it with AIDS. Due to the stigma, children may be denied access to schooling and health care. Once their parents die, children may be denied their inheritance and property and once a child has lost their parent through AIDS, they are often assumed to be HIV positive.

4.3.3.3 Sub-theme 3: Emotional challenges

The findings of this study revealed that there is a lot of emotional sacrifice that caregivers have to render in the process of caregiving. In some instances, caregivers come across families who live in shacks that are indecent and unpleasant to live in. Caregivers come across patients living with HIV and AIDS who do not have any source of income and have children to feed and there is not enough available food for them to take in order to take their treatment. All of these situations takes a huge toll on the emotional wellbeing of the caregivers. They wish there was something they could do, but being volunteers themselves and not even earning enough money does not help the caregivers in any way.

Furthermore, the findings of the study revealed that caregivers get emotionally affected when they get rejected by their patients; the help they offer is not considered and they lose the patient (s) they had hoped would get better when they are under their care and guidance.

When participants were asked about how being a caregiver affects their emotional component, some reported that they are used to caring for people living with HIV and AIDS and it does not hurt them like before, when others put themselves in the shoes of their patients and get badly hurt.

Participant 15 said, *"Sometimes I get hurt, when I get into a home and find a person sick, and having left treatment. Sometimes when I speak to them they chase me away, I leave with a broken heart. Even when I try to give a report, I am unable to, I either tell somebody or I draft on a book and give it to my supervisor to read"*.

She further went on to say, *"I am also hurt by children who were born with the virus and their mothers don't care about them, and drinking alcohol. When you go to them, they tell you that they don't have an income, they don't work, so they need food to give them energy."*

Participant 11 said, *"It pains me to be working with people living HIV and AIDS because when I put myself in their shoes, it would not be easy for me to accept."*

Although caregivers may have adequate experience in caring for people living with HIV and AIDS, it still pains them to see their patients at their lowest. Hunk (as cited by Tsheboeng, 2015: 12) found that whilst trying to provide the best care possible to their patients, caregivers sacrifice a lot of their emotional and physical needs. Both their physical and emotional experiences that are involved in providing care could strain the most capable person.

A study of Miller (as cited by Tsheboeng, 2010: 84) has advised that caregivers must learn to strike a balance when caring for their patients. A caregiver can become immersed in the patient's life by feeling his or her feelings, even fears. A good caregiver must be able to maintain his or her separateness, which seem very impossible or rather difficult for some caregivers of this study. This is mainly because they are human beings themselves and detaching from a person you have developed a bond with is difficult.

The failure to exercise a skilled detachment can be a source of high stress as the caregivers can experience a sense of failure and guilt when the patient dies or when their health deteriorated (Bharat & Mahendra as cited by Mabusela, 2010: 85).

4.3.4 Theme 4: Coping mechanisms

In this theme, the researcher will analyse the findings of the study on the coping mechanisms that the caregivers face. When they were asked about how they cope with the multiple challenges they face, the researcher has learned that caregivers do not only rely on the professional mechanisms such as debriefing, but on other many ways that works for them.

Lazarus (1991: 112) refer coping as an individual's constant cognitive and behavioural efforts utilized to be able to control certain internal and external demands that are beyond their resources. Coping mechanisms on the other hand are strategies that people employ to deal with the minor or major stress, traumatic experiences, anguish and pain or natural changes they're bound to experience in life (Thoits, 2011). The following are the mechanisms that caregivers utilize to cope with the challenges they face when giving care to people living with HIV and AIDS:

4.3.4.1 Sub-theme 1: Debriefing

The findings of this study revealed that a few of the caregivers get debriefing sessions from their healthcare facilities. Some caregivers have never received caregiving at all and the other only get it once a year. These findings pose a huge question of how do the caregivers deal with their stressful occupation, when they lack professional counselling that can help them with that.

Debriefing is seen as a process that involves venting out feelings, emotions as well as fears in order to relieve oneself in the stress encountered previously (Maselesele and Mashau as cited by Tsheboeng, 2005: 36). They further indicated that these interventions can be conducted by professionals such as Social Workers, Psychologists or Counsellors for management. The principal goal of debriefing is to lessen the likelihood of Post-Traumatic Stress Disorder (Tsheboeng, 2015:9). The following is what most participants said about debriefing.

Participant 1 said, *“In order to help ourselves, we go to debriefing so that we can refresh out minds and relieve stress”*.

Participant 2 said, *“The help we get from the centre is sitting down as colleagues and sharing the challenges we encountered and get advices of how to deal with them”*.

Participant 4 said, *“We have debriefing once in a year”*.

Participant 5 said, “We have debriefing, there are times when our superiors call us together to go to debrief”. Participant 9 said, “We get debriefing sessions every first Wednesday of the month”.

According to Tsheboeng (2015:56), debriefing is an ideal assistance for caregivers, as they deal with traumatic and emotionally draining situations when giving care to people living with HIV and AIDS

4.3.4.2 Sub- theme 2: Other coping strategies

Apart from the abovementioned professional manner of dealing with the challenges they face in caring for their patients, the findings of the study had revealed that caregivers have learned and adopted other effective ways of dealing with the challenges. The following is a discussion of those manners:

Throughout the interview sessions, the researcher has learned that a lot of the caregivers are God-fearing. Most participants depend entirely on praying and going to church to refresh their minds and help them to forget about the challenges they face while on the field conducting home visits. Participant 2 mentioned that, *“...Pastors come and pray for us, they strengthen us and tell us that our job is tough but we must accept it and love it and once we do, it will be easy to love everybody who is HIV positive”*. This is an indication that caregivers do acknowledge that their job is stressful, hence they have come up with other alternative strategies that works for them.

Among the twenty participants that were interviewed by the researcher, about two of them admitted that the coping mechanism they sometimes use is displacement. For the purpose of this study, displacement is understood as an act of directing anger, frustration, anguish, disappointment or any other bad emotions to a person who never caused the emotion. One participant even went on to say she feels very relieved after shouting her children after a long and draining day at work. Participant 15 said, *“I want to be very honest, sometimes when I feel burdened from work, whatever my children do is wrong. I take all my frustration on them such as saying “some children don’t have margarine but you’ve taken it all and put it in the table, instead of the fridge. After shouting, I feel better.”* The researcher then wondered whether the facilities never get to hold workshops where information is shared and caregivers are taught about other positive ways to deal with their frustrations, anguish and anger without hurting the feelings of other people.

A few participants reported that they rely entirely on sharing their experience with their colleagues. They believe by so doing, they get a lot of better advices and strategies of tackling similar matters shall they be faced with them in future. When other depend on sharing their experiences with their colleagues, a few participants reported that resting is an effective coping strategy for them. Participant 7 said, *“I rest a bit and when I wake up, I feel refreshed and I have forgotten about what I went through”.*

The following are the coping mechanisms mentioned by Mabusela (2010: 89):

- Consultation with senior staff members

According to Mabusela (2010:89), at times, the caregivers find themselves having problems with their patients and they cannot resolve, so they refer the matter to their supervisors. If the manner is beyond the capacity of the supervisor, it is either the patient is referred to another centre or other superiors.

- Informal support groups

Mabusela (2010:90) mentioned that some participants resort to sharing their fears and challenges with fellow caregivers. Sometimes they know that it would not help them much but sharing their experiences provide them with comfort as they all experience similar situations and they are all able to maintain confidentiality. There is no schedule for such meetings, it happens haphazardly.

- Spirituality

Mabusela (2010:90) also reported that some people believe in God and prayer to cope with their work. They believe and have faith that with God everything is possible. The caregivers pray together every morning before they start working and some do it in their own. Religion is one of the best coping strategies that is used by the caregivers. Religion plays a significant role in the HIV and AIDS arena (Makoe & Jubber as cited by Mabusela, 2010:92).

In relation to the Transactional Model of stress and coping, it is apparent that the caregivers apply problem-focused form of coping throughout their work. Lazarus and Folkman (1984 as cited by Mabusela, 2010:14) has indicated this form of coping to the strategies of the process of problem solving. In this type of coping, they have outlined that the strategies of this type of coping are concerned with defining the problem, operating alternate solutions, weighing alternatives in terms of cost and benefit choosing the best probable alternate and finally implementing the chosen strategies (Lazarus & Folkman as cited by Mabusela, 2010:14).

The findings of the different coping mechanisms that caregivers apply in their lives relates to the strategy of defining the problem which is the first step outlined by Lazarus and Folkman (as cited by Mabusela, 2010:14). In order to know which coping mechanism works for them, caregivers initially try to understand the problem before they can define it. After a whole definition of a problem discovered, it is then that the

caregiver selects different mechanisms and ultimately apply the one that is effective to them.

4.4 Summary of the findings.

In closure, this chapter presented findings obtained from the structured one-on-one interviews that were conducted with twenty caregivers of people living with HIV and AIDS. Arising from these interviews, the researcher identified themes that elaborated the findings and relate to the research question asked. A critical reference was made to Chapter 2 to substantiate and support some of the findings discussed under themes.

The main findings of the study in relation to the themes developed by the researcher suggests the following: -

Caregivers are not fully knowledgeable about HIV and AIDS pandemic as a whole. All twenty participants gave different versions of what they have about the pandemic which the researcher covered in Chapter 2 of this study. They never touched on what the abbreviations stand for, which is what the researcher initially expected. They never mentioned ways to prevent contracting the virus and the misconceptions that the society hold about the pandemic. Some participants have never received any training about HIV and AIDS, which pose a risk for themselves and their patients.

Most participants admitted that working with people living with HIV and AIDS is very fun. This statement does not overlook the reality that they face multiple challenges which may sometimes be complex. Working with people living with HIV and AIDS teaches them a lot and it is easy for them to differentiate between the truth and misconceptions about the pandemic.

Just as stated in Chapter 2, and just as Homan, Searle, Esu-Williams, Aguirre, Mafata, Meidany (as cited by Njau, Kariuku & Wambu, 2015:72) some challenges identified

range from high levels of stress, anxiety, and financial burden, and can be draining physically, psychologically and emotionally, as well as socially. These are indeed challenges that caregivers face. However, the dominant challenges that the researcher identified include interaction challenges, social challenges, mainly stigma and discrimination and emotional challenges.

The researcher learnt that a few caring facilities organize debriefing sessions for the caregivers. It is only one facility which holds monthly debriefing sessions and the others get it once a year. Other caregivers do not receive any debriefing sessions at all. As a result, they have adopted strategies which help them to relieve the pressure of their work. They exercise, rest, pray and go to church, as well as displacing their frustration which is wrong.

Overall, the researcher learnt a lot about the different working environments that caregivers work in. Caregivers are very passionate, warm-hearted and patient with their patients. They cannot help everybody in the world, but they feel happy, fulfilled and confident that they have changed somebody's life or helped someone bedridden to get up, regain their strength and look at their HIV status in a different perspective.

4.5 Conclusion

This chapter presented and deliberated the findings of this study. It provided brief information about the demographic information of the participants. The findings highlighted themes that emerged from the findings of the study and ultimately the different coping mechanisms that the caregivers apply in the context of the challenges they face in caring for people living with HIV and AIDS.

From the findings of this study, the following deductions can be made:

Training for caregiving and HIV and AIDS is a dire need for caregivers as the researcher picked that most of them merely use their own experience, knowledge and understanding in caring for people living with HIV and AIDS. This can be risky in some cases because depending merely on their own judgment can pose dangers to themselves and their patients. Caregivers need to be precise about what action they take in caring for their patients. For instance, caregivers need to be equipped with knowledge about the kind of diet that is advisable for people living with HIV and AIDS. Some caregivers may think their patients can have any food to take their treatment, when in fact, not every food variety is healthy and beneficial for people living with HIV and AIDS.

It is clear that some participants live in communities where people still believe that living with HIV is a death penalty. From the caregiver's responses, the researcher has established that they have grown in their occupation and understand people's different characters, they continue being indirect caregivers to even the community members who discriminate against them. Caregivers use polite and strategic responses to lure and motivate them to take their treatment accordingly in order to see its effectiveness.

CHAPTER 5

5. CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter seeks to draw the overall conclusions on the topic under study and to make general recommendations and those specific to stakeholders and researchers. Further conclusions are made in relation to the knowledge, experience and data gathered and examined in all chapters. This chapter makes an estimation of whether the aims and objectives of the study were met or not. It also seeks to re-assess the research question in the light of the findings presented in both the literature review and Chapter 4. The importance of this is emphasised in Motswasele (2015: 75) who suggests that the end research report should answer all the research questions of the study.

5.2 Re-statement of the study objectives

This study had two major objectives at the onset which were set to:

- Explore the overall challenges that caregivers of people living with HIV and AIDS face.
- Identify and explore the coping mechanisms that caregivers utilize in dealing with people living with HIV and AIDS.

5.3 Research findings as per objective of the study

Under this sub- heading, the researcher provides an explanation of how the objectives of the study were achieved. Reference is made to the findings and the literature that was reviewed in Chapter 2 of this study.

5.3.1 To explore the overall challenges that caregivers of people living with HIV and AIDS face.

This objective has been achieved. Caregivers do face multiple challenges when caring for people living with HIV and AIDS. The findings of the study revealed that there are three dominant challenges that caregivers of people living with HIV and healthcare facilities experienced. The first challenges relate to interaction and anxiety. Although the interaction is a finding of this study, there is no literature to support this finding, the researcher assumes that it is a point that many researchers tend to ignore. Within the work schedule of all participants of this study, they have a responsibility of conducting home visits, which they refer to as being in the field. Caregivers approach and encounter multiple characters of people living with HIV and AIDS. Some patients do not give an ear to what the caregivers propose and some chase them away in contrast to some who are very welcoming and kind. This often leads caregivers to be anxious about the type of treatment they are likely to get from their other patients.

Just as it was explained in Chapter 2 of this study, stigma and discrimination is still very rife. For caregivers to be focused on HIV and AIDS alone and not most other diseases, the community members question their commitment. The stigma and discrimination are also a result of perceptions the community have of people living with the HIV. This also makes the researcher wonder if communities are knowledgeable about the pandemic and whether they still think living with the pandemic is a death sentence. The last challenge that the study found is on the emotional wellbeing of caregivers. The different situations that caregivers come across subject caregivers to emotional strain. They come across people on the verge of death and looking at them makes one uneasy about the hard facts of this inevitable end. When their patients lack food, this reality makes them lose hope.

Although the findings of this study do not fully tally with some of the literature review in Chapter 2 of this study, the challenges that were established are unique and different from those that other researchers found in different areas across the world.

5.3.2 To explore the coping mechanisms that caregivers utilize in dealing with people living with HIV and AIDS.

The objective has been achieved as the researcher has learnt that there are a number of coping strategies used by caregivers. Although debriefing is the only professional coping mechanism that caregivers depend on, some never get to be debriefed while others get it once in a blue moon. Caregivers have adopted other unprofessional strategies to deal with the challenges they face, amongst them exercising, resting, praying and going to church, as well as sharing with their colleagues. It was ascertained that caregivers displace their anger and frustrations in people close to them to feel unburdened.

The caregivers believe that sharing their problems with their colleagues and God can help them relieve stress in their work. Some caregivers find comfort in praying, resting to wake up feeling better, relaxed and as if they had never come across a stressful situation and even displacement of frustration and anger to people close to them when they encounter a difficult situation at the field.

According to Mabusela (2010:89), one way that caregivers deal with the pressure of their work is by consulting with their senior staff members. At times, caregivers face problems with the patients that they cannot solve on their own, as a result they refer them to their seniors. This happens when the condition of the patient deteriorates such as, when the patient experiences severe pain and life-threatening symptoms such as chest pains, difficult breathing, coughing, diarrhoea, nausea and vomiting. The ability to solve problems through consultation and referral is associated with positive experiences on the part of the HBCG (Makoe & Jubber as cited by Mabusela, 2010: 89).

Mabusela (2010: 30) further observes that caregivers have informal support groups, where they resort to sharing their fears, anxieties and most work-related challenges with fellow caregivers. Even though sometimes they know that nothing can be done by their fellow caregivers, sharing provides them with some comfort and solace that

makes them feel that they are not alone and they get advice because some of them come across similar situations and all know that confidentiality is respected. There is usually no formal time set aside for such sharing of experiences; it happens informally and spontaneously.

Mabusela (2010: 92) also emphasises the point of spirituality. He mentions that some of the research participants believe in God and prayer to cope with their work. They believe that through God anything is possible. They pray as a group every morning when they get to work before they start with their daily routine, and other research participants mentioned that they do it on their own as this chore is part of their spirituality.

5.4 Recommendations of the study

- Since most caregivers who were interviewed in the study do not have professional skills, or rather have never received training in Caregiving and HIV and AIDS, it is recommended that they should be offered training in caregiving before they can start working at different caring facilities. This is likely to add to the basic knowledge that caregivers have about caregiving and the pandemic and to avoid risks encountered in caring for people living with HIV and AIDS using their knowledge and judgment.
- More male volunteers should be recruited as caregivers to promote diversity and gender balance in the caring facilities.
- Debriefing sessions for caregivers should be conducted on a monthly basis so that they can offload the stress and pressure they get from caring for people living with HIV and AIDS.
- The caregivers who do not have Matric should be provided with financial assistance to complete their Matric. This could enable them to apply for advanced courses linked to caregiving and HIV and AIDS.
- The Departments of Health and Department of Social Development should provide the caregivers with transport to conduct home visits as planned. This is due to the

reality that the weather conditions are sometimes unfavourable to conduct the home visits and it disadvantages the caring facilities. Inability to conduct home visits is a low point to the centre and conducting the home visits in bad weather may pose health risks to the caregivers such as flu if they get caught in the rain, headache from walking in the sun and fatigue from walking long distances from house to house.

5.5 Recommendations for future research

This study has confirmed that there are so many caregivers in Mafikeng. Some that were excluded from this study focus on other diseases such as people living with different disabilities and other centres that focus on children and the youth.

- The researcher recommends that subsequent researchers conduct a quantitative study that focuses on other caregivers concentrating on these other different areas so that statistical and numeric data can be gathered. The statistics would indicate how many caregivers do not have qualifications in caregiving in Mafikeng so that training is recommended so that the different Departments sponsor them.
- One other thing that other researchers could look into is the factors that lead one into being a caregiver because this study established that the caregivers do not get enough money. They volunteer at their facilities and their stipends are not enough to meet all their basic needs and those of their children.

5.6 Contribution

This study contributes towards a holistic understanding of caregiving. As an outcome, this study is helpful to the entire society in understanding the concept of caregiving and makes society ultimately change their perceptions about it. Service providers could utilize the findings of this study to identify and close loopholes in the recruitment of caregivers. This study makes a positive impact towards social science body of knowledge and research field.

5.7 Conclusion

The findings of this study discovered that caregivers do face a lot of challenges when working with people living with HIV and AIDS. The three main challenges that were identified by the researcher are interaction, social and emotional challenges. Experiences of caregivers are different. Some caregivers find their job very interesting and some feel the pressure most of the time. Putting themselves in the shoes of the people living HIV and AIDS makes them wonder how they would feel if they were in that positive status. A few caregivers do get professional help such as debriefing from the Social Workers and other superiors but the researcher is convinced this is not enough as they deal with challenges daily, weekly and monthly but some never get debriefing at all. With the acknowledgement that their work is stressful and demanding, the caregivers do not only rely on their facilities to organize professional help that each one of has developed and adopted different strategies that work effectively for them to carry out their work with the utmost enthusiasm and confidence.

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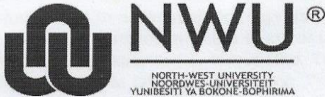
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APPENDICES

APPENDIX A: Approval letter to conduct research from North-West University Health Ethics Committee (HREC)

 **NWU**
NORTH-WEST UNIVERSITY
NOORDWES-UNIVERSITEIT
YUNIBESITHI YA BOKONE-BOPHIRIMA

Private Bag X6001, Potchefstroom
South Africa 2520
Tel: 018 299-1111/2222
Web: <http://www.nwu.ac.za>
**Health Sciences Ethics Office for Research,
Training and Support**
Health Research Ethics Committee (HREC)
Tel: 018-285 2281
Email: Wayne.Towers@nwu.ac.za

Prof NH Ntombela
Social Work
COMPRES

23 August 2018

Dear Prof Ntombela

**APPROVAL OF YOUR APPLICATION BY THE HEALTH RESEARCH
ETHICS COMMITTEE (HREC) OF THE FACULTY OF HEALTH SCIENCES**

Ethics number: NWU-00024-18-S1

Kindly use the ethics reference number provided above in all future correspondence or documents submitted to the administrative assistant of the Health Research Ethics Committee (HREC) secretariat.

Study title: Challenges and coping mechanisms of caregivers of people living with HIV and AIDS in care facilities in Mahikeng

Study leader: Prof NH Ntombela

Student: T Macinga-24291250

Application type: Single study

Risk level: Medium (monitoring report required six-monthly)

Expiry date: 31 August 2019 (monitoring report due the end of February and August annually until completion)

You are kindly informed that after review by the HREC, Faculty of Health Sciences, North-West University, your ethics approval application has been successful and was determined to fulfil all requirements for approval. Your study is approved for a year and may commence from 23/08/2018. It, however, requires the following further conditions specific to *the progress* of the study:

- Please provide the HREC with a copy of the permission letters from managers of relevant care centres, indicating access to the required individuals and facilities.
- If any changes are made to the interview schedule after review by the expert and the participants, it is requested that the researchers please submit it to the HREC for review and approval, before it is implemented in the study.

As the study progresses the aforementioned conditions should be submitted to Ethics-HRECProcess@nwu.ac.za with a cover letter with a specific subject title indicating "Outstanding documents for approval: NWU-XXXX-XX-XX." The letter should include the title of the approved study, the names of the researchers involved, that the documents are being submitted as part of the conditions of the approval set by the HREC, the nature of the document i.e. which condition is being fulfilled and any further explanation to clarify the submission.

The *e-mail*, to which you attach the documents that you send, should have a *specific subject line* indicating the nature of the submission e.g. "Outstanding documents for approval: NWU-XXXX-XX-XX". The e-mail should indicate the nature of the document being sent. This submission will be handled via the expedited process.

Continuation of the study is dependent on receipt of the annual (or as otherwise stipulated) monitoring report and the concomitant issuing of a letter of continuation. A monitoring report should be submitted two months

1

prior to the reporting dates as indicated i.e. annually for minimal risk studies, six-monthly for medium risk studies and three-monthly for high risk studies, to ensure timely renewal of the study. A final report must be provided at completion of the study or the HREC, Faculty of Health Sciences must be notified if the study is temporarily suspended or terminated. The monitoring report template is obtainable from the Faculty of Health Sciences Ethics Office for Research, Training and Support at Ethics-HRECMonitoring@nwu.ac.za. Annually, a number of studies may be randomly selected for an internal audit.

The HREC, Faculty of Health Sciences requires immediate reporting of any aspects that warrants a change of ethical approval. Any amendments, extensions or other modifications to the proposal or other associated documentation must be submitted to the HREC, Faculty of Health Sciences prior to implementing these changes. These requests should be submitted to Ethics-HRECApply@nwu.ac.za with a cover letter with a specific subject title indicating, "Amendment request: NWU-XXXXX-XX-XX". The letter should include the title of the approved study, the names of the researchers involved, the nature of the amendment/s being made (indicating what changes have been made as well as where they have been made), which documents have been attached and any further explanation to clarify the amendment request being submitted. The amendments made should be indicated in **yellow highlight** in the amended documents. The *e-mail*, to which you attach the documents that you send, should have a *specific subject line* indicating that it is an amendment request e.g. "Amendment request: NWU-XXXXX-XX-XX". This e-mail should indicate the nature of the amendment. This submission will be handled via the expedited process.

Any adverse/unexpected/unforeseen events or incidents must be reported on either an adverse event report form or incident report form to Ethics-HRECIncident-SAE@nwu.ac.za. The *e-mail*, to which you attach the documents that you send, should have a specific subject line indicating that it is a notification of a serious adverse event or incident in a specific project e.g. "SAE/Incident notification: NWU-XXXXX-XX-XX". Please note that the HREC, Faculty of Health Sciences has the prerogative and authority to ask further questions, seek additional information, require further modification or monitor the conduct of your research or the informed consent process.

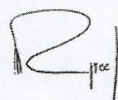
The HREC, Faculty of Health Sciences complies with the South African National Health Act 61 (2003), the Regulations on Research with Human Participants (2014), the Ethics in Health Research: Principles, Structures and Processes (2015), the Belmont Report and the Declaration of Helsinki (2013).

We wish you the best as you conduct your research. If you have any questions or need further assistance, please contact the Faculty of Health Sciences Ethics Office for Research, Training and Support at Ethics-HRECApply@nwu.ac.za.

Yours sincerely



Prof Wayne Towers
HREC Chairperson



Prof Minrie Greeff
Ethics Office Head

APPENDIX B: Permission letters to conduct research from Department of Social Development

	social development Department: Social Development North West Provincial Government REPUBLIC OF SOUTH AFRICA	
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CHIEF DIRECTORATE: CORPORATE SERVICES
Private Bag X 6 • Mmabatho, 2735 • Provident House Building, University Drive • MMABATHO
Tel: +27 (18) 388 – 2989/2293 • Fax: +27 (18) 384 – 5967 • E-mail: mmotshedi@nwpg.gov.za

Enq: Dr. Motshedi, 082 474 9189

TO	: MS. PD. MOTHOBİ HEAD OF DEPARTMENT	
FROM	: MR. O.E. KOLE ACTING CHIEF DIRECTOR: CORPORATE SERVICES	
DATE	: 09 APRIL 2018	
SUBJECT	: PERMISSION TO CONDUCT RESEARCH WITHIN THE DEPARTMENT IN RESPECT OF MS. TSHOLOFEL0 MACİNGA - A MASTER'S DEGREE CANDIDATE AT THE NORTH WEST UNIVERSITY – MAFİKENG CAMPUS	

PURPOSE

The submission serves to request the Head of Department to grant approval for Ms Tsholofelo Macinga to conduct research in the Department for personal academic development purposes. Ms Tsholofelo Macinga, is a Candidate for Master's Degree in Social Work at the North West University, Mafikeng Campus.

BACKGROUND

The office of the Acting Chief Director Corporate Services received a request for permission to undertake research study within the Department. Ms Tsholofelo Macinga, Student Number: 24291250 is a registered Masters student at the North West University- Mafikeng Campus. The study is titled: **"the Challenges and Coping mechanisms of Caregivers of People living with HIV and AIDS at the care facilities in Mahikeng"**.

REQUEST FOR PERMISSION TO CONDUCT RESEARCH: Ms.Tsholofelo Macinga, 2018

The **primary aim** of the qualitative study is to explore challenges that care-givers face and coping mechanisms that they apply when working with people living with HIV and AIDS. The applicant seeks to conduct the study, with care facilities registered and supported by the Department. The following facilities were identified: **Tsibogang Home-based Care Centre; Karabo Home Based Care Centre; Feel at home Disability Centre; Boikagong Child and Youth Care Centre.**

DISCUSSION

The Research Sub: Directorate has vigorously assessed the request of the applicant in ensuring that all the professional research standards are adhered to and satisfied in all respects. It is against that stance that the applicant is urged to consider all ethical considerations during the course of this research project. Failure to comply with these requirements may lead to this permission being rescinded or suspended. Strict measures will also be undertaken to ensure the security of the Departmental classified and confidential information. Once approval by the Head of Department has been granted the research component will further provide technical research support to the researcher during the course of the research.

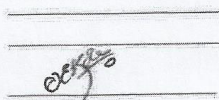
The Departmental Research Policy and other research procedures necessitate that upon completion of the research study, the Researcher or Applicant should share a copy of the research report with the Head of Department.

It is on the basis of the afore-mentioned background that the Research Sub: Directorate recommend that approval be granted to Ms Tsholofelo Macinga to conduct the study as proposed.

RECOMMENDATIONS

It is therefore recommended that the Head of Department approves the request made by the applicant to undertake research study under the auspices of the Department.

RECOMMENDED/~~NOT RECOMMENDED~~



MR. OE. KOLE

09/04/2018

DATE

ACTING CHIEF DIRECTOR: CORPORATE SERVICES

APPROVED/NOT APPROVED

- ① NPOs must be approached independently for permission.
- ② Permission is given to conduct research at Botetong CTCC

Ms. PD. MOTHOB

10/4/2018

DATE

HEAD OF DEPARTMENT

cc. Mr ML Malaka

Mr IK Kgobe

Ms S. Sizji

Ms K. Thebe - Institution Manager.

REQUEST FOR PERMISSION TO CONDUCT RESEARCH: Ms. Tsholofelo Macinga, 2018

PAGE 3

APPENDIX C: Permission letter to conduct the study from healthcare facilities.

13 APRIL 2018



NORTH-WEST UNIVERSITY
YUNIBESITHI YA BOKONE-BOPHIRIMA
NOORDWES-UNIVERSITEIT
MAFIKENG CAMPUS

TO: Ms MOKONE

CENTRE MANAGER (ISIBINDI CHILD AND YOUTH CARE CENTRE)

SUBJECT: PERMISSION TO CONDUCT THE STUDY AT THE CENTRE

Dear Ms Mokone

This letter is hereby compiled by a Masters Student from the University of North West (Mahikeng Campus): Tsholofelo Macinga to request for your goodwill permission to conduct the study at your facility.

The title of the study is, "Challenges and coping mechanisms of caregivers of people living with HIV and AIDS in care facilities in Mahikeng. The Centre has been chosen together with the other four facilities due to having caregivers, or rather volunteers who on a daily basis work with people living with HIV and AIDS. The intention is not to know anything about the people living with the pandemic, but rather to interview the caregivers about the challenges, experiences and coping mechanisms they apply when working with such people. The student researcher will provide all the information regarding this study in a personal contact.

Your permission will be highly appreciated as it will facilitate the process of goal achievement.

Yours truly

Tsholofelo Macinga

Tsholofelo Macinga

Masters Student at NWU (Mahikeng Campus)

073 623 4072

Approved by:

M.V. Mokone

Initials and Surname

PROJECT MANAGER

Designation

08.05.2018

Date

13 APRIL 2018



NORTH-WEST UNIVERSITY
YUNIBESITHI YA BOKONE-BOPHIRIMA
NOORDWES-UNIVERSITEIT
MAFIKENG CAMPUS

TO: Ms SEBOKOLODI

CENTRE MANAGER (KARABO HOME-BASED CARE CENTRE)

SUBJECT: PERMISSION TO CONDUCT THE STUDY AT THE CENTRE

Dear Ms Sebokolodi

This letter is hereby compiled by a Masters Student from the University of North West (Mahikeng Campus): Tsholofelo Macinga to request for your goodwill permission to conduct the study at your facility.

The title of the study is, "Challenges and coping mechanisms of caregivers of people living with HIV and AIDS in care facilities in Mahikeng. The Centre has been chosen together with the other four facilities due to having caregivers, or rather volunteers who on a daily basis work with people living with HIV and AIDS. The intention is not to know anything about the people living with the pandemic, but rather to interview the caregivers about the challenges, experiences and coping mechanisms they apply when working with such people. The student researcher will provide all the information regarding this study in a personal contact.

Your permission will be highly appreciated as it will facilitate the process of goal achievement.

Yours truly

Tsholofelo Macinga

Tsholofelo Macinga

Masters Student at NWU (Mahikeng Campus)

073 623 4072

Approved by:

Sebokolodi

Initials and Surname

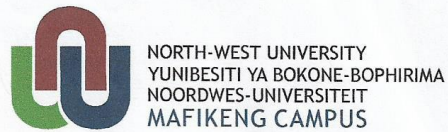
Manager

Designation

14/05/2018

Date

13 APRIL 2018



TO: MMAJA MOTJALE

EXECUTIVE DIRECTOR (LIFELINE MAFIKENG)

SUBJECT: PERMISSION TO CONDUCT THE STUDY AT THE CENTRE

Dear Mmaja

This letter is hereby compiled by a Masters Student from the University of North West (Mahikeng Campus): Tsholofelo Macinga to request for your goodwill permission to conduct the study at your facility.

The title of the study is, "Challenges and coping mechanisms of caregivers of people living with HIV and AIDS in care facilities in Mahikeng. The Centre has been chosen together with the other four facilities due to having caregivers, or rather volunteers who on a daily basis work with people living with HIV and AIDS. The intention is not to know anything about the people living with the pandemic, but rather to interview the caregivers about the challenges, experiences and coping mechanisms they apply when working with such people. The student researcher will provide all the information regarding this study in a personal contact.

Your permission will be highly appreciated as it will facilitate the process of goal achievement.

Yours truly

Tsholofelo Macinga

Masters Student at NWU (Mahikeng Campus)

073 623 4072

Approved by:

Initials and Surname

Designation

Date

13 APRIL 2018



NORTH-WEST UNIVERSITY
YUNIBESITHI YA BOKONE-BOPHIRIMA
NOORDWES-UNIVERSITEIT
MAFIKENG CAMPUS

TO: KEFILWE MOENG

CENTRE MANAGER (LOMANYANENG CARE CENTRE)

SUBJECT: PERMISSION TO CONDUCT THE STUDY AT THE CENTRE

Dear Kefilwe

This letter is hereby compiled by a Masters Student from the University of North West (Mahikeng Campus): Tsholofelo Macinga to request for your goodwill permission to conduct the study at your facility.

The title of the study is, "Challenges and coping mechanisms of caregivers of people living with HIV and AIDS in care facilities in Mahikeng. The Centre has been chosen together with the other four facilities due to having caregivers, or rather volunteers who on a daily basis work with people living with HIV and AIDS. The intention is not to know anything about the people living with the pandemic, but rather to interview the caregivers about the challenges, experiences and coping mechanisms they apply when working with such people. The student researcher will provide all the information regarding this study in a personal contact.

Your permission will be highly appreciated as it will facilitate the process of goal achievement.

Yours truly

Tsholofelo Macinga

Tsholofelo Macinga

Masters Student at NWU (Mahikeng Campus)

073 623 4072

Approved by:

B.m. Moshwaele

Initials and Surname

Supervisor

Designation

10.05.2018

Date

13 APRIL 2018



NORTH-WEST UNIVERSITY
YUNIBESITHI YA BOKONE-BOPHIRIMA
NOORDWES-UNIVERSITEIT
MAFIKENG CAMPUS

TO: CENTRE MANAGER (TSIBOGANG CARE CENTRE)

SUBJECT: PERMISSION TO CONDUCT THE STUDY AT THE CENTRE

Dear Sir/Madam

This letter is hereby compiled by a Masters Student from the University of North West (Mahikeng Campus): Tsholofelo Macinga to request for your goodwill permission to conduct the study at your facility.

The title of the study is, "Challenges and coping mechanisms of caregivers of people living with HIV and AIDS in care facilities in Mahikeng. The Centre has been chosen together with the other four facilities due to having caregivers, or rather volunteers who on a daily basis work with people living with HIV and AIDS. The intention is not to know anything about the people living with the pandemic, but rather to interview the caregivers about the challenges, experiences and coping mechanisms they apply when working with such people. The student researcher will provide all the information regarding this study in a personal contact.

Your permission will be highly appreciated as it will facilitate the process of goal achievement.

Yours truly

A handwritten signature in cursive script, appearing to read 'Tsholofelo Macinga', written over a dotted line.

Tsholofelo Macinga

Masters Student at NWU (Mahikeng Campus)

073 623 4072

Approved by:

A handwritten signature in cursive script, appearing to read 'I.R. Moepi', written over a dotted line.

Initials and Surname

A handwritten signature in cursive script, appearing to read 'Lomanyane', written over a dotted line.

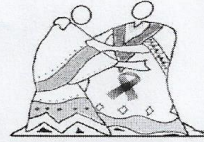
Designation

A handwritten date '10-05-2018' written over a dotted line.

Date

Tsibogang Christian Action Group

Coordinator: Dr. Wolfgang Oratile Hermann
P.O. 3574, Mmabatho 2735| South Africa| Phone: 018-0112823
Cell: 083-7161274 | e-mail: tsibogang@truenw.co.za
Registration Number: 023-524-NPO



Mahikeng, 2018-09-10

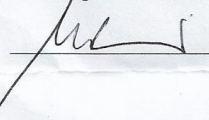
Dear Ms/ Mr Macinga

Your letter has been received and studied by the Management committee of Tsibogang Christian Action Group in its last sitting held on 20.08.2018. The management agreed that you can go ahead and include participants from our organization in your research, provided they consent.

You are welcome to do the interviews as stipulated in your application. We only request that you also feed-back your results to our organization as a matter of courtesy and that we also keep abreast with latest developments.

Your contact partner for this matter will be Ms Kesentseng Nanyane. Kindly contact her through our office for any further matters relating to this research.

Kind regards

 U. Rauter, Secretary

APPENDIX D: Informed consent document



NORTH-WEST UNIVERSITY
YUNIBESITHI YA BOKONE-BOPHIRIMA
NOORDWES-UNIVERSITEIT
MAFIKENG CAMPUS

Health Research Ethics Committee
Faculty of Health Sciences
NORTH-WEST University
(Potchefstroom Campus)

2018 -08- 29

HREC Stamp

INFORMED CONSENT DOCUMENTATION FOR CAREGIVERS OF PEOPLE LIVING WITH HIV AND AIDS IN CARE FACILITIES IN MAHIKENG.

TITLE OF THE RESEARCH STUDY: Challenges and coping mechanisms of caregivers of people living with HIV and AIDS at care facilities in Mahikeng.

ETHICS REFERENCE NUMBERS: NWU-00024-18-S1

PRINCIPAL INVESTIGATOR: Professor Ngenisiwe Henrietta Ntombela

POST GRADUATE STUDENT: Tsholofelo Macinga

ADDRESS: 1261 Mokale Street, Unit 7, Mmabatho, 2735

CONTACT NUMBER: 073 623 4072

You are being invited to take part in a **research study** that forms part of the qualitative research. Please take some time to read the information presented here, which will explain the details of this study. Please ask the researcher or person explaining the research to you any questions about any part of this study that you do not fully understand. It is very important that you are fully satisfied and that you clearly

understand what this research is about and how you might be involved. Also, your participation is **entirely voluntary** and you are free to say no to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part now.

This study has been approved by the **Health Research Ethics Committee of the Faculty of Health Sciences of the North-West University (NWU-00024-18-S1)** and will be conducted according to the ethical guidelines and principles of Ethics in Health Research: Principles, Processes and Structures (DoH, 2015) and other international ethical guidelines applicable to this study. It might be necessary for the research ethics committee members or other relevant people to inspect the research records.

What is this research study all about?

- *This researcher is about exploring the challenges and coping mechanisms of caregivers of people living with HIV and AIDS in care facilities in Mahikeng.*
- *There will be no other experienced researchers included in the study because the researcher has been trained to conduct effective interviews throughout the years obtaining her Bachelor's Degree in Social Work*
- *We plan to explore the challenges you face in your care facility when giving care to people living with HIV and AIDS and the coping mechanisms you apply to deal with those challenges.*

Why have you been invited to participate?

- *You have been invited to be part of this research because you are a caregiver of people living with HIV and AIDS in your care facility, you are over the age of 18 years, have more than three months of service in your care facility and are of any gender, racial affiliation and ethnicity.*
- *You also fit the research because you are not just any caregiver, but that of people living with HIV and AIDS, which is a specification of this study.*

- *You will not be able to take part in this research if you are a caregiver at any other care facilities not forming part of the study and if you are a caregiver at that centre, but not caring for people living with HIV and AIDS*

What will be expected of you?

- *You will be expected to answer 7 demographic questions which gives an insight into your background and 5 questions related to the study. The questions are as follows:*

CATEGORY 1: SOCIO- DEMOGRAPHIC INFORMATION

- (a) Age:
- (b) Gender:
- (c) No. of dependents:
- (d) Area of residence:
- (e) Marital status:
- (f) Highest Qualification obtained:
- (g) Training for Caregiving: (I)
(ii)

CATEGORY 2: CHALLENGES AND EXPERIENCES

- (a) What do you know about HIV and AIDS?
- (b) What challenges have you faced ever since you started caring for people living with HIV and AIDS (emotionally, physically, socially, psychologically and otherwise)?
- (c) What is your experience in caring for people living with HIV and AIDS?
- (d) What do you understand by coping?
- (e) What coping mechanisms do you often apply when dealing with the difficulties arising from being a caregiver?

- *The interview is expected to take an estimation of 45 minutes, however, the period of time will strictly be determined by the need to talk of the questions and the dialogue if there will be any. The interview will be a once off session.*
- *This study will be conducted either under a tree or in an unused room in your care facility in Mahikeng and will involve semi-structured interviews where an interview schedule will serve as a guide to the questions directed to you.*

Will you gain anything from taking part in this research?

- *There will be no gain when you participate in the study.*
- *The other gains of the study are for subsequent researchers who will acquire knowledge of challenges and coping mechanisms that caregivers face and apply in their daily lives.*

Are there risks involved in you taking part in this research and what will be done to prevent them?

- *Due to the nature of the interview being semi-structured, the interview will take approximately 45 minutes and be conducted in the morning. The following table is a possible risk that you may experience and the measures that will be taken to take care of the risk.*

Risks	Precautionary Measure
• Emotional Risk The caregivers of people living with HIV and AIDS may be badly affected by the state of their care-receivers and may carry emotional wounds of some of their patients who have no hope of getting better from the disease. Interviewing them about matters relating to their work may remind them of their painful experiences and ultimately breakdown.	• Pre and Post- Counselling session. The researcher has made an arrangement with the Clinical psychologist to provide pre and post-counselling session to the caregivers who initially feel the need for counselling and those who will breakdown as a result of the interview.

How will we protect your confidentiality and who will see your findings?

- *Anonymity of your findings will be protected by using Pseudonyms where participants will be named as, "interviewee 1, Interviewee 2 ..." instead of their real name. Your privacy will be respected by conducting the interview in a place such as under the tree and at an unused room where nobody goes to. Your results will be kept confidential by being locked in a cabinet with nobody except the researcher having access to. Only the researcher will be able to look at your findings. Electronic data it will be password protected.*

The other ways the researcher will ensure confidentiality is as follows:

- *The researcher will never talk about the interview process to the caregivers themselves in public places and will also avoid being tempted to share the details of the interview with a friend, family member or partner.*
- *The researcher will not talk to the participants on the phone, especially if there is somebody in the same environment who can either get ideas of what the*

- *(As soon as data has been transcribed it will be deleted from the recorders.) Data will be stored for 5 years.*

What will happen with the findings or samples?

- *The findings of this study will only be used for this study and the findings will be captured in Chapter 4 of the research study.*

How will you know about the results of this research?

- We will give you the results of this research when the study has been completed and the researcher will come in person to the care facility to give feedback. There will be a concise presentation about what themes were explored from the data and how it answers the research questions.
- You will be informed of any new relevant findings by coming to the care facility or giving the information telephonically.

Will you be paid to take part in this study and are there any costs for you?

- This study is funded by the Masters Bursary from North West University, however, the money only covers the Module.
- You will not be paid to take part in the study because the researcher does not have a funding to cover that.
- Travel expenses will only be for the researcher as she will be the one travelling.
- Refreshments/a meal will be served during the interview.
- There will thus be no costs involved for you, if you do take part in this study.

Is there anything else that you should know or do?

- You can contact Tsholofelo Macinga at 073 6234 072 if you have any further questions or have any problems or need clarity.
- You can also contact the Health Research Ethics Committee via Mrs Carolien van Zyl at 018 299 1206 or carolien.vanzyl@nwu.ac.za if you have any concerns that

were not answered about the research or if you have complaints about the research.

- You will receive a copy of this information and consent form for your own purposes.

Declaration by participant

By signing below, I agree to take part in the research study titled: Challenges and coping mechanisms of caregivers of people living with HIV and AIDS at care facilities in Mahikeng.

I declare that:

- I have read this information/it was explained to me by a trusted person in a language with which I am fluent and comfortable.
- The research was clearly explained to me.
- I have had a chance to ask questions to both the person getting the consent from me, as well as the researcher and all my questions have been answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.
- I may choose to leave the study at any time and will not be handled in a negative way if I do so.
- I may be asked to leave the study before it has finished, if the researcher feels it is in the best interest, or if I do not follow the study plan, as agreed to.

Signed at (place) on (date)
20....

.....
Signature of participant

.....
Signature of witness

Declaration by person obtaining consent

I (name) declare that:

- I clearly and in detail explained the information in this document to
- I did/did not use an interpreter.
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above
- I gave him/her time to discuss it with others if he/she wished to do so.

Signed at (place) on (date)
20....

.....
Signature of person obtaining consent

.....
Signature of witness

Declaration by researcher

I (name) declare that:

- I explained the information in this document to
- I did/did not use an interpreter
- I encouraged him/her to ask questions and took adequate time to answer them
- The informed consent was obtained by an independent person.
- I am satisfied that he/she adequately understands all aspects of the research, as described above.
- I am satisfied that he/she had time to discuss it with others if he/she wished to do so.

Signed at (place) on (date)
20....

.....
Signature of researcher

.....
Signature of witness

APPENDIX E: Interview schedule

INTERVIEW SCHEDULE

NORTH WEST UNIVERSITY (MAHIKENG CAMPUS)

Participant:

CATEGORY 1: SOCIO- DEMOGRAPHIC INFORMATION

- (a) Age:
- (b) Gender:
- (c) No. of dependents:
- (d) Area of residence:
- (e) Marital status:
- (f) Highest Qualification obtained:
- (g) Training for Caregiving: (I)
(ii)

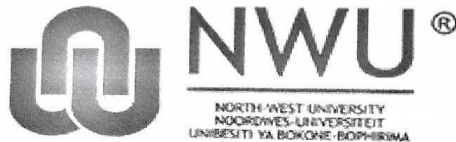
CATEGORY 2: CHALLENGES AND EXPERIENCES

- (a) What do you know about HIV and AIDS?
- (b) What challenges have you faced ever since you started caring for people living with HIV and AIDS (emotionally, physically, socially, psychologically and otherwise)?
- (c) What is your experience in caring for people living with HIV and AIDS?
- (d) What do you understand by coping?
- (e) What coping mechanisms do you often apply when dealing with the difficulties arising from being a caregiver?

Thank you for your cooperation and participation. God bless you.

Date:

APPENDIX F: Certificate of Editing



Office: 0183892451

FACULTY OF EDUCATION

Cell: 0729116600

Date: 12th December, 2018

TO WHOM IT MAY CONCERN

CERTIFICATE OF EDITING

I, Muchativugwa Liberty Hove, confirm and certify that I have read and edited the entire dissertation **CHALLENGES AND COPING MECHANISMS OF CAREGIVERS TO PEOPLE LIVING WITH HIV AND AIDS IN CARE FACILITIES IN MAHIKENG** by **TSHOLOFELO MACINGA**, Student Number: 24291250, submitted in the fulfilment of the requirements for the degree **Master of Social Work** at the North-West University.

Tsholofelo Macinga was supervised by Professor Ngenisiwe Henrietta Ntombela of the North-West University.

I hold a PhD in English Language and Literature in English and am qualified to edit such a thesis for cohesion and coherence. The views expressed herein, however, remain those of the researcher/s.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Liberty Hove', is written over a horizontal line.

Dr M.L.Hove (PhD, MA, PGDE, PGCE, BA Honours – English)

