A DESCRIPTION OF SUPPORT SERVICES AVAILABLE FOR NURSES WHO CARE FOR PATIENTS WITH HIV/AIDS IN PRETORIA URBAN PUBLIC HOSPITALS

by

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DECLARATION

I declare that A DESCRIPTION OF SUPPORT SERVICES AVAILABLE FOR NURSES WHO CARE FOR PATIENTS WITH HIV/AIDS IN PRETORIA URBAN PUBLIC HOSPITALS is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.

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A DESCRIPTION OF SUPPORT SERVICES AVAILABLE FOR NURSES WHO CARE FOR PATIENTS WITH HIV/AIDS IN PRETORIA URBAN PUBLIC HOSPITALS

KEY CONCEPTS

The following key concepts were used for this study:
* Availability
* Care/caring
* HIV/AIDS patients
* Nurses
* Pretoria urban public hospitals
* Support
A DESCRIPTION OF SUPPORT SERVICES AVAILABLE FOR NURSES WHO CARE FOR PATIENTS WITH HIV/AIDS IN PRETORIA URBAN PUBLIC HOSPITALS

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ABSTRACT

The purpose of the study was to describe the support services available for nurses who care for patients with human immunodeficiency virus / acquired immune-deficiency syndrome (HIV/AIDS) in Pretoria urban public hospitals. Problems faced by nurses in HIV/AIDS care support preferences were also investigated.

The study was conducted between March and April 2003, using a descriptive design. Respondents comprised eighty-seven (87) nurses who were conveniently selected from five (5) hospitals.

Results reveal that support available is inadequate in both quality and coverage of nurses. Other significant findings are inadequate job preparation, shortage of nurses and that nurses prefer to receive support from both within and outside the hospital.

It has been recommended that management should work with nurses to design support interventions that match the identified problems/needs. Nurses need to take an active role in caring for themselves and more in-service training opportunities need to be created for nurses.
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List of abbreviations

The following abbreviations were used during this study:

AHRTAG = Appropriate Health Resources and Technologies Action Group
AIDS = Acquired Immune-Deficiency Syndrome
DOH = Department of Health
FHI = Family Health Trust
HIV = Human Immune-deficiency Virus
KCTT = Kara Counseling and Training Trust
MOMS = Multi-center Occupational Morbidity Study
NIOSH = National Institute for Occupational Safety and Health
RSA = Republic of South Africa
SADC = Southern African Development Community
SANC = South African Nursing Council
TASO = The AIDS Support Organisation
UK = United Kingdom
UN = United Nations
UNAIDS = Joint United Nations programme on AIDS
USA = United States of America
WHO = World Health Organization
WPTPSD = White Paper on Transforming Public Service Delivery
CHAPTER 1

BACKGROUND INFORMATION

1.1 Introduction

Support for nurses who provide care to patients with Human Immunodeficiency Virus infection or Acquired Immune Deficiency Syndrome (HIV/AIDS) is a topic which is beginning to receive worldwide attention because of the demanding nature of the job (Bennett, Miller & Ross 1995:4-6; Miller 2000:87; Webber & Zulu 2000:8). Though caring for any terminally ill patient can be emotionally demanding, nurses who care for patients with HIV/AIDS are usually faced with stresses and problems that are not common in other care settings. Examples of such problems according to Palmer (1995:21) and the Joint United Nations Programme on HIV/AIDS (UNAIDS 2000:39) are:

- Stigma associated with AIDS.
- Personal identification with patients’ suffering.
- Fear of infection.
- Lack of confidence in caring for the multiple physical and emotional problems of the patients.
- Negative attitudes and prejudices about patients who may be drug users or have a different sexual orientation.
- Frequent deaths of young people.
- Taboos related to discussing issues of sex and death.

Providing care under such circumstances makes nurses vulnerable to emotional distress and creates the need for support to be able to cope.
1.2 Background information about the research problem

The health department of every country including the Republic of South Africa (RSA) aims at providing a high standard of care and support to patients with HIV/AIDS in order to improve their quality of life (Department of Health (DOH) 2001:4; UNAIDS 2001:13; World Health Organization (WHO) 2000:23). However, the quality of care given to these patients is dependent on the quality of support given to care providers. Stoter (1997:3) states that patients can only receive a high standard of care if the carers themselves feel valued and cared for. The same author gives an example of intensive care unit equipment, which is checked and serviced regularly so that it is reliable and effective in saving lives. He suggests that in the same way, care providers can only render safe and effective patient care if they are valued and cared for (Stoter 1997:3). Employers are under obligation to provide a safe and conducive working environment for employees. In the RSA, the White Paper on Transforming Public Service Delivery (WPTPSD) states that “staff dealing with the public directly should be given the necessary support and tools to carry out their functions effectively and efficiently” (Government Gazette 1997:23). This is in line with the South African Nursing Council (SANC) standards for nursing practice, which states that every nurse has a right to a working environment that is safe and equipped with the minimum physical, material and personnel requirements (SANC[Sa]:13). However, the media and other reports suggest that some nurses, especially in Sub Saharan Africa, may not be working under such conducive and supportive environments. This has been attributed to inadequate resources due to the impact of HIV/AIDS on already overburdened health care services. Many health institutions have been depleted of long serving and skilled nurses as a result of voluntary severance packages, active recruitment of nurses by overseas countries and increased death rate due to HIV/AIDS (Boulle, Blecher & Burn 2000:237; Southern African Development Community (SADC) 2000:19; Unger, Welz & Haran 2001.)
In the RSA the number of people living with HIV/AIDS is expected to rise to 6 million by 2005 (DOH 2000:5). Even if further spread of HIV infection was halted today, the country would still be faced with the burden of caring for the already infected 4.7 million as they progress to AIDS. Since much of the burden of caring for people with AIDS is borne by nurses they need support to be able to fulfill their obligation to patients. Nurses can only be expected to provide care if they are in good health. Health has been defined by WHO as not merely the absence of illness or ill health but also includes the psychological and spiritual well being of an individual (Pera & Van Tonder 1996:204). Therefore a nurse who is emotionally distressed is not in good health and cannot be expected to meet the huge responsibility of caring for HIV/AIDS patients. Furthermore, the long-term effects of stress and burnout on the individual and the organization have been well documented (for example Geyer 2001:21; Miller 2000:16; Stoter 1997:19-22). It would therefore be more cost effective for institutions to prevent stress and burnout among nurses by supporting them than to deal with the effects. However, institutions can only provide appropriate support to nurses if they know the problems being experienced by nurses, sources of those problems and what form of support the nurses prefer. Although much has been written about the existence of stress among nurses who care for patients with HIV/AIDS, no research could be found to describe what support systems are available for nurses in Pretoria’s hospitals.

The above observations coupled with the researcher’s personal experience of caring for people with HIV/AIDS over many years is what aroused the researcher’s desire to carry out this study. The aim of this study was to describe the support available for nurses who care for patients with HIV/AIDS in Pretoria urban hospitals.
1.2.1 Statement of the research problem

The RSA has one of the fastest growing epidemics in the world with about 4.7 million people living with HIV infection (UNAIDS/WHO 2001:16). The majority of people with HIV related infections are among the economically poor who seek treatment at public health institutions. The ability of nurses to cope with provision of quality care to HIV/AIDS patients in public hospitals may be compromised if nurses do not receive the necessary support. Review of literature related to the subject of support for nurses suggests the existence of several factors that may influence the availability of support. These factors may be related to the organisation, nursing management or the individual nurse. These factors will thus form the basis for this study.

1.2.1.1 Organisational factors

Working conditions for public health institutions are influenced by government policies. However each institution is responsible for creating a caring and supportive environment for its staff. This is highlighted by Stoter (1997:94) who states that effectiveness of any staff support system is influenced by the culture of an organization. This author further states that such a system must be built into the organisation’s philosophy (Stoter 1997:66). An institution can create a caring and supportive environment by removing or minimizing stressful situations, for example, (1) ensuring adequate staffing to prevent work overload for nurses, (2) setting clear policy guidelines and work standards, (3) providing opportunities for continuing education, (4) providing adequate equipment and supplies for patient care, (5) arranging counseling services for staff and (6) providing adequate remuneration and accommodation.

If the working conditions are poor and basic necessities for patient care not available, a supportive environment cannot thrive. One of the
objectives of this study was to find out from the nurses what problems they experience while providing care to patients with HIV/AIDS.

1.2.1.2 Management factors

Achievement of a supportive environment appears to be directly related to the knowledge, attitude and skills of nurse managers. Nurse managers can only support their nurses effectively if they have a positive attitude towards support (Stoter 1997:3). Managers need to recognize and appreciate the emotional demands of caring for HIV/AIDS patients and use leadership styles that foster respect for staff and enhance teamwork. Managers who do not have genuine interest in their staff will not know their nurses’ personalities, family backgrounds or levels of experience. Such managers would not be able to offer meaningful support. Where a manager has no time to listen to nurses’ problems or thinks caring for nurses is an extra burden, nurses do not feel valued and are reluctant to share their problems. The lack of interaction would also make it impossible for the manager to monitor and evaluate the appropriateness and effectiveness of any support mechanisms that may be available. Nurse managers should be trustworthy and be able to keep confidences. This may enable even nurses who are HIV positive to disclose their status to them.

Health care settings in the RSA, like many other nations, have nurses from diverse cultural backgrounds. Managers therefore need to have skills in leading a multicultural workforce (Andrews & Boyle 2003:366). If nurse managers, for example, do not recognize the fundamental value systems embraced by their staff, they will not understand the behaviour patterns of staff and will ultimately not be able to offer appropriate support. It is also important for managers to have adequate knowledge of issues related to caring for patients with HIV/AIDS because managers cannot supervise staff whose work they do not understand. This research explored how nurse
managers could contribute to ensuring a supportive work environment for nurses who care for patients with HIV/AIDS.

1.2.1.3 Nurse related factors

Any support strategies made available would be useless unless nurses make use of them. Nurses need to recognize the emotional demands of caring for HIV patients and accept their vulnerability. They need to be aware of their weaknesses and strengths, be able to recognize signs and symptoms of emotional stress and take an active role in maintaining their health (UNAIDS 2001:55). If nurses do not accept their vulnerability or are unable to recognize their need for help, they are not likely to seek help or engage in self-care behaviours. Any service is of no value if the intended users do not know about its existence. Similarly, nurses may not utilize available services if they are ignorant about their availability. Nurses also need to build trusting and supportive relationships amongst themselves so that they can accept and protect one another (Rasmussen, Sandman & Norbeg 1997:335). If nurses cannot work together in harmony or do not have concern for each other, they cannot share problems and responsibilities or support one another.

Cultural values influence how individuals define problems, perceive their needs and expect others to behave (Andrews & Boyle 2003:373). In the context of this research, nurses’ values regarding interpersonal relationships, communication patterns, religion, family obligations, meaning of work and personal traits may influence their perception of support. This research sought to find out from the nurses their personal coping strategies and how they would prefer to be supported.
In light of the above factors, there was a need to investigate the problems experienced by nurses who care for patients with HIV/AIDS and what support systems are in place to help them cope with their work.

1.3 Aim of the research

The aim of this study was to describe the support available for nurses who care for patients with HIV/AIDS in Pretoria urban public hospitals.

1.4 Objectives of the research

1.4.1 General objective

To describe the support available for nurses who care for patients with HIV/AIDS in Pretoria urban public hospitals.

1.4.2 Specific research questions

In order to achieve the above objective, the following specific research questions directed the study:

1.4.2.1 What preparation was given to nurses for HIV/AIDS caregiving roles?

1.4.2.2 What problems did nurses experience while providing care to patients with HIV/AIDS?

1.4.2.3 How did nurses caring for patients with HIV/AIDS perceive their support needs?

1.4.2.4 What were the support systems available for nurses who care for patients with HIV/AIDS?
1.4.2.5 What were the personal coping strategies used by nurses who care for patients with HIV/AIDS?

1.5 Significance of the research

- Previous nursing studies in relation to HIV/AIDS done in the RSA focused mainly on prevention (Health Systems Trust 2001:7). This study focusing on nurses as caregivers will add to the body of knowledge on HIV/AIDS.
- The study will attempt to give nurses an understanding of the role they can play in taking responsibility for their own emotional well being.
- Nurse Managers may also use the results to plan and implement appropriate support systems for nurses who care for patients with HIV/AIDS.
- It is hoped that this study will ultimately help to raise the quality of care rendered to patients with HIV/AIDS.

1.6 Operational definitions used in the research report

For the purpose of this research the following operational definitions were used:

1.6.1 Availability

Availability is defined by the concise Oxford Dictionary (1995: 85) as something that is “capable of being used, at one’s disposal, or obtainable within one’s reach.” For the purpose of this study availability means obtainable within the reach of nurses.
1.6.2 Care/caring

Within the scope of professional nursing, care refers to “those cognitively learned humanistic and scientific modes of helping or enabling an individual, family or community to receive personalized services through specific culturally defined or ascribed modes of processes, techniques and patterns to improve or maintain a favorable health condition for life or death” (Leininger 1988:9). The emphasis by this author is on helpful and enabling activities, which are culturally acceptable to the person being cared for.

Bevis refers to caring as a “feeling of dedication to another to the extent that it motivates and energizes action to influence life constructively and positively by increasing intimacy and mutual self actualization” (Bevis in Leininger 1988:50). This author describes caring as the only human feeling which is always positive by its nature and definition. Bevis furthermore states that caring helps to “raise human relationships to satisfying experiences of pleasure, security, trust, growth and positive activity” (Bevis in Leininger 1988:49). According to this definition, caring is a feeling which is translated into behaviours that enhance improvement in the condition and experiences of the person being cared for.

Caring has been defined by Stanhope and Lancaster as “behaviour that is directed towards the protection and maintenance of the health and welfare of clients” (Stanhope & Lancaster 2000:G3).

Orem defines care as “watching over, providing for and looking after a person, performed by a responsible individual or group.” This author refers to caring as “an element of brotherly love that is interdependent, with the elements of responsibility, respect and knowledge demonstrated by persons who move out, respond to and give of themselves” Orem (2001:514).

Caring according to Watson (cited in Falco 1995:319), can assist an individual to gain control, become knowledgeable and promote health changes. Andrews and Boyle (1999:456) view caring as “emotional commitment to and a willingness to act on behalf of persons
with whom we have a significant relationship.” It involves insight into and understanding of the circumstances, needs and feelings of the person receiving care.

What appears to be common in the above definitions is that (1) caring involves one person’s responsibility for another person; (2) the person to be cared for has specific needs or characteristics that define how the person should be looked after and (3) the person providing the care should know the specific needs or characteristics.

For the purpose of this research caring for patients refers to those helpful and enabling activities performed by nurses to improve the patients’ human condition or help them face disability or death. When used in the context of caring for staff, care means concern for the welfare of nurses.

1.6.3 Patients with HIV/AIDS

The term refers to people requiring nursing or medical care at a public hospital in Pretoria with an underlying diagnosis of HIV/AIDS. (The terms ‘patient’ and ‘client’ are used interchangeably in the report).

1.6.4. Nurses

This includes qualified registered nurses, enrolled nurses and nursing assistants who provide nursing care to patients with HIV/AIDS regardless of any other qualifications or positions they may have.

1.6.5 Pretoria urban public hospitals

Hospitals in urban Pretoria that are funded by the state.
1.6.6 Support

Support according to Orem (2001:57), refers to sustaining another person in an effort to “prevent the person from failing or from avoiding an unpleasant situation or decision.” The sustaining influence of the helper may enable the person being supported to do something with undue stress. This author explains that physical and emotional support will enable an individual to control and direct the action in the situation. The action in the context of this study would be caring for patients with HIV/AIDS.

Gardner and Wheeler (in Leininger 1988:70) view support as assisting individuals to become stronger and be able to adapt to the situation they are in. It is concerned with giving an individual the strength to be able to function and adapt. The term ‘care’ has sometimes been used to describe support. Gardner and Wheeler suggest that there is a difference between the two in that support is more goal-oriented than caring. Caring is viewed as a pre-requisite for support and these authors argue that it appears practically impossible to offer support without at least initially caring. In the context of this research, support would include behaviours adopted by nurse supervisors to strengthen the self-caring ability of nurses (Gardner & Wheeler in Leininger 1988:73.)

For the purpose of this research, support means to give nurses the necessary strength and help to enable them adapt to the demands of caring for patients with HIV/AIDS. The availability of support in this research was determined by the respondents’ expression of feeling supported (Brooks, Wilkinson & Popkess-Vawter 1994:306).

1.7 Scope and limitations of the study

This study investigated the availability of support for nurses who care for patients in Pretoria urban public hospitals. Hence the results may not be applicable to private hospitals or rural hospitals in the RSA. Experiences of
the nurses studied may or may not be similar to those of nurses in other African or foreign countries, therefore these results may not be generalisable beyond the RSA.

1.8 Organization of the report

Chapter 1- Background information
Outlines the background information about the research problem, also discusses the aims, objectives and significance as well as the operational definitions and limitations of this study.

Chapter 2- Literature review
Discusses concepts and theories used in the study and literature related to the research topic.

Chapter 3- Methodology
This chapter discusses the study design, data collection approach and instrument. It includes reliability and validity issues, how the data was analysed and ethical considerations.

Chapter 4- Presentation and discussion of data
Presents the analyzed data followed by discussion of the research findings.

Chapter 5- Conclusions, implications and recommendations
In this chapter conclusions made from the findings, implications to the health system and recommendations for management, nurses, nursing education and research are presented.

1.9 Summary
This study aimed at describing the support available for nurses who care for patients with HIV/AIDS in Pretoria urban public hospitals. Caring for patients with HIV/AIDS can be physically and emotionally demanding. Lack of support for nurses may have a direct impact on the care given to patients. Availability of support may be influenced by factors related to the
organisation, nursing management or the nurses. This research sought to identify the problems experienced by nurses who care for patients with HIV/AIDS, how the nurse’s view their support needs and what systems are in place to help them cope with their work.
CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

Information for the literature review was obtained from library and CD-ROM searchers for references in nursing journals and books. Some information was also obtained from conference presentations, DOH, non-governmental organizations (NGO’S) and some United Nations (UN) agencies. Both local and international literature was reviewed. The literature search reflects that (a) most of the studies done on the topic under study have been in developed countries; (b) very few studies have been done in Africa focusing on nurses as caregivers for people with HIV/AIDS. (c) The majority of studies done in African region have focused on supporting community caregivers.

This study aimed at describing the support available for nurses who care for patients with HIV/AIDS in Pretoria urban public hospitals.

2.2 Purpose of the literature review

The purpose of this literature review was;
(1) To acquaint the researcher with the existing data base on the subject so as to prevent duplication of work already investigated.
(2) To enhance the researcher’s understanding of the topic.
(3) To identify theories or models relevant to the topic investigated.
(4) To assist integrate this research with previous work on the topic.
2.3 Scope of the literature review

Sources for this review included both theoretical and empirical literature. Every effort was made to utilize most current literature on the subject studied. However some old theoretical sources which were considered to be classics, for example, Maslow (1970), Lazarus and Folkman (1984), Leininger (1988) were utilized due to the nature of the research topic. The majority of sources were primary sources. Secondary sources were used only when considered to contain information pertinent to the study.

2.4 Theoretical Framework

The aim of this study was to describe the support available for nurses who care for patients with HIV/AIDS. The basic assumption underlying support according to Lazarus and Folkman (1984:250) is that people will have better morale and health and function better if they receive support when it is needed. Support is a subjective phenomenon which is determined by an individual’s expression of feeling supported (Brooks et al 1994:306) and is closely linked to satisfaction. The assumption of this study therefore was that nurses’ expression of being supported will depend on the extent to which their needs are met.

To conceptualize the nurses’ experience of support, two comparable theories, Maslow’s Theory of Human Motivation and Abdellah’s Theory regarding the typology of nursing problems were used. The two theories provided a framework for understanding the factors that influence support and also guided construction of the data collection instrument and interpretation of the findings.
2.4.1 Maslow’s Theory of Human Motivation

Maslow’s theory, borrowed from psychology, appears to be relevant for nurse researchers investigating issues surrounding motivation and satisfaction. Maslow (1970:15-22) organizes the basic human needs into a hierarchy of relative prepotency. This means that when the lower needs are satisfied, new and higher needs emerge. The needs are classified into two groups, lower level needs consisting of physiological, safety and belongingness / love needs and higher level needs comprising esteem and self actualization needs.

2.4.1.1 The basic needs hierarchy

(1) Physiological needs
These are the most basic needs necessary to maintain homeostasis. Included in this category are water, food, oxygen, exercise, rest, sleep and elimination processes.

(2) Safety needs
Safety needs are the next basic needs that emerge when physiological needs are relatively well gratified. These include security, stability, dependency, protection and freedom from fear, anxiety and chaos.

(3) Belongingness and love needs
If both the physiological and safety needs are fairly well gratified, the need for love, affection and belonging emerges. This level includes giving and receiving affection, relations with people and having a place in the family or group.

(4) Esteem needs
These are the first of the higher level needs. They are classified into two subsidiary sets. The first set includes the desire for strength, achievement, adequacy, mastery and competence, feelings of confidence and freedom. The second set describes the human need for respect from other people. Included in this set are status, fame, and glory, dominance,
recognition, attention, dignity, and appreciation. If esteem needs are not met, feelings of weakness, helplessness or discouragement develop.

(5) Self-actualization need
Emergence of this need is dependant upon prior satisfaction of the first four levels of needs. Self-actualization refers to people's desire for self fulfillment, that is, to become more and more what one is individually fitted for and capable of becoming.

2.4.1.2 Pre-conditions of the basic needs
According to Maslow (1970:23), the basic needs can only be satisfied if certain conditions exist. This author argues that without these prerequisites, the basic satisfactions are quite impossible or severely endangered. These conditions include freedom to express oneself, freedom to seek information, freedom to defend oneself, justice, fairness, honesty and orderliness in the organization.

2.4.1.3 Application of Maslow's Theory in this research.
According to Maslow (1970:15-22), individuals strive to satisfy their needs by moving up the hierarchy from physiological needs through to self-actualization needs so as to function at their best. Motivation to satisfy these needs is influenced by the environment comprising the pre-conditions stated above.

In this research, the researcher views nurses as individuals who need to be in optimal health in order to provide high quality care to patients with HIV/AIDS. This statement is consistent with the views of Stoter (1997:3). The levels of needs represent the various problems and needs of nurses who care for HIV/AIDS patients. The environment can be viewed as organizational, management and personal factors that influence satisfaction of the needs. Conductive environmental factors coupled with support will assist nurses to reach optimal health (refer to Figure: 2.1).
Figure 2.1 Maslow’s hierarchy of needs applied to nurse support (Compiled from Maslow 1970:15-23).
2.4.2 Abdellah's Theory regarding the typology of nursing problems.

Abdellah identifies twenty-one groups of common nursing problems. These problems focus on the physical, biological and socio-psychological needs of the clients. Each of the groups of nursing problems consist of numerous overt and covert problems which are specific for each client. The groups are meant to guide care planning and provision as well as promote the development of nurses' judgmental ability (Falco 1995:146-147).

2.4.2.1 Abdellah's twenty-one nursing problems.

(1) To maintain good hygiene and physical comfort.
(2) To promote optimal activity, exercise, rest and sleep.
(3) To promote safety through the prevention of accidents, injury or trauma and through the prevention of the spread of infection.
(4) To maintain good body mechanics and prevent and correct deformities.
(5) To facilitate the maintenance of a supply of oxygen to all body cells.
(6) To facilitate the maintenance of nutrition of all body cells.
(7) To facilitate the maintenance of elimination.
(8) To facilitate the maintenance fluid and electrolyte balance.
(9) To recognize the physical responses of the body to disease conditions; pathological and compensatory.
(10) To facilitate the maintenance of regulatory mechanisms and functions.
(11) To facilitate the maintenance of sensory function.
(12) To identify and accept positive and negative expressions, feelings and reactions.
(13) To identify and accept the interrelatedness of emotions and organic illness.
(14) To facilitate the maintenance of effective verbal and non-verbal communication.
(15) To promote the development of productive interpersonal relationships.
(16) To facilitate progress toward achievement of personal spiritual goals.
(17) To create and/or maintain a therapeutic environment.
(18) To facilitate awareness of self as an individual with varying physical, emotional, and development needs.
(19) To accept the optimum possible goals in the light of limitation, physical and emotional.
(20) To use community resources as an aid in resolving problems arising from illness.
(21) To understand the role of social problems as influencing factors in the case of illness (Falco 1995:147.)

2.4.2.2 Application of Abdellah’s theory to this research.
Abdellah’s theory is similar to Maslow’s theory and can therefore be applied to the objectives of this research. In this research the twenty-one problems represent the various goals that need to be accomplished by the nurses and/or for the nurses in order for nurses to maintain health and function at their best.

2.4.3 Comparison of Maslow and Abdellah’s frameworks.
Abdellah’s typology of nursing problems is comparable to Maslow’s hierarchy of needs with the exception of self-actualization that is not met by Abdellah’s typology of nursing problems. This is attributed to the fact that self-actualization is an on-going process and not a goal to be accomplished.
The rationale for having used both theories in this study was that while Maslow’s theory provided broad categories of needs, Abdellah’s theory guided the researcher with regard to the specific questions to be included in the data collection instrument (refer to Table 2.1). The numbers in brackets in table 2.1 refer to the relevant items in the research instrument (See annexure C).
Table 2.1 Comparison of Maslow and Abdellah’s frameworks

<table>
<thead>
<tr>
<th>Maslow</th>
<th>Abdellah</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Physiological needs</td>
<td>5. To facilitate a supply of oxygen to all body cells (6.2)</td>
</tr>
<tr>
<td></td>
<td>6. To facilitate the maintenance of nutrition of all body cells (6.2)</td>
</tr>
<tr>
<td></td>
<td>7. To facilitate the maintenance of fluid and electrolyte balance (6.2)</td>
</tr>
<tr>
<td></td>
<td>8. To facilitate the maintenance of elimination (6.2)</td>
</tr>
<tr>
<td></td>
<td>4. To maintain good body mechanics and to prevent correct deformities (6.1; 6.2)</td>
</tr>
<tr>
<td>2. Safety needs</td>
<td>2. To promote optimal activity: exercise, rest and sleep (6.1; 6.2)</td>
</tr>
<tr>
<td></td>
<td>10. To facilitate the maintenance of regulatory mechanisms and functions (6.1; 6.2)</td>
</tr>
<tr>
<td></td>
<td>1. To maintain good hygiene and physical comfort. (3.11; 6.2)</td>
</tr>
<tr>
<td>3. Belonging and love needs</td>
<td>3. To promote safety through the prevention of accidents, injury, or other trauma and through the prevention of the spread of infection (3.10; 3.11; 5.16; 6.2)</td>
</tr>
<tr>
<td></td>
<td>11. To facilitate the maintenance of sensory function (4.4; 5.7; 6.1; 6.2)</td>
</tr>
<tr>
<td>4. Esteem needs</td>
<td>14. To facilitate the maintenance of verbal and non verbal communication (4.1-4.4)</td>
</tr>
<tr>
<td></td>
<td>15. To promote the development of productive interpersonal relationships (3.17; 4.1; 4.4; 5.11; 5.12; 5.15)</td>
</tr>
<tr>
<td></td>
<td>16. To facilitate progress toward achievement of personal spiritual goals (6.1)</td>
</tr>
<tr>
<td>5. Self-actualization</td>
<td>19. To accept the optimum possible goals in the light of limitations, physical and emotional (3.15; 3.16)</td>
</tr>
<tr>
<td></td>
<td>9. To recognize the physiological responses of the body to disease conditions- pathological, physiological and compensatory. (3.18)</td>
</tr>
<tr>
<td></td>
<td>12. To identify and accept positive and negative expressions, feelings and reactions (3.6; 3.9; 4.2)</td>
</tr>
<tr>
<td></td>
<td>13. To identify and accept the interrelatedness of emotions and organic illness (3.1)</td>
</tr>
<tr>
<td></td>
<td>17. To create and/or maintain a therapeutic environment. (3.17; 5.1-5.6; 6.3)</td>
</tr>
<tr>
<td></td>
<td>18. To facilitate awareness of self as an individual with varying physical, emotional and developmental needs (2.1- 2.3; 4.5; 4.6; 5.7)</td>
</tr>
<tr>
<td></td>
<td>20. To use community resources as an aid in resolving problems arising from illness. (3.7; 3.8; 4.6)</td>
</tr>
<tr>
<td></td>
<td>21. To understand the role of social problems as influencing factors in the case of illness.</td>
</tr>
</tbody>
</table>
2.4.4 Factors that may influence the availability of support for nurses who care for patients with HIV/AIDS

Figure 2.2 illustrates the discussion given in chapter 1 on factors that may influence availability of support for nurses who care for HIV/AIDS patients. These factors which relate to the organisation, management and nurses will form the basis of the literature review that follows.
Figure 2.2 Factors that may influence the availability of support for nurses who care for patients with HIV/AIDS
2.5 Stress

Several authors have suggested that nurses caring for patients with HIV/AIDS may experience stress and anxiety, which are not common in other areas of care (Figueiredo & Turato 2001:634; Flakerud cited in Palmer 1995:20; Gillispie & Davis 1996:292; Jackson 2002:208; Slone & Stephany 1995:32). Hence an understanding of the nature and effects of stress is essential in order to appreciate the need for support.

2.5.1 Definition of stress.

Lally and Pearce (1996:17) define stress as “a response to perceived demand which occurs when there is an imbalance between the perceived demand and one’s ability to cope.” Stress has also been defined as the “harmful physical and emotional response that occurs when the requirements of the job do not match the capabilities, resources or needs of the worker” (National Institute for Occupational Safety and Health (NIOSH) cited in Tappen 2001:380).

Selye, who is considered as the ‘father of stress management,’ defines stress as “the non-specific response of the body to any demand made up on it” (Selye 1976 cited in Gibson 1990:306). This author further states that when stress is not too intense, it can be a motivation factor and it is called eustress or positive stress. According to Gibson (1990:306) and NIOSH (1999 cited in Tappen 2001:380), it is only when stress is too high and continuous that it becomes harmful to human beings. Such stress, called distress or negative stress, places an individual in a constant state of arousal, eventually depleting the body’s ability to respond and defend itself due to exhaustion. The individual then becomes susceptible to illness or injury. When stress is not addressed, it leads to burnout. Burnout according to UNAIDS (2000:25) is a process where the individuals “mental and physical health are gradually undermined to an extent where care giving and personal relationships suffer.”
2.5.2 Factors that influence stress appraisal

How individuals react to stress depends on their appraisal of stress. Appraisal refers to “an evaluation of the significance of what is happening” (Lazarus 1999:74). According to this author, appraisal is influenced by environmental and personal variables. Environmental variables include demands, constraints and opportunities. Personal variables include goals and goal hierarchy, beliefs about self and the world and personal resources (Lazarus 1999:70-71).

2.5.2.1 Environmental variables

(1) Demands: comprise implicit or explicit pressures from the social environment to act in a certain way and manifest attitudes, which are socially correct. These may include pressure to excel, to do what one’s job entails, to behave with integrity, to be thoughtful and kind towards others, to love and be loved and to be concerned with the wellbeing of one’s family. When environmental demands conflict with a person’s inner goals and beliefs, psychological stress occurs.

(2) Constraints: these define what people should not do. Individuals who violate the laid down prohibitions are liable to punishment. Stress arises when individuals feel they have to do a particular thing, which is not allowed in that environment.

(3) Opportunity: involves taking advantage of opportunity by being able to recognize the opportunity and knowing what action to take at the right time. People with the necessary knowledge and skills may view difficult situations as challenges and opportunities for personal growth. Others may view the same situation as stressful (Lazarus 1999:70).

2.5.2.2 Personal variables

(1) Goals and goal hierarchy: when there is no goal at stake, there is no potential for stress. Stress, according to Lazarus, arises when an individual’s goals are thwarted or delayed. When individuals make progress towards goal gratification, they experience positive emotions. For example,
if a nurse’s goal is provision of quality nursing care to patients, inability to do so for whatever reason may result in stress. The more important the affected goal is to an individual the more the stress (Lazarus 1999:70).

(2) Beliefs about self and the world: these are concerned with how people view themselves and their place in the environment. According to Lazarus (1999), these beliefs influence people’s expectations about what is likely to happen in any encounter (Lazarus 1999:71). These include commitment, self-efficacy and locus of control.

Commitment, according to Banyard (2002:78), refers to a person’s sense of purpose or involvement in their life. Lazarus and Folkman state that commitment influences vulnerability, hence the deeper one’s commitment is, the more vulnerable the person is to psychological stress in the area of that commitment. However, these authors point out that the depth of commitment also determines the amount of effort a person is willing to put in so as to ward off the threat to that commitment (Lazarus & Folkman 1984:58,61). This would mean that though very committed nurses may be more vulnerable to stress when they are not able to meet patients’ needs, the same nurses would make every effort to overcome problems that are threatening their goal.

Self-efficacy is the belief that one can perform adequately in a particular situation. People’s beliefs about self-efficacy influence how much effort they will put into any activity (Banyard 2002:140).

Control refers to the belief that a person can influence events in their life (Banyard 2002:78). People who have an external locus of control do not feel in control of events. Such people perceive their lives as being controlled by outside forces. They believe that things just happen to them.
People with an internal locus of control perceive themselves as having personal control over their lives and events.

(3) Personal resources: these include intelligence, social skills, education, money, sanguinity, health and energy and a supportive family and friends. Personal resources influence what individuals are able and unable to do as they seek to gratify their needs achieve goals or cope with stress (Lazarus 1999:71).

2.5.3 Signs and symptoms of stress among HIV/AIDS caregivers

The following signs and symptoms of stress are based on responses to interviews of people working with AIDS Support Organizations in the RSA and Uganda (UNIAIDS 2000:6).

- Loss of interest in work as well as lack of commitment to work.
- Loss of punctuality and neglect of duties.
- Feeling of inadequacy, helplessness and guilt.
- Loss of confidence and self-esteem.
- A tendency to withdraw from both clients and colleagues.
- Loss of sensitivity in dealing with clients.
- Loss of quality in performance of work.
- Irritability.
- Tearfulness.
- Loss of concentration.
- Sleeplessness.
- Excessive fatigue.
- Depression.
- Bowel disturbance.

If the above early signs and symptoms of stress are ignored, impaired immune function may follow which may lead to long term damaging
effects on health. White (1990 cited in Stoter 1997:21) states that this may result in more serious illnesses such as:

- Hypertension
- Migraine
- Constipation/Colitis
- Nervous dyspepsia
- Skin Disorders
- Back problems
- Coronary thrombosis
- Asthma, hay fever and other allergies.
- Peptic ulcers
- Rheumatoid arthritis
- Diabetes
- Depression.

Such effects, according to Stoter may affect a whole team leading to a build up of aggression, poor communication, mental problems, social isolation, increased sickness and absenteeism, increased accident rates, poor quality of patient care, increased turnover and ultimately increased costs to the organization (Stoter 1997:21-22).

2.6 Problems experienced by nurses caring for people with HIV/AIDS

According to Miller (2000:71), most of the problems causing stress among staff caring for clients with HIV/AIDS can be categorized under (a) staff fears, (b) issues of association, (c) professional and role issues or (d) stigma, discrimination and ethical issues.
2.6.1 Staff fears

Fear of contracting HIV infection has been identified as an issue contributing to stress among nurses who care for patients with HIV/AIDS.

Slone and Stephany conducted an exploratory study to define the stresses experienced by hospice home care nurses when caring for AIDS patients in California, United States of America (USA). Results revealed that risk of infection was one of the reasons why nurses face increased stress when caring for AIDS hospice patients. All the study participants felt that there was always a potential for exposure to HIV infection. The constant fear of infection made them reluctant to draw blood from patients or perform other invasive procedures (Slone & Stephany 1995:3).

Similar findings were made by UNAIDS (2000) in the RSA and Uganda. Staff and volunteers working with AIDS care programs in both countries, reported fear of infection as a common cause of stress and burnout (UNAIDS 2000:39).

In the RSA a study was conducted by Unger et al (2001) to assess the impact of HIV/AIDS on health care staff at Hlabisa District Hospital in Kwa-Zulu Natal. Findings indicated that 86% of respondents on medical wards felt they were more at risk of getting HIV infection at work than outside work.

These findings are consistent with findings by Diaz who investigated nurses’ anxiety when dealing with patients with HIV/AIDS. The study was conducted in state and private hospitals in Johannesburg, RSA. Results of the study indicated that judgment of risk was a significant contributor to nurses’ anxiety when dealing with patients with HIV/AIDS. Diaz however suggests that the judgment of risk was influenced by emotive reasons rather than rational reasons (Diaz 2001:73).
However, for some nurses, it appears improved knowledge on the transmission of HIV has made them realize that the risk of contracting HIV infection from patients while providing care is very low as long as universal precautions are taken.

One example is a descriptive, correlational study of nurses’ willingness to care for patients with AIDS by Sherman. The study was conducted in New York City metropolitan area using a convenience sample of 220 registered nurses. The findings indicated that nurses dedicated to caring for patients with AIDS recognized that the risk of infection in AIDS care, though real, was minimal. Nurses studied and focused on their professional values and obligations to treat every patient with dignity regardless of the diagnosis. They pointed out that patients with AIDS had a right to be cared for like everyone else and that all they needed to do as caregivers was to take necessary safety precautions (Sherman 1996:5).

2.6.2 Issues of association

The magnitude of the HIV/AIDS pandemic in sub-Saharan Africa has led to a situation where almost all families are affected by HIV/AIDS. Almost every nurse has experienced loss of a relative, friend or colleague due to HIV/AIDS and some nurses have to go home, after a day’s hard work, and be faced with the suffering of an infected family member. This scenario, according to UNIAIDS (2000:34), makes it difficult for caregivers to be professionally detached from their jobs when they are not on duty and also increases the risk of stress.

Similar observations were made by Palmer (1995:21). According to Palmer, staff that are personally affected by HIV may experience a loss of boundaries between the job and personal life, leading to exhaustion, loss of perspective and burnout.
Most nurses receive encouragement when the patients they care for recover. If nurses do not see the successes of their care because of frequent deaths of their patients, they may develop anxiety, guilt and frustration. This is especially so for nurses who care for patients with HIV/AIDS. These nurses develop close relationships with patients whom they work with over long periods. When the patients go through suffering and death, nurses constantly experience grief (Vachon 1998:152), which leads to burnout. Apart from frequent deaths of patients, dealing with individuals or families who had experienced multiple losses of loved ones from AIDS was also a source of stress for nurses (Rasmussen et al 1997:334; Slone & Stephany 1995:35).

Furthermore, the majority of patients dying from AIDS are young people who may be of the nurses’ own age group or younger. This is more distressing for nurses as they tend to identify themselves with the patients. In the study by Slone and Stephany, female nurses reported that caring for young women with AIDS was a special source of stress for them. Study participants described having cared for two women, who were young, infected by their husbands, diagnosed in the late stages of the disease, were breadwinners, without emotional support from their families or community and had few treatment opportunities. The women also had children whose future was uncertain. Nursing these women had caused strong emotions to surface in the nurses as they identified with the women (Slone & Stephany 1995:35-36).

For nurses who are themselves HIV positive, the problem of identification with patients tends to be worse. Such nurses may see themselves in the patient they care for and become frightened at the thought of the suffering and disfigurement they may have to go through. This may reinforce feelings of helplessness (UNAIDS 2000:35).
Similar views are expressed by Jackson (2002:302) who highlights the high rate of HIV infection among health personnel in many Southern African countries. This author states that, as nurses with HIV infection watch their colleagues go through long illness, suffering and death without being able to do much to help, it is a devastating experience for them.

However, identifying with people who are HIV positive has been the motivating factor to work in the field for some nurses. For example, results of the studies by Sherman and UNAIDS indicate that nurses who had family members with HIV/AIDS were more willing to care for patients with AIDS. These nurses felt that caring for patients with AIDS made them feel that they were caring for their infected family members and it helped them to cope (Sherman 1996:7; UNAIDS 2000:15).

2.6.3 Professional and role issues

This category accounts for a wide range of issues that have been known to contribute to stress and burnout among nurses caring for people with HIV/AIDS.

One of the identified issues is that of role expansion for nurses. The complex nature of the disease demands that nurses acquire new knowledge and skills such as psychosocial counseling skills. Inadequate knowledge and skills to plan and implement effective care for patients with HIV/AIDS has been reported to be a cause of stress, especially for nurses trained before the HIV/AIDS advent.

For example, participants in the study by Slone and Stephany state that HIV/AIDS did not fit the cancer model even though both involve terminal care. They attribute this to the fact that, unlike cancer patients who usually have a predictable decline, the course of AIDS is never the same, it varies greatly from one patient to another. The treatment plan and plan of care therefore has to change constantly. The participants also expressed their
feelings of frustration and lack of confidence arising from dealing with unpredictable symptoms. Unpredictability makes it difficult for them to prevent or control problems because they are unable to plan ahead. One of the study participants reported that the extra reading required to keep up-to-date with new knowledge on HIV/AIDS management was as additional stress as it took a lot of her leisure time (Slone & Stephany 1995:34).

Similar views are expressed by Ryden and Krichbaum (1996:4) who state that the basic nursing education cannot adequately meet the growing needs for new knowledge and skills. Nurses need to have adequate information about the disease, prevention, management and care to be able not only to function effectively but also to educate clients and primary care givers.

The need for nurses to have adequate knowledge to be able to interpret issues to patients and care givers is also highlighted by Morrisey (1997:375). According to this author, physicians usually break the news concerning a patient's diagnosis. Nurses are then left to interpret issues into simpler non-medical language and help the patient and the family deal with the post diagnosis confusion and emotional reaction surrounding a terminal illness. The same author explains that clients often assume that nurses have a better understanding and are able to interpret whatever physicians have said. Nurses are therefore expected to give an accurate translation to help patients make their own decisions and choices. Furthermore nurses are accountable for their translating abilities (Morrisey 1997:371,375,377). Hence, if nurses do not have adequate knowledge and skills about issues surrounding HIV/AIDS, they are unable to fulfill this role. This makes them feel anxious and incompetent to practice and causes stress.

These findings are supported by results of a study done by Diaz in Johannesburg, RSA on nurses’ anxiety when dealing with HIV/AIDS
patients. The results indicate that lack of knowledge was a contributing factor to nurses’ HIV anxiety and to nurses’ attitudes towards HIV/AIDS patients (Diaz 2001:73).

A study done by Kara Counseling and Training Trust (KCTT), TVT Associates INC / Synergy Project and Family Health International (FHI) (2002:43,44,97) on HIV/AIDS care and support capacity and needs in Zambia revealed similar findings. Seventy seven per cent of health workers interviewed identified lack of training for staff as the biggest obstacle to improving HIV/AIDS care in their setting. Among nursing staff, 70% of the registered nurses and 81% of the enrolled nurses/midwives indicated they needed additional training in pre and post-test counseling of HIV/AIDS clients. This study indicates that the greatest training need for nurses is in the area of counseling. This has been attributed to the fact that many nurses were trained 15-20 years ago when HIV/AIDS was not even heard of. Fifty percent of the respondents in the above study reported not having had any in-service training after the pre-service training. This makes it difficult for staff to have confidence in their care giving role.

Inadequate knowledge also becomes a cause of stress for nurses when clients, their friends or relatives who are better read and more aware of current management trends of HIV/AIDS begin to make demands on nurses and the nurses are not even aware of such information (Slone & Stephany 1995:35).

Inadequate staffing is another issue which Lally and Pearce (1996:18) term as a major stressor that could be an underlying factor in other stressors such as overwhelming workload, inability to meet patients’ needs, difficulties in dealing with relatives as well as communication and conflict problems between nurses.
A descriptive study by Harding on managing stress in nurses caring for children with cancer reveals that nurses experience stress when they have no time to teach, support or talk and listen to patients due to shortage of staff. It makes them feel they are not giving as much as they should, particularly at the time of diagnosis and terminal stages when they need to be available for the patients and their families (Harding 1996b: 28).

Similar findings were made by Rasmussen et al (1997:333) who explored the lived experiences of 18 hospice nurses in Sweden using a phenomenological approach. Participants reported that inadequate staffing leading to a lack of time to care for patients in accordance with their values was a major burden for most nurses. They complained of having only enough time to give basic care but unable to be fully present and leaving patients with unmet needs. The nurses reported that it was heartbreaking for them.

The problem of not having enough time to do what needs to be done for patients was also identified as a major cause of stress by The AIDS Support Organization (TASO) staff in Uganda. The staff felt that there was too much to do in very little available time and therefore overworked (UNAIDS 2000:31).

Experienced nurses in the study by Rasmussen et al (1997:335) noted working with inexperienced and less educated colleagues as being burdensome. Experienced nurse’s felt guilty about not being able to support junior colleagues who despair. There was usually no time available to share burdensome experiences because apart from having to teach and supervise junior staff, the more experienced nurses were left to care for ‘difficult’ clients while juniors cared for easygoing clients. The term ‘difficult patients’ refers to patients who “exhibit behavioural characteristics that result in the nurses experiencing some discomfort during the provision of care” (Santa Maria 2000:21). This term according to Santa Maria is
commonly used by clinical nurses and is not meant to be a pejorative term. This author explains that behaviours which nurses regard as difficult include emotional instability, high levels of anxiety, depression, hostility, over dependence or independence, aggression, impatience and lack of appreciation (Santa Maria 1997:21). The anger, mental decline, dementia and paranoia displayed by patients with HIV/AIDS (Slone & Stephany 1993:35; UNAIDS 2000:38) results in some patients with HIV/AIDS being termed as ‘difficult patients.’

Job dissatisfaction has been identified as a cause of stress among nurses. Job satisfaction is influenced by a wide range of factors such as job security, work environment, work schedule, salary, peer relations / teamwork, supervision and relationship with supervisor, recognition, personal growth and challenging work (Buys & Muller 2000:52-53; Fletcher 2001:321-329). The study by Diaz among nurses caring for patients with HIV/AIDS found a significant correlation between occupation satisfaction and HIV anxiety. Results of the study indicate that the more satisfied nurses were with the job, the less likely they were to experience anxiety in dealing with patients with HIV/AIDS (Diaz 2001:79).

Lack of teamwork and poor working relations is a major cause of dissatisfaction for nurses, for example working with colleagues who have negative attitudes such as disrespect for patients was identified as a cause of dissatisfaction among committed nurses (Fletcher 2001:326). The importance of good interpersonal relationships among nurses and its effect on job satisfaction needs to be emphasized to nurses from the time they join the profession as students. If nurses do not learn to value teamwork among themselves from the outset, it may become very difficult to correct such attitudes later on.
Solombela and Ehlers conducted a quantitative descriptive study to determine whether or not student nurses develop interpersonal relationships during training. Participants included 117 first year and 140 fourth year student nurses from six nursing colleges in the Eastern Cape, RSA. Findings of the study revealed that student nurses did not seem to develop interpersonal relationships with their colleagues from the first till the fourth year of training (Solombela & Ehlers 2001:56-57). Such an environment not only breeds job dissatisfaction and stress but also would make it impossible for any form of peer support system to operate.

Physician issues have also been reported by nurses as contributing to job satisfaction, for example resident doctors who are unprofessional in their work performance, unresponsive to patients’ needs, not available when needed or do not explain diagnoses to patients. In a study by Chinnis, Summers, Doerr, Paulson and Davis, nurses complained of physicians who are very patronizing and evoke feelings of manipulation and intimidation in nurses thereby causing stress (Chinnis et al 2001:256). It is therefore important to address the issue of job satisfaction when planning support systems for nurses who care for HIV/AIDS patients.

2.6.4 Stigma, discrimination and ethical issues

The association of HIV/AIDS with certain high-risk groups that have historically been discriminated against brings about a stigma, which contributes to the attitudes developed by nurses who care for such people. Palmer (1995:21) states that, nurses may be uncomfortable with relating to people who are considered to be promiscuous, such as gay people, sex workers and intravenous drug users. Having to care for HIV/AIDS patients with such backgrounds may be distressing for nurses as they may feel stigmatized themselves. The study by Diaz revealed that nurses in the RSA associated homosexuality with HIV/AIDS. Results of the study indicate that
nurses experienced discomfort in dealing with homosexuals because homosexuality was associated with high-risk groups (Diaz 2001:75, 76).

Nurses are also stigmatized for working in an environment where people are always dying. Nurses in the study by Rasmussen et al (1997:334) reported that people around them did not understand why they had chosen to work in such a depressing place, which was considered a ‘death house’ by the public. The nurses expressed being hurt by the remarks that were being said about the hospice.

Literature indicates that nurses working in oncology units where there are frequent deaths also face similar problems. A descriptive study of stress management in a group of pediatric oncology nurses was done by Kushnir, Rabin and Azulai (1997:416). Results revealed that the professional image of the oncology nurse was a source of stress. One of the respondents described how people reacted with shock and disbelief at the fact that she could be willing to work with terminally ill patients. This made the nurse feel anxious, confused, defensive and unappreciated.

Earlier studies done in Zambia also indicated that health workers caring for people with HIV/AIDS identified secondary stigmatization as a source of stress (Appropriate Health Resources and Technologies Action Group [AHRTAG] 1997:45). However more recent studies revealed that stigma was not considered a major obstacle in the provision of care to patients with HIV/AIDS in Zambia. For example only 16% of respondents said their care provision was affected by stigma in the study by KCCT et al (2002:97,108).

Due to the stigma associated with HIV/AIDS individuals and families often prefer to keep information about HIV positive results secret. Dealing with secrets was reported as stressful by four of the five nurses interviewed in
the study by Slone and Stephany (1995:35). Client confidentiality is not only necessary due to the stigma attached to HIV/AIDS but also an important aspect of professional ethics (Pera & Van Tonder 1996:176; Jackson 2002:205).

The problem of disclosing one’s HIV positive status is not only among people ignorant about the disease, it affects even those who offer support and counseling to others. For example, in the RSA, a survey revealed that about 50% of members of an AIDS support group had not disclosed their HIV positive status to their families for fear of discrimination (UNAIDS 2000:32). According to Jackson (2002:148) less than 50% of HIV positive antenatal women in the RSA felt able to disclose their status to others and out of these, only a small percentage could discuss it with their husbands or partners. Results of the survey by KCCT et al (2002:107) reveal that even among health workers, the majority of respondents did not want to know their status for fear of how their colleagues, friends and family might react. Secrecy over HIV diagnosis is burdensome for caregivers, as they have to operate under false pretences (UNAIDS 2000:32). This also creates a barrier to possible support for the patient and family and hampers prevention efforts.

The whole issue of confidentiality in the area of HIV/AIDS raises ethical dilemmas. Nurses very often have to struggle with the benefits and costs of disclosing a client’s HIV positive status in cases where they perceive that lives of other people are at risk. For example carers who need to take safety precautions with handling blood and body fluids of an infected person or a regular sexual partner or spouse who may not be infected (Jackson 2002:206). According to Pera and Van Tonder (1996:177), in a case where the patient’s condition may endanger the lives of others, the patient’s right to secrecy may be disregarded in order to protect others. On the other hand, a patient may forbid the nurse to disclose the information
and the nurse may feel that disclosure may threaten the well-being or safety of the patient (UNAIDS 2000:32). Such situations raise conflicts within nurses.

The literature discussed above gives evidence of the existence of various issues that cause stress in nurses caring for people with HIV/AIDS. It is therefore important for these nurses to be supported in order for them to cope.

2.7 Nurses’ perceptions of their support needs

It is common for the health care system to expect health care workers to hide their emotions and cope even when working in a very stressful environment. Some people may not even acknowledge that feelings of grief or frustration experienced by nurses who face frequent deaths of their patients ought to be a problem. Literature reviewed reveals that nurses who give care to people with HIV/AIDS need to receive care themselves. Without extra support nurses caring for patients with HIV/AIDS would not be able to cope with the emotional trauma of HIV/AIDS. Moreover, having stressed staff creates a stressful atmosphere, which is easily passed on to patients, relatives and colleagues around them. However, for any support interventions to be meaningful, the nurses should acknowledge their vulnerabilities and recognize their need for support (Jackson 2002:208; Stoter 1997:6; Vachon 1998:152). Due to the differences in work environment, nurses’ personalities, attitudes, cultures and past experiences, it is necessary to explore what the nurses perceive to be their needs as far as support is concerned.

2.7.1 Perception

Lancaster (1999:257) defines perception as a “psychological process that helps people interpret what they see, hear, feel, taste, or smell” while Gibson (1990:49) views perception as “a person’s interpretation of reality”.
Perception of a similar situation can vary from one individual to another. For example, one nurse may perceive a supervisor as very caring and supportive while another nurse may view the same supervisor as very demanding and overbearing. These differences are due to the fact that, peoples' values, attitudes and past experiences differ (Gibson 1990:23, 49).

Perception according to King (1995:212) is “a process in which data obtained through the senses and from memory are organized, interpreted and transformed.” This author explains that perception influences ones behaviour and gives meaning to experiences. Perception is a concept that is universal, subjective and selective for each person (King in George 1995:211).

It is evident from the above definitions that strategies that may be successful in helping nurses cope with pressures of caring for patients with HIV/AIDS in one care setting or culture may not be appropriate for another. During this study, views of nurses regarding what form of support they would prefer were investigated.

### 2.7.2. Support

According to Stoter (1997:64), staff support is about valuing staff as individuals and as a whole, seeing them as a valuable resource in the organization. It involves creating and developing a sense of personal worth and respect as individual persons. When staff are valued, they will be able to value colleagues. Stoter (1997) further explains that where staff are valued, it is shown in the quality of patient care, team work and overall work standards. It will also positively affect the attitudes and personal appearance of staff as well as how they relate to everyone around them (Stoter 1997:66).
Brooks et al (1994:305) note that support is a subjective attribute and can only be said to be available when nurses express a feeling of being supported. This means that the concept of support needs to be translated into practice.

For support to be practical, Stoter (1997:67) states that it requires the following:

- Consistently good management and decision-making.
- Decisions need to be communicated in a language understood by staff.
- Good communication channels with clear and concise policy statements.
- Evidence that policies are actually being carried out.
- Use of teaching and in-service training opportunities.
- Support networks in place with access for all.
- Debriefing facilities following exceptional trauma.
- Good occupational health and counseling services accessible to all.
- Recognition of special needs where there are long-term pressures.
- Support during periods of uncertainty such as closures on threatened redundancy.

Stoter (1997:63) also notes that though staff care and staff support are related they are different. Care has to do with nourishing or nurturing while support has a more positive and proactive sense.

UNAIDS makes similar observations with regard to supporting staff that care for people with HIV/AIDS. This author concludes that no single time-limited activity can solve the problem of stress and burnout because of the variability of causes and manifestations. Stress management interventions needs to be broad-based, appropriate and on-going with good support and supervision as essential elements (UNAIDS 2000:55).
One example that indicates the need for support strategies to be broad-based and sensitive to the needs of particular individual or group, is highlighted by Stoter (1997:8). A group of conference participants were asked to write their definition of staff support according to their own understanding. The following responses were obtained:

- An organization having mechanisms in place to help staff that may be experiencing unwanted stress.
- Not only reactive but also proactive.
- Genuine care at all levels, to encourage those in great and small posts of responsibility to feel equally important.
- Enabling people to be fully and creatively present in the work they do.
- A collection of safety nets by which staff can feel held, regarded and valued.
- Empowering and enabling individuals to care more effectively for themselves and for others.
- Providing the same sort of health service for staff as one would for patients.
- Caring for staff, understanding their needs, being available on the spot, listening, sharing in problems, ensuring people know where they can find and use services which can help in the longer term and ensuring those services are available.
- Mechanisms that help to create an environment of care whereby individuals are enabled or empowered to receive and give care (Stoter 20006:8.)

The above reasons indicate the wide variation in people’s perception of staff support. This confirmed the need to find out from nurses what support they would prefer to have so that appropriate support could be given.
2.7.3 Nurses’ preferences for support

An evaluative study to assess the effects of clinical supervision and informal support on qualified nurses was conducted by Teasdale, Bockleburst and Thom in England. The study utilized both quantitative and qualitative methods. A convenient sample of 211 qualified nurses was selected from 11 randomly selected hospitals. Clinical supervision in the context of the study was operationally defined as “having a meeting with a designated supervisor or a supervision group at least every 8 weeks to talk about issues arising from clinical work”. Results of this study reveal that junior nurses appreciated clinical supervision and reported higher levels of perceived support when they had contact with their line managers. Senior nurses, on the other hand, preferred to use informal support networks (Teasdale et al 2001:55).

The United Kingdom (UK) Multi-center Occupational Morbidity Study (MOMS) investigated staff preferences for stress management and support. The sample included HIV/AIDS and Oncology staff. With regard to the preferred sources of support, 66% of HIV/AIDS staff reported that they would prefer to access support from outside the organization. Reasons given were lack of trust in how colleagues would handle their vulnerability and that outside facilitators would be more neutral, confidential and have a clearer perspective. The 14% who preferred support from inside felt that, insiders would be more accessible and understanding. Twenty per cent of the respondents reported that they would like to have support from both inside and outside. When asked about the form of support preferred, 15% of the respondents preferred support in a group, 44% (majority) preferred individual, 12% said either and 29% said both. The results also indicate that the majority (55%) of staff would like to talk about professional issues and coping while 35% would like to talk about personal feelings and issues. Of those who wanted to talk about professional issues and coping, the majority (41%) had work experience of more than 97 months. The majority
of those who wanted to talk about personal feelings and issues had work experience of less than 48 months. This was attributed to the fact that junior staff had a relative lack of experience in coping with emotionally challenging aspects of their work (MOMS cited in Miller 2000:152-155).

The UK burnout prevention study by Miller, Gillies and Elliot (cited in Miller 2000) reveals similar findings regarding preferred source of staff support. Thirty eight per cent of respondents preferred external support because of perceived impartiality and increased confidentiality. Twenty seven per cent of the respondents indicated they preferred an internal facilitator who would be more familiar with the true working conditions of staff. However unlike the MOMS study in which individual support was preferred by the majority (57%) of respondents, 47% of the respondents in this study wanted group support only while 15% wanted individual support only.

Results of the study by Miller et al also indicate that not all staff view staff support as beneficial. When asked what they felt staff support was trying to achieve, 25% of the respondents indicated it was a means for management to gather information so that they keep an eye over staff. Forty eight per cent of the respondents felt that staff support was successful as it helped with problem solving, provided relief from the pressures of the job and encouraged a sense and ethos of teamwork. However 42% indicated that it was not successful because they felt that “regular discussions had a negative impact of magnifying or encouraging stressors in the workplace” (Miller et al cited in Miller 2000:165-167).

In the study by Sherman, nurses caring for patients with HIV/AIDS expressed experiencing support when:

- They were given enough autonomy and funding in their nursing practice to enable them make decisions and provide competent and safe nursing care;
• They received feedback and appraisal from supervisors and administration;
• There was good communication and teamwork between nurses and medical staff;
• They had the necessary supplies to properly carry out universal blood and body fluid precautions;
• There are lower nurse/patient ratios to enable nurses give emotional and psychological care to patients as well as teaching;
• A sense of camaraderie and membership existed so that nurses were able to talk about their feeling with colleagues who were having similar experiences;
• They felt respected and trusted by patients and were able to form close bonds with patients (Sherman 1996: 5, 6.)

For the hospice nurses in the study by Rasmussen et al, a supportive environment was seen as one with:
• Leaders who are guiding stars;
• Boards of directors who understands both the nature of hospice nursing and the necessity of providing time for nurses to share a multitude of issues;
• Access to voluntary emergency counseling;
• Individual and group supervision with a person who has experience in terminal care and dying;
• Teamwork, drawing strength from each others resources;
• Colleagues and caring leaders who trust, accept, support, protect and value various outlooks on life and death;
• Colleagues who are whole human beings, familiar with each others philosophy of life and death, accepting each others strengths and weaknesses, sharing possibilities, ventilate and validate feelings and thoughts, cry, laugh, inspire and confirm each other (Rasmussen et al 1997:335).

The cultural background of nurses appears to influence perception of support needs. A qualitative study was conducted by Minnaar in Kwa-Zulu Natal,
RSA. The study explored the meaning and the lived experiences of nurses being cared for within the management context. Data were obtained from a convenience sample of 12 nurse managers at different levels through interviews. Results revealed that African nurses wanted matrons to show care by visiting the nurses that were ill in hospital. African nurses also expected management to take the lead in organizing funerals for nurses as well as attend the funerals (Minnaar 2001:24). This may be attributed to the fact that most Africans value collectivism, which regards interpersonal harmony and group solidarity as more important than autonomy and self-sufficiency (Andrews & Boyle 2003:366). According to Andrews and Boyle (2003:373), values form the core of a culture and affect people’s definition of problems, perceived needs and expectations of behaviour. Results of the study by Minnaar (2001) highlight the need for managers to know the values of their staff regarding communication patterns, interpersonal relationships, meaning of work, family obligations, personal traits and moral / religious beliefs as they may influence their perception of a supportive work environment (Andrews & Boyle 2003:373). In order for support to be acceptable and appreciated it needs to be culturally appropriate.

Findings of the study by Minnaar also indicate how some nurse managers perceive the support and care needs of staff. For example, participants described caring for nurses in practical terms such as; caring is “like serving a machine, which if you look after it, service it, then it will perform well” (Minnaar 2000:21).

Other caring behaviours expressed by the same participants include:

- Being interested in and open to nurses, counseling nurses to help them cope with increased work demands of caring for HIV/AIDS patients and frequent deaths.
- Communication with nurses by listening to nurses, having regular meetings with nurses, sharing and discussing problems and looking at situations together.
• Helping staff to develop to grow by mentoring, leading by example, providing feedback and providing opportunities to allow nurses to improve their skills and rectify mistakes.

• Using a participative approach to leadership and being role models for nurses. Some nurse managers expressed that if nurses observed caring behaviours in their leaders, they would also develop caring attitudes.

• Ensuring nurses have everything they need to provide nursing care to patients.

• Being sensitive to the social needs of nurses by making arrangements to enable them participate in sports and clubs within the hospital.

• Helping to meet personal needs of nurses outside the workplace such as family issues, illnesses of family members and other social problems. With regard to nurses living with HIV infection the participants reported that they showed care and support by:

  • Counseling and guiding nurses in dealing with the disease and maintaining confidentiality of nurses’ HIV status.

  • Organizing funerals for nurses who died of AIDS.

  • Allocating nurses with HIV infection to suitable departments where they would be able to cope.

• Being involved in family problems of nurses, especially where a nurse who was the breadwinner dies.

It is also worth noting that some nurse managers find it difficult to apply the concept of caring to their managerial role. In this study by Minnaar (2001), one participant reported having difficulties with caring that did not involve physical or direct contact such as relieving pain or stopping bleeding. This raises the need for nurse managers to have positive attitudes towards support and perspectives that are in line with that of nurses in order for support activities to be successful.
2.8 Coping Mechanisms used by nurses

2.8.1 Definition of coping

Lazarus and Folkman define coping as “constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person” (Lazarus & Folkman 1984:141). This definition implies that coping is a process and the ‘efforts to manage’ may include anything that a person does or thinks, regardless of whether it is effective or not. The use of the word ‘managing’ implies that coping cannot be equated to ‘mastery’, but can include efforts to minimize, avoid, tolerate and accept the stressful situation as well as attempts to master the environment (Lazarus & Folkman 1984:141).

Because of the stressful nature of caring for terminally ill patients, nurses adopt coping behaviours that help to protect them from adverse effects of stress. The ability to cope, according to Brookes et al (1994:305), does not depend so much on the type of stress but on an individual’s perception of the experience. This means that an individual’s choice of response to any event will depend on how one interprets the meaning of their perception (Lachman 1998:49). Hence coping strategies may differ depending on the culture, age, sex, care setting or level of experience of the nurses.

2.8.2 Main features of the coping process

The main features of the coping process are:

1. Observations and assessments are based on what individuals actually think or do, and not what they would or should do.

2. Coping can only be understood and evaluated if what the people are coping with is known because coping thoughts/actions are always directed towards specific conditions.
(3) Coping thoughts and acts change as a stressful encounter unfolds. Thus, individuals rely on different coping strategies as the nature of the stressful situation changes (Lazarus & Folkman 1984:142.)

2.8.3 Functions of coping

Coping functions refer to the purpose of the coping strategies and is independent of the outcome or effect a strategy has (Lazarus & Folkman 1984:149). Coping can be either emotion focused or problem solving focused.

2.8.3.1 Emotion focused forms of coping

These processes, according to Lazarus and Folkman (1984:151), help to maintain hope and optimism by changing the meaning of the situation, refusing to acknowledge the worst or denying the facts and implications of a situation. Eventually reality is distorted. This group includes defensive processes such as avoidance, minimizing, distancing, selective attention and wresting positive value from negative events. Behavioural strategies including physical exercise, meditation, alcohol consumption, smoking and seeking emotional support are all defensive processes that temporarily put aside thoughts about a stressful encounter.

2.8.3.2 Problem focused forms of coping

These are directed at defining the problem and generating alternative solutions, choosing among the alternatives on the basis of costs and benefits and implementing the best solution. The processes focus on both the environment and the individual. Those directed at the environment include strategies for altering environmental pressures, barriers, resources or procedures, for example, provide more staff to needy areas. Strategies directed at the individual include; learning new skills and procedures, developing new standards of behaviour or finding alternative channels of gratification (Lazarus & Folkman 1984:152.)
2.8.4 Coping Resources

What the person will actually do depends, to a large extent, on the resources that are available to them and the constraints that may inhibit use of these resources. Coping resources according to Lazarus and Folkman may be categorised as follows:

- **Health and energy** - it is easier for a nurse who is healthy and strong to cope with the physical demands of caring for HIV/AIDS than a sick, tired nurse.

- **Positive beliefs** - people with the belief that they have the power to control events and outcomes tend to view problems as challenges. Having an external locus of control can lead to helplessness and discourage individuals from engaging in problem focused coping as they believe in fate.

- **Problem solving skills** - possessing the ability to search for information, analyse situations, select and implement appropriate actions.

- **Social skills** - the ability to communicate and behave with others in ways that are socially appropriate and effective. This enables individuals to work in cooperative relationships with others and draw support from others.

- **Social support** - having access to people from which one is able to receive emotional, tangible and informational support. Emotional support is concerned with reassurance and having a person who one can rely on and confide in. It makes one feel loved and cared for. Tangible support has to do with provision of direct services or gifts. For example, providing nurses with equipment and supplies to do their work or care for a nurse who is ill. Informational support includes provision of necessary information or advice and giving a feedback about a person’s performance.

- **Material resources** - having money and the goods and services that money can buy. People need money for food, housing, leisure, holidays and education (Lazarus & Folkman 1984:159-164.)
2.8.5 The concept of self-care

Stoter (1997:70) highlights the fact that it is common for staff to expect management to provide support without realizing that each person has a responsibility for their own well-being and actions. Management may be able to address those stressors that arise due to the job and working environment, but the individuals have to act to lessen stressors created by personal lifestyles, understanding and attitudes. This raises the need for a staff to be empowered with knowledge on how to care for themselves.

Self-care according to Orem (2001:521) is “the practice of activities that maturing and mature persons initiate and perform within time frames, on their own behalf in the interests of maintaining life, healthful functioning, continuing personal development and well being through meeting known requisites for functional and developmental regulations.” In the context of this study, this definition suggests that a nurse who does not practice self-care activities that are required may not be in good health and ultimately not be able to care for others.

2.8.6 Orem’s universal self-care requisites applied to nurses

These are 8 universally required actions to be performed by or for individuals:

- The maintenance of sufficient intake of air. One needs to live and work in a well-ventilated environment and prevent air pollution.
- The maintenance of sufficient intake of food. One needs a well balanced diet with plenty of fresh vegetables and fruits. Processed and refined foods, chemicals and too much sugar should be avoided.
- Provision of care associated with elimination process and excretements. Healthy elimination habits, adequate intake of fluid and roughage, avoid or deal with constipation.
- Maintenance of a balance between activity and rest. Establish priorities, set boundaries between home and work, know when to rest, have adequate
sleep. Schedule time for exercises that are enjoyable. Use of activities that allow relaxation such as massage, deep breathing, knitting.

- Maintenance of a balance between solitude and social interaction. Avoid isolation by joining support groups and professional organizations, consult colleagues and supervisors to exchange ideas and knowledge, schedule time to be alone for reflection, meditation and relaxation; a retreat to refresh and heal; time to be with family and friends, vacation, fun and humour.

- Prevention of hazards to human life, human function and human well-being. Recognize own risk of contracting HIV/AIDS infection; carry out universal safety precautions when handling blood or other body fluids. Adopt a risk-free healthy life style. Detection and prevention tests such as Pap smear, mammogram, blood screens and rectal examination for men (for early detection of prostate cancer), dental check-up and blood pressure check.

- Promotion of human functioning and development within the social groups in accord with human potential, known human limitations, and the human desire to be normal. Recognize and acknowledge own vulnerability, strengths and weaknesses; seek counseling and support of others when necessary, share own experiences, struggles and pain to help peers get real; it reduces weight of difficulties and isolation, network with other care givers. Know what behaviors are accepted in the organizations, have access to information, further own knowledge and improve skills.

Orem further explains that the practice of actions to meet the above eight (8) requisites brings about the internal and external conditions that maintain human structure and functioning. These in turn support human development and maturation (Orem 2001:225).
2.8.7 Personal coping strategies

Literature reviewed reveals that nurses in different care settings adopt various coping strategies to help them manage the stress associated with caring for terminally ill patients.

For example, HIV/AIDS workers interviewed in Uganda and RSA (UNAIDS 2000b: 40), reported using the following coping strategies:

- Prayers and Bible reading.
- Not talking about AIDS at home.
- Rest, off duty one day a week.
- Diet, exercise, enough sleep.
- Nurturing oneself.
- Having time out.
- Talking to a spouse or partner.
- Relaxation techniques.
- Talking and listening to each other as colleagues.
- Deep breathing.
- Taking a break from work when on duty - to just walk around outside or watch birds.

In the study by Vachon (1998:156), the most important coping strategies for health workers in oncology and palliative care were:

- Developing of a sense of team philosophy, support and team building.
- Belonging to support groups.
- Supportive network both within and outside the work environment.

Nurses in hospice care (Rasmussen et al 1997:333,335) expressed being helped through turbulent times by:

- Having someone whom they could confide in and from whom they could gain strength, inspiration and confirmation.
• Abundance of humour, joking and laughter to relieve tension related to tragic experiences.
• Exercising, walking, and engaging in other fulfilling activities.
• Participating in study visits and courses.
• Personal counseling.
• Keeping a diary to transfer their feelings on paper to distance themselves.
• Taking a sauna, reflecting through situations while sweating and cleansing the body as well as “cleansing the mind”.
• Wearing special clothes at work, so when one changes to go home, they feel like they “undress the job”.
• “Taking out and emptying out” uneasy feelings with colleagues immediately so that feelings do not “get stuck or clinging on”.

Nurses caring for children with cancer and leukemia (Harding 1996b: 29) were helped to cope by:-
• Talking to staff/friends on the ward/hospital.
• Talking to friends/family outside the ward.
• Leaving work behind.
• Not taking home problems to work.
• Having outside interests such as sports.
• Access to funeral support.
• Church/faith.
• Being cheerful and supportive.
• Engaging in projects such as teaching students.

The above literature reveals that nurses, mostly utilised emotion focused forms of coping.
2.9 Summary

Overall, the literature reviewed indicates that caring for patients with HIV/AIDS is associated with stress, some of which may not be common in other care settings. It is also clear that the different individuals and groups of nurses have different perceptions of what is stressful, use different coping mechanisms and have different support preferences. Strategies would therefore not be successful without a clear picture of the problems being experienced by staff and how they would like to be supported. This study investigated the problems faced by nurses caring for HIV/AIDS patients, what support systems were in place to help them cope, the nurses’ support preferences and self-caring behaviours.
CHAPTER 3

RESEARCH METHODOLOGY

3.1 Introduction

Research methodology refers to “the steps, procedures and strategies for gathering and analysing the data in a research investigation” (Polit, Beck & Hungler 2001:465). The aim of this study was to describe the support available for nurses who care for patients with HIV/AIDS in Pretoria urban public hospitals.

3.2 Research Design

Research design has been defined as the overall plan which guides the researcher on how the research question will be answered and ways of ensuring accuracy of the information obtained (Cliffort, Carnwell & Harken 1997:58; Polit et al 2001:167).

This study focused on examining the support available for nurses who care for patients with HIV/AIDS in Pretoria urban public hospitals. A quantitative approach was used for this study. This approach, according to Brockopp and Hastings-Tolsma (1995:10), generates knowledge by measuring how much of a given behaviour or phenomenon exists in a particular population. The approach was chosen because this study aimed at examining the support that exists. In quantitative research, data can be collected at a distance from the subject, yielding findings, which are free from the researcher’s influence (Polit et al 2001:13). Objectivity and the ability to generalize the findings to the larger population is of particular concern when utilizing this approach (Brockopp & Hastings-Tolsma 1995:10). The focus is on a small number of concepts and uses
deductive reasoning, by starting with the little knowledge available and exploring it further (Cliffort et al 1997:58). Other characteristics are that there is control over the research setting and scheduled procedures and instruments are used to collect numerical data which can be quantified and analyzed using statistical procedures (Polit et al 2001:13). Against the above background, a descriptive research design was used so as to obtain a complete, accurate and thorough description of the situation as it exists (Brink & Wood 1998:15; Burns & Grove 1999:24). Brink and Wood (1998:289) state that the descriptive design is used where a variable has been either understudied or unstudied. This made the design the most appropriate because the topic investigated had not been adequately researched in the RSA. Descriptive designs are usually conducted in natural settings though a partially controlled setting may also be used (Burns & Grove 1997:42). Data is collected through interviews, questionnaires and observations which may be structured or semi-structured (Brink & Wood 1998:293). A limitation of this design is that control over data is limited because the subjects are examined in a natural setting (Brink & Wood 1998:291).

3.2.1 Validity of the research design

External validity is a major issue in descriptive studies. Polit et al (2001:194) define external validity as the extent to which the results of a study can be generalized to other settings or samples. According to Bless and Higson-Smith (1995:82), this is mainly dependent on how representative the sample is. The use of a non-probability sampling method for this study posed a threat to external validity. The inclusion of five hospitals in the study was an effort to make the sample more representative.
Internal validity is defined by Bless and Higson-Smith (1995:82) as the extent to which a research design has excluded all other possible explanations for the observed changes in the dependent variable. Internal validity was not an issue in this study because it was not aimed at examining causal relationships between variables (Brink & Wood 1998:293).

### 3.3 Research setting

The study was conducted in five (5) public hospitals in Pretoria urban. To uphold anonymity, the hospitals have been referred to as hospitals A B C D and E. All the participating hospitals did not have HIV/AIDS dedicated units. Patients with HIV/AIDS were admitted to units depending on what medical or surgical problems they presented. Participants were drawn from units that had high HIV/AIDS patients' census.

### 3.4 Study Population

The target population to whom the findings of this study will be generalized (Polit & Hungler 1995:232) included professional and auxiliary nurses who care for patients with HIV/AIDS in Pretoria urban public hospitals. Accessible population included all permanently employed registered, enrolled and auxiliary nurses caring for patients with HIV/AIDS in five (5) public hospitals who were present while the study was in progress.

### 3.5 Data collection approach

A structured self-report approach was utilized for data collection. This has been described by Polit et al (2001:267) as an approach in which data are
collected by means of a formal, written document. The structured approach has the following characteristics as stated by Polit et al (2001:263), (1) respondents are given the same questions in the same order with predetermined response alternatives to choose from; (2) data collected can be analyzed statistically because they are quantifiable and (3) objective data are collected. This approach was chosen because it is appropriate for a quantitative study.

### 3.6 Data collection instrument

A self-administered questionnaire was designed for this study based on literature review and views of experts in the field of HIV/AIDS. This method requires the respondent to answer questions without the help of the interviewer (Bless & Higson-Smith 1995:108). Advantages of a questionnaire as stated by Bless & Higson-Smith (1995:112) are: (1) the privacy of the respondent is respected and anonymity is assured which encourage respondents to give honest answers; (2) it avoids any bias due to characteristics of interviewers; (3) respondents have more time to deal with questions which may require reflection or consultation; (4) it is cheaper than personal interviews in terms of time and transport costs. Use of a questionnaire however, has disadvantages: (1) low response rate and (2) questions which are misunderstood cannot be clarified (Polit et al 2001:270). The researcher made efforts to overcome these disadvantages by: (1) personally handing out the questionnaire only to those nurses who gave consent to participate; (2) arranging a specific date and time for collection of completed questionnaires; (3) ensuring that questions were clearly phrased and (4) reviewing the items in the questionnaire with the participants to ensure that all items were understood.

The questionnaire consisted of closed-ended questions. According to Polit et al (2001:267), such questions are easier to administer and analyze and
also less time consuming for respondents. In order to avoid missing potentially important responses, there was provision for respondents to state any other experiences or opinions, which may not have been reflected in the fixed responses and in some cases, motivate their responses (Bless & Higson-Smith 1995:121). Use of a questionnaire was considered to be the most appropriate method for this study in view of the advantages stated above and because the busy schedules of participants, who were geographically dispersed, would have made personal interviews uneconomical with regards to time and finances. Data were collected over a four (4) week period from March to April 2003.

3.6.1 Questionnaire construction

The questionnaire, based on an in-depth literature review and views of experts in the field of HIV/AIDS consisted of the following sections:

- Section 1: Comprising biographical data of the respondents including gender, age, rank, years of service, marital status, race, level of nursing education, number of children, number of years in caring for patients with HIV/AIDS and category of patients cared for. This background information was used for comparing and contrasting the participants’ responses.

- Section 2: Comprising organizational and management factors dealt with preparation for HIV/AIDS care giving role. It included what and how much information was given to respondents who attended in-service training and the level of understanding for relevant topics even for those who did not have any formal preparation.

- Section 3: Comprising nurse, management and organisational factors, was the longest section. It consisted of 18 items exploring problems experienced by respondents while caring for patients with HIV/AIDS.
Section 4: Comprising nurse and management factors related to support, focused on eliciting the respondents’ perceptions of their support needs.

Section 5: Comprising management and organisational factors, had items which attempted to find out what support systems were in place at the 5 hospitals to help nurses to cope with the demands of their work.

Section 6: Comprised nurse-related factors regarding self-care and covered personal coping strategies including how the respondents dealt with emotional stress and how they maintained their physical health.

3.6.2 Reliability and validity of the research instrument

Reliability refers to “how consistently the measurement technique measures the concept of interest” (Burns & Grove 1999:257; Polit et al 2001:305). This was achieved through item analysis method (Bless & Higson-Smith 1995:134) during the pre-test of the study instrument. The method enabled the researcher to identify any items in the questionnaire, which did not provide useful information about the participants or confused the data. Such items were removed from the instrument.

Validity is “the degree to which an instrument measures what it is supposed to be measuring” (Polit et al 2001:308). Validity was enhanced by: (1) consulting experts in the field of caring for HIV/ADS patients during construction of the instrument, the experts were asked to analyze the adequacy of the items in capturing the domain of inquiry and (2) doing an extensive literature review.

3.7 Pre-test of the research instrument

Pre-test is the trial administration of a research instrument to “determine whether it is clearly worded, free from major biases and useful in
generating desired information” (Polit et al 2001:269). Pre-testing of the research instrument was done two weeks before data collection. A convenience sample of six (6) nurses who were involved in caring for HIV/AIDS patients and four (4) experts in the field of HIV/AIDS care were utilised. The aims of the pre-test were to:

1. Determine respondents understanding of the concepts used in the research.
2. Determine the responsiveness of respondents.
3. Refine the data collection instrument and plan
4. Determine how much time was needed to complete the questionnaire.

After analyzing the data, the following adjustments were made to the instrument:

1. Five items were re-phrased, as they were not clearly understood.
2. Three items were added.
3. Two items were considered inappropriate, hence were eliminated.
4. Sequencing of responses in some items was attended to.

### 3.8 Sample selection method

Convenience sampling method, which is a non-probability approach, was used. Non-probability sampling refers to the selection of elements by non-random methods. This approach does not give every element a chance of being included in the study (Polit et al 2001:235). Despite the above disadvantage, this approach is commonly used in quantitative studies because of its advantages of convenience and economy (Polit et al 2001:236, 240).

After permission to conduct the study was given by the Chief Executive Officers (CEO) of each hospital, the researcher made appointments to meet with the Nursing Service Managers. Lists of units to be used for the study
were obtained from the Nursing Service Managers who also advised the researcher on the best timings for meeting with nurses. Convenience sampling method was used to recruit participants. This means that the nurses who were on duty and willing to participate were used as study participants (Polit et al 2001:236). The disadvantage of this method is that it does not yield a representative sample. However, it was the most appropriate method because of the sensitive nature of the topic. Moreover, the quantitative descriptive design usually lends itself to voluntary participation. The criteria for inclusion in the study were that the nurses must have been:

1. Actively involved in caring for patients with HIV/AIDS for at least one year, so as to obtain valid data.
2. Full time employed.
3. On duty during the data collection.

3.8.1 Sample size

The sample consisted of eighty seven (87) participants recruited from the five (5) hospitals as follows: A- 23, B- 30, C- 8, D- 6 and E- 20. Finding volunteers in hospitals C and D was problematic. Nurses complained of being so short-staffed and over-worked that they would not have the time to complete the questionnaires.

3.9 Administration of questionnaires

After gaining access to the relevant units, nurses on duty were approached in small groups and a description of the study was given. The explanation included the purpose of the study, the voluntary nature of participation, opportunity to withdraw from the study as well as issues of confidentiality and anonymity. Nurses who volunteered to participate were given questionnaire packs and the researcher reviewed the questions with them to
ensure that all the items were clearly understood. A date and time for collection of completed questionnaires was agreed upon and some participants volunteered to act as contact persons to facilitate collection. Envelopes were provided with the questionnaires and respondents were requested to return the questionnaires in sealed envelopes to enhance confidentiality.

Out of the 100 questionnaires that were distributed, 93 (93%) were returned, giving a non-response rate of 7%. Upon editing of data for completeness, 6 (6.45%) questionnaires were found to be incomplete and were excluded to avoid compromising the quality of the data. Hence, the total number of usable questionnaires was 87 (refer to Table 3.1).

**Table 3.1: Response rate according to hospital**

<table>
<thead>
<tr>
<th>NUMBER OF QUESTIONNAIRES</th>
<th>HOSPITALS</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A  B  C  D  E</td>
<td></td>
</tr>
<tr>
<td>Distributed</td>
<td>26  33 13 8 20</td>
<td>100(100%)</td>
</tr>
<tr>
<td>Returned</td>
<td>24  31 12 6 20</td>
<td>93 (93%)</td>
</tr>
<tr>
<td>Not- returned</td>
<td>2  2 1 2 0</td>
<td>7 (7%)</td>
</tr>
<tr>
<td>Incomplete</td>
<td>1  1 4 0 0</td>
<td>6 (6.5%)</td>
</tr>
<tr>
<td>Usable</td>
<td>23  30 8 6 20</td>
<td>87(93.6%)</td>
</tr>
</tbody>
</table>

**3.10 Data Analysis**

The data were analysed between July and August 2003. Data from the questionnaires were entered into an excel spreadsheet. The data were then coded and analysed using the Statistical Analysis System (SAS) computer package with the assistance of a statistician from the Royal Free Hospital department of Public Health and Population Sciences. Frequency tables were generated from which tables and figures were later produced.
Univariate and bivariate descriptive statistics were used to describe the data. Univariate descriptive statistics used include simple frequencies, percentages, means and standard deviation. Bivariate descriptive statistics were utilized to describe relationships between two variables by means of contingency tables. This was necessary to determine whether there were any relationships worth following up in another study (Polit et al 2001:340).

Responses to open ended questions were first separated into mutually exclusive categories of similar content. The number of responses within each category was tabulated and frequencies reported (Brink & Wood 1998:300).

3.11 Ethical consideration

Permission to carry out the study was sought by writing to the CEO of each participating hospital who each gave the researcher written permission to conduct the study. To uphold anonymity, names of the hospitals are not used in this report. However the participants were made aware of which hospital code referred to them.

An explanation of the nature and purpose of the study was given to participants after which they gave informed consent to participate, completion and return of questionnaire was an indication of consent for participating.

Participation was purely voluntary without any coercion and participants were free to withdraw from the study at any time without any negative effects on them.

Not using participant’s names or divulging information obtained to others and destruction of questionnaires at the end of the project ensured confidentiality.
To uphold anonymity, participants were kept nameless in relation to their participation in the study. Code numbers were used when discussing data so that information could not be linked to any individual participant.
The researcher maintained honesty and accuracy in reporting of findings (Polit et al 2001: 75-84.)

3.12 Summary

The chapter describes the overall plan that guided the researcher in investigating the support available for nurses who care for patients with HIV/AIDS. A quantitative descriptive design was utilized for the study. The study was conducted in five public hospitals in Pretoria urban. Research ethics and human rights were adhered to. A convenience sample of hundred participants was selected from units that have HIV/AIDS patients. Data were collected using a questionnaire that was specifically designed for this study. The instrument was pre-tested on a sample similar to the target population and helped to refine the instrument and enhance reliability and validity of the study.
CHAPTER 4

PRESENTATION AND DISCUSSION OF DATA

4.1 Introduction

The purpose of this study was to describe the support available for nurses who care for patients with HIV/AIDS in Pretoria urban public hospitals. Support refers to the organizational, managerial and nurse support available in these hospitals. The findings presented and discussed in this chapter are based on analysis of data obtained from 87 nurses who were conveniently selected from 5 public hospitals in Pretoria urban.

4.2 Presentation and discussion of findings

The statistical information in this chapter was derived from 87 questionnaires completed out of 100 identified nurses permanently employed and working with HIV/AIDS patients at that time in five different hospitals in Pretoria. Most of the analysed data are presented in form of tables and graphs with numerical description. Presentation of data in this format makes it easy to interpret findings and reduces on narration process.

4.2.1 Demographic data of respondents (Section 1: questions 1.1 to 1.10 in questionnaire - factors related to nurses)

Table 4.1 indicates that the majority 83 (95.40%) of respondents were female, only 4 (4.6%) were male. This was attributed to the fact that there are more female than male nurses in the nursing profession. Respondents ranged from 20-59 years of age with the majority 38 (43.7%) in the age group 30-39 years. Only 8 (9.2%) were in the 50-59 age group. The mean
age was 37.8 years with a standard deviation of 8.58. Fifty (57.5%) were registered nurses, 21 (24.1%) enrolled nurses and 16 (18.4%) were auxiliary nurses.

Table 4.1 Age of respondents in relation to rank

<table>
<thead>
<tr>
<th>AGE GROUP IN YEARS</th>
<th>RANK.</th>
<th></th>
<th></th>
<th></th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Registered Nurses</td>
<td>Enrolled Nurses</td>
<td>Auxiliary Nurses.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20-29</td>
<td>8(9.2%)</td>
<td>3(3.5%)</td>
<td>3(3.5%)</td>
<td>14</td>
<td>(16.1%)</td>
</tr>
<tr>
<td>30-39</td>
<td>21(24.1%)</td>
<td>12(13.8%)</td>
<td>5(5.8%)</td>
<td>38</td>
<td>(43.7%)</td>
</tr>
<tr>
<td>40-49</td>
<td>17(19.6%)</td>
<td>5(5.8%)</td>
<td>5(5.8%)</td>
<td>27</td>
<td>(31.0%)</td>
</tr>
<tr>
<td>50-59</td>
<td>4(4.6%)</td>
<td>1(1.2%)</td>
<td>3(3.5%)</td>
<td>8</td>
<td>(9.2%)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>50(57.5%)</td>
<td>21 (24.2%)</td>
<td>16(18.4%)</td>
<td>87</td>
<td>(100%)</td>
</tr>
</tbody>
</table>

Table 4.1 indicates that the majority 21 (24.1%) were registered nurses aged 30-39 years, followed by registered nurses 40-49, then enrolled nurses 30-39 years.

The majority of respondents were married 44(50.6%) followed by never married 31 (35.6%) and the rest were widowed (3.5%), divorced (9.2%) or separated (1.2%). Forty-one, (47.1%) had 1-2 children 24 (21.6%) had none and 21 (24.1%) had 3-4 children only one male respondent reported having 7 and above children.
Table 4.2 Years of nursing service according to hospital (question 1.4)

<table>
<thead>
<tr>
<th>Years of Service</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-5</td>
<td>3</td>
<td>6</td>
<td>2</td>
<td>1</td>
<td>4</td>
<td>16(18.4%)</td>
</tr>
<tr>
<td>6-10</td>
<td>2</td>
<td>8</td>
<td>1</td>
<td>1</td>
<td>9</td>
<td>21(24.1%)</td>
</tr>
<tr>
<td>11-15</td>
<td>2</td>
<td>6</td>
<td>3</td>
<td>2</td>
<td>4</td>
<td>7(19.5%)</td>
</tr>
<tr>
<td>16-20</td>
<td>4</td>
<td>5</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>13(14.9%)</td>
</tr>
<tr>
<td>21-25</td>
<td>4</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>10(11.5%)</td>
</tr>
<tr>
<td>26-30</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>5(5.8%)</td>
</tr>
<tr>
<td>31-35</td>
<td>4</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>5(5.8%)</td>
</tr>
<tr>
<td>Total</td>
<td>23</td>
<td>30</td>
<td>8</td>
<td>6</td>
<td>20</td>
<td>87(100%)</td>
</tr>
</tbody>
</table>

Table 4.2 indicates that the majority of respondents 21 (24.1%) had been in nursing service for 6-10 years followed by 17 (19.5%) who had worked for 11-15. Only 5 (5.8%) had worked for 31-35 years. The mean was 13.9 years with a standard deviation of 8.7.
Figure 4.1 Race distribution of respondents (question 1.7)

Figure 4.1 indicates that the majority of respondents 63 72.4%) were black, 16 18.4%) were white and only 8 (9.2%) were coloured (mixed race).

Table 4.3 Number of years in HIV/AIDS care by hospital (question 1.8)

<table>
<thead>
<tr>
<th>YEARS OF HIV/AIDS CARE</th>
<th>HOSPITAL</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A</td>
<td>B</td>
</tr>
<tr>
<td>1-3</td>
<td>11</td>
<td>7</td>
</tr>
<tr>
<td>4-6</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>7-9</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>10-12</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>13-15</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>TOTAL</td>
<td>23</td>
<td>30</td>
</tr>
</tbody>
</table>
Responding to question 1.8, respondents indicated in table 4.3 their experience in caring for HIV/AIDS patients. The majority of respondents (35.6%) had been caring for HIV/AIDS patients for 4-6 years. Only 4 (4.6%) had 13-15 years of experience in caring for patients with HIV/AIDS.

The majority of respondents 45 (61.7%) had diplomas, followed by 33 (37.9%) with certificates, 7 (8.1%) with bachelor’s degrees. Honours and masters degrees each accounted for 1(1.2%) respondent. The majority 32 (36.9%) cared for adult female HIV patients, 16 (18.5%) for adult males, 15 (17.2%) for children, 14 (16.1%) both female and male patients, 9 (10.3%) males, females and children and 1 (1.2%) for females and children.

4.2.2 Job preparation (Section 2: questions 2.1 to 2.3 in the questionnaire – factors related to the organisation and management)

Table 4.4 Respondents who attended in-service training according to hospital (question 2.1)

<table>
<thead>
<tr>
<th>ATTENDED IN-SERVICE TRAINING</th>
<th>HOSPITAL</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A</td>
<td>B</td>
</tr>
<tr>
<td>Yes</td>
<td>10</td>
<td>12</td>
</tr>
<tr>
<td>No</td>
<td>13</td>
<td>18</td>
</tr>
<tr>
<td>TOTAL</td>
<td>23</td>
<td>30</td>
</tr>
</tbody>
</table>

The results, as shown in table 4.4, indicate that there were more respondents (62.1%) who did not attend any training for HIV/AIDS care than those who attended (37.9%).
Hospital A had a higher percentage of respondents who attended in-service training in relation to the number of respondents. Hospitals B, C, and E had the lowest number of respondents who attended.

The majority of respondents indicated that most of the topics in the list provided in item 2.2 of the questionnaire (annexure C) were adequately covered. It is worth noting that even for respondents who attended in-service training, some important topics were reported as either not covered or inadequately covered. These topics include caring for caregivers (54.5%), staff support groups (63.6%), recognizing and managing stress and preventing burnout (66.7%), legal and ethical issues in HIV/AIDS (51.5%). The above topics have implications on the ability of nurses to care for themselves as individuals and support one another.

When asked to indicate their level of understanding for each of the listed topics, the results reveal that the majority of respondents had an adequate or excellent understanding of epidemiology (57.5%), transmission (85.1%), prevention (66.2%), pathogenesis (60.9%), clinical features (73.6%), diagnosis (70.1%), care of a dying patient (64.4%) and dealing with bereaved families (60.9%) in the context of HIV/AIDS. However, a good number of respondents, including those who attended in-service training, reported a poor or inadequate level of understanding for almost half of the topics in the list. These topics include counseling (54%), staff support groups (64.4%), legal and ethical issues in HIV/AIDS (62.1%), home-based care (63.2%), recognition and management of stress and prevention of burnout (62.1%), anti-retroviral management of HIV/AIDS (54%), cultural and spiritual context of death and bereavement (62.1%) and HIV/AIDS disease monitoring (54%).
Table 4.5 Attendance of in-service training in relation to rank

<table>
<thead>
<tr>
<th>ATTENDED IN-SERVICE TRAINING</th>
<th>RANK</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>REGISTERED NURSES</td>
<td>ENROLLED NURSES</td>
</tr>
<tr>
<td>Yes</td>
<td>23(46%)</td>
<td>5(23.8%)</td>
</tr>
<tr>
<td>No</td>
<td>27(54%)</td>
<td>16(76.2%)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>50(100%)</td>
<td>21(100%)</td>
</tr>
</tbody>
</table>

Results from question 2.1 show in table 4.5 that a higher percentage of enrolled nurses (76.2%) than registered nurses (54%) did not attend in-service training.

These results are similar to the findings of the study by KCTT et al (2002:43,44,97) in which lack of training, especially in counseling, was identified as the greatest need for health workers. The same study also found that enrolled nurse midwives were less likely to have had training. The above findings suggest that job preparation for nurses who care for patients with HIV/AIDS is inadequate.

Esteem needs, according to Maslow’s hierarchy of needs, include mastery, competence and the ability to feel confident with one’s role (Maslow 1970:21). Nurses can only be competent and feel confident to practice if they have adequate knowledge and skills in their field of practice. Adequate knowledge and skills will not only lead to high levels of confidence but will also enhance nurses ability to discuss issues as equals with other professional colleagues. The above results are a cause for concern because without adequate knowledge and skills, nurses will have lower levels of confidence which may lead to low professional image, and would ultimately compromise nurses’ self esteem.
4.2.3 Problems experienced while providing care to patients with HIV/AIDS (Section 3: questions 3.1 to 3.18 in questionnaire – factors related to nurses, management and the organisation)

Responding to question 3.1, the majority of respondents 38 (43.7%) indicated in table 4.6 that they considered caring for patients with HIV/AIDS to be more stressful than caring for other patients. Thirty (34.5%) indicated ‘sometimes’ while 19 (21.8%) indicated that they did not consider it to be more stressful. Out of those who indicated that it was more stressful, the majority 13 (34.2%) gave the reason of too many deaths, followed by 11 (28.9%) who indicated that patients with HIV/AIDS had complex needs requiring more time. Only 2 (5.3%) gave inadequate knowledge and skill and 3 (7.9%) risk of infection as causes of stress. It is worth noting that 23.1% of respondents who gave the reason of too many deaths indicated that frequent death of children was very stressful. Out of the 30 (34.5%) respondents who indicated experiencing stress sometimes, 11 (36.7%) also gave frequent deaths as a cause of stress. These findings are similar to findings made by Rasmussen et al (1997:334); Slone and Stephany (1995:35); Unger et al (2002) and Vachon (1998:152). This implies that unless nurses are helped to effectively cope with the anxiety and trauma of frequent deaths, their safety needs will not be met. Indication by the majority of respondents that caring for patients with HIV/AIDS was more stressful than caring for other patients does not appear to be related job preparation. Results, as shown in table 4.6, indicate that the majority of respondents 14 (73.7%) who gave a negative response did not attend in-service training.
Table 4.6 Respondents’ report as to whether caring for patients with HIV/AIDS is more stressful in relation to attendance of in-service training

<table>
<thead>
<tr>
<th>WHETHER MORE STRESSFUL</th>
<th>IN-SERVICE TRAINING</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Yes</td>
<td>15</td>
<td>23</td>
</tr>
<tr>
<td>Sometimes</td>
<td>13</td>
<td>17</td>
</tr>
<tr>
<td>No</td>
<td>5</td>
<td>14</td>
</tr>
<tr>
<td>TOTAL</td>
<td>33(37.9%)</td>
<td>54(62.1%)</td>
</tr>
</tbody>
</table>

Table 4.6 shows that the majority of respondents (73.7%) who did not experience caring for patients with HIV/AIDS to be more stressful than caring for other patients were among those who had not attended in-service training.

All the hospitals included in the study did not have HIV/AIDS dedicated units. The average daily HIV/AIDS census was estimated at 25-49% by the majority (26.4%) of respondents while 17 (19.5%) indicated above 75% and 13 (14.9%) indicated 50-74%. HIV diagnosis was usually made by blood test (95.4%).

The common means of HIV transmission among patients nursed by respondents were heterosexual (42.5%) and mother to child (17.2%) for children. When asked in question 3.6 whether knowledge of patients’ mode of HIV infection influenced their feelings, results indicate that the majority of respondents were comfortable and empathetic in cases of blood transfusion (70.1%), mother to child (69%), intravenous drug use (58.6%)
and unknown transmission (69%). However, respondents ranging between 7 (8%) to 20 (27%) indicated that they felt uncomfortable nursing any HIV/AIDS patient regardless of the mode of infection. Fourteen (18.7%) indicated that they blame patients who are homosexual or bisexual.

The feelings of some respondents towards patients who are bisexual or homosexual are consistent with findings by Diaz (2001:75,76) who found that nurses in South Africa experienced feelings of discomfort in dealing with homosexuals because of its association with high-risk groups. This implies that more education is needed to help nurses develop a non-judgmental attitude towards people whose sexual orientations differ from their own.

The majority of respondents 41 (47.1%) reported in question 3.7 that their families were supportive of their work followed by 33 (37.9%) who reported that their families fear that they may get infected. Only 1 (1.2%) indicated that the family resented the work she did. With regard to social interaction, 44 (50.6%) reported that their job had no effect on social interaction while 38 (43.7%) indicated that their friends helped them cope with work. Only 5 (5.8%) reported that some friends avoided them. Stigma as a caregiver does not appear to be a major problem in this study unlike findings by AHRTAG (1997), Kushnir et al (1997) and Rasmussen et al (1997), which revealed that nurses felt stigmatised for nursing dying patients. Responding to question 3.9, respondents indicated that AIDS related conditions, which caused them to experience extreme emotional distress included loss of sight (50.6%), chronic diarrhoea (48.3%) and cryptococcal meningitis (47.1%). Reasons given for distress were disfigurement, mental disturbance, identification with patient, inadequate knowledge about AIDS related conditions, knowledge that patient is facing death, severe pain and suffering of patients without being able to do much to alleviate patients’ suffering.
In Table 4.7 the respondents’ rating of the risk of being infected with HIV while performing some procedures appears to be consistent with findings by Diaz (2001). The study by Diaz (2001:73) revealed that judgment of risk of infection significantly contributed to nurses’ anxiety when dealing with HIV/AIDS patients. The same author suggested that the judgment of risk was influenced by emotive reasons rather than rational reasons. In the current study, drawing blood and giving injections were viewed as having high or very high risk by the majority of respondents (79.3% and 67.8% respectively). This is in spite of the earlier indication by the majority of respondents that their understanding of HIV transmission and prevention of HIV infection were either adequate or excellent. These results are similar to the findings by Slone and Stephany (1995:3) whose study participants felt that there was always a potential for exposure to HIV infection when performing invasive procedures. The results are also consistent with findings made by UNAIDS (2000:39) in the RSA and Uganda. These fears need to be addressed as some procedures on patients may be left undone or patients neglected due to nurses’ fear of HIV exposure. Nurses need to understand that the risk of contracting HIV infection while providing care to patients is minimal for as long as the necessary safety precautions are taken. Without this understanding, safety needs of nurses may not be fulfilled.
Table 4.7 Risk of being infected with HIV (question 3.10)

<table>
<thead>
<tr>
<th>PROCEDURE</th>
<th>RISK OF INFECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NO RISK</td>
</tr>
<tr>
<td>Drawing blood</td>
<td>2 (2.3%)</td>
</tr>
<tr>
<td>Giving injections</td>
<td>2 (2.3%)</td>
</tr>
<tr>
<td>Dressing wounds</td>
<td>8 (9.2%)</td>
</tr>
<tr>
<td>Bathing patients</td>
<td>29 (33.3%)</td>
</tr>
<tr>
<td>Changing soiled linen</td>
<td>24 (27.6%)</td>
</tr>
<tr>
<td>Oral toilet</td>
<td>22 (25.3%)</td>
</tr>
</tbody>
</table>

Table 4.7 indicates that drawing blood was rated as very high risk by more respondents (41.4%) followed by giving injections as high risk (39.1%) while bathing patients was rated as having the lowest risk.

Responses to question 3.11 indicate that availability of equipment and supplies was not a major problem in the sampled hospitals. Most of the basic equipment and supplies required for patient care were reported to be available either adequately or in excess by the majority of respondents. A small number of respondents reported that bed linen (25.3%) and gloves (12.6%) were scarce. However, that appeared to be more a reflection of poor planning at the level of unit managers rather than scarcity at institutional level. Unit managers need to ensure that they order and stock adequate...
supplies to facilitate patient care. It is very stressful when nurses who are already short-staffed and overworked have to go round looking for supplies from other units.

![Bar Chart](chart.png)

**Figure 4.2 Respondents’ report of nursing staff shortage (question 3.12)**

Figure 4.2 shows that the majority of respondents, (88.5%) indicated in question 3.12 that shortage of nursing staff was a major problem.

Shortage of staff was identified as a major problem by respondents. Seventy-seven (88.5%) of the respondents indicated that shortage of nursing staff was a major problem in their workplace. Only 10 (11.5%) did not consider it to be a major problem. Time to provide emotional care to patients was the activity mostly affected by shortage of staff (60.9%) followed by time for break (47.1%). This revelation is similar to findings of studies by Harding (1996(a):28), Lally and Pearce (1996:18), Rasmussen et al (1997:333) and UNAIDS (2000:31) which identified shortage of nursing staff as a major problem.
The majority of respondents indicated in question 3.14 that they felt confident with giving spiritual care (50.6%), supporting patients’ relatives (47.1%) and providing emotional care to dying patients (41.4%). The majority of respondents (39%) felt very confident in separating work from their personal lives while only 7 (8.1%) were not confident (refer to Table 4.8).
When asked in question 3.15 to rate their levels of job satisfaction, the majority, 35 (40.2%) indicated satisfactory, followed by 33 (37.9%) who indicated moderate, then 10 (11.5%) poor, 7 (8.1%) very satisfactory and 2 (2.3%) poor (refer to Figure 4.3).

The results show that there was no association between job satisfaction and job preparation. Of the 35 (40.2%) respondents who expressed satisfactory job satisfaction, 17 (48.6%) had not attended in-service training. Similarly all the 7 (8.1%) respondents who reported very satisfactory job satisfactory had not attended in-service training (refer to Table 4.9). This suggests the existence of other factors influencing job satisfaction.
Table 4.9 Job satisfaction in relation to in-service training

<table>
<thead>
<tr>
<th>LEVEL OF JOB SATISFACTION</th>
<th>ATTENDED IN-SERVICE TRAINING</th>
<th>IN-SERVICE</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>YES</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>Very poor</td>
<td>1</td>
<td>1</td>
<td>2(2.3%)</td>
</tr>
<tr>
<td>Poor</td>
<td>2</td>
<td>8</td>
<td>10(11.5%)</td>
</tr>
<tr>
<td>Moderate</td>
<td>13</td>
<td>20</td>
<td>33(37.9%)</td>
</tr>
<tr>
<td>Satisfactory</td>
<td>18</td>
<td>17</td>
<td>35(40.2%)</td>
</tr>
<tr>
<td>Very satisfactory</td>
<td>0</td>
<td>7</td>
<td>7(8.1%)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>3(37.9%)</td>
<td>54(62.1%)</td>
<td>87(100%)</td>
</tr>
</tbody>
</table>

Figure 4.9 indicates that all the 7 (8.1%) respondents who reported their job satisfaction as very satisfactory had not attended in-service training to prepare them for HIV/AIDS care-giving role.

Table 4.10 Job satisfaction in relation to whether HIV/AIDS care is more stressful

<table>
<thead>
<tr>
<th>LEVEL OF JOB SATISFACTION</th>
<th>WHETHER HIV/AIDS CARE IS MORE STRESSFUL</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Very poor</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Poor</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Moderate</td>
<td>16</td>
<td>8</td>
</tr>
<tr>
<td>Satisfactory</td>
<td>13</td>
<td>8</td>
</tr>
<tr>
<td>Very satisfactory</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>TOTAL</td>
<td>38(43.7%)</td>
<td>19(21.8%)</td>
</tr>
</tbody>
</table>
Table 4.10 indicates that of the 35 (40.2%) respondents who reported experiencing satisfactory job satisfaction, 14 (40%) indicated ‘sometimes’ 13 (37.1%) indicated ‘yes’ while 8 (22.9%) indicated ‘no’ to question 3.1.

Diaz (2001:79) found a significant correlation between occupational satisfaction and HIV anxiety contrary to the findings of this study which do not indicate a relationship between job satisfaction and whether HIV/AIDS care is more stressful than caring for other patients (Table 4.10). This revelation is supported by responses given to the question on whether the respondents would choose to work in the same department.

When asked whether they would choose to work in the same department (question 3.16), the majority 55 (63.2%) of respondents answered ‘yes’, 21 (24.1%) answered ‘no’ while 11 (12.6%) were unsure. Of the 32 respondents who gave reasons for wanting to work in the same unit, the majority 11 (34.4%) explained that they enjoyed caring for patients with HIV/AIDS and it is worth noting that 7 (63.6%) of these were trained HIV/AIDS counselors. Nine (28.1%) indicated that they had the knowledge, skills and experience needed to work in those particular units.
Figure 4.4 indicates that the majority of respondents, (54.02%), rated the level of teamwork between nurses and doctors as average.

![Figure 4.4](chart.png)

**Figure 4.4 Level of teamwork between nurses and doctors**

Figure 4.5 indicates that the level of teamwork among nursing staff was rated as average by the majority (44.83%) of respondents.

The level of teamwork was reported as average by the majority of respondents both between nurses and doctors and among nurses. Reasons given for poor teamwork between nurses and doctors include bad attitude of some doctors towards patients, lack of respect for nurses and lack of communication. Reasons given by those who indicated ‘average’ include illegible writing of some doctors, inadequate knowledge and skills in handling HIVAIDS patients and that some doctors had bad attitude towards patients and nurses. Reasons given for high level of teamwork between nurses and doctors include doctors had good attitude toward patients and doctors were always willing to do their work.
Reasons given for poor teamwork among nurses were bad attitude of some nurses towards patients and some nurses were uncooperative. Reasons for average teamwork include bad attitude of some nurses towards patients and towards work in general and shortage of staff. For high level of teamwork reasons given were that nurses were always ready to help and support one another, ready to attend to patients and took very good care of patients.

Teamwork is a major factor contributing to gratification of Maslow’s belongingness and love needs (Maslow 1970:21). Moreover good interpersonal relationships among staff create a relaxed environment in which staff can not only be better able to meet patients’ needs, but also able to support one another. The average teamwork reported by the majority of respondents is a cause for concern that needs to be addressed. This revelation is consistent with the findings of the study by Solombela and Ehlers (2002:57) that revealed that student nurses did not seem to develop good interpersonal relationships with their colleagues from the 1st till the 4th year of training. Reasons indicated for lack of teamwork are similar to those found by Fletcher (2001:326).

4.2.4 Perceived support needs (Section 4: questions 4.1 to 4.9 in questionnaire – factors related to nurses and management)

Respondents were asked in question 4.1 whether they found it easy to ask colleagues for help with work. The majority 30 (34.5%) indicated ‘sometimes’, followed by often 27 (31%). Only 4 (4.6%) indicated never. Reasons given by respondents who indicated sometimes include:
- Colleagues have their own problem
- Low morale among nurses
- The wards are very busy - it is difficult to find help
- Some nurses are not helpful
- Some times they refuse because they are over-worked
The above responses suggest that shortage of nurses may be an underlying factor for reasons why nurses are sometimes not able to get help from colleagues when necessary.

In response to question 4.2.1 the majority of respondents 34 (39.1%) felt that their work was sometimes appreciated by patients, 26 (29.9%) indicated ‘often’ while 21 (24.1%) indicated ‘always’.

Appreciation of their work by colleagues, in question 4.2.2, was rated as ‘sometimes’ by 30 (34.5%), ‘always’ by 29 (33.3%), ‘often’ by 24 (27.6%) and ‘never’ by only 4 (4.6%) respondents.

Appreciation of their work by supervisors was rated as ‘sometimes’ by 25 (28.7%), ‘always’ by 24 (27.6%), ‘often’ by 20 (23%) and ‘never’ by 18 (20.7%).

| Table 4.11 Appreciation of work by supervisor in relation to job satisfaction. |
|-------------------------------|-------------------------------|----------------|----------------|
| LEVEL OF JOB SATISFACTION     | APPRECIATION BY SUPERVISOR    |                |                |
|                               | Never                        | Sometime(s)    | Often          | Always         |
| Very poor                     | 0                            | 2              | 0              | 0              | 2(2.3%)        |
| Poor                          | 4                            | 2              | 3              | 1              | 10(11.5%)      |
| Moderate                      | 8                            | 12             | 5              | 8              | 33(37.9%)      |
| Satisfactory                  | 4                            | 8              | 11             | 12             | 35(40.2%)      |
| Very satisfactory             | 2                            | 1              | 1              | 3              | 7(8.1%)        |
| TOTAL                         | 18(20.7%)                    | 25(28.7%)      | 20(23%)        | 24(27.6%)      | 87(100%)       |

The majority of respondents 12 (36.4%), out of those who reported moderate satisfaction 33 (37.9%), indicated in table 4.11 that they felt appreciated by their supervisors only sometimes. The majority of those who
reported satisfactory and very satisfactory job satisfaction reported being appreciated by their supervisor (50% and 12.5% respectively). Out of the 10 (11.5%) respondents who reported poor job satisfaction the majority 4 (40%) reported that they never felt appreciated by their supervisors. Recognition and appreciation are important human needs which influence self-esteem (Maslow 1970:21). Low self-esteem may lead to low morale, discouragement and low job performance. Therefore nurse managers need to recognize good performance of their staff and appreciate their contribution. Furthermore, when nurses are valued and seen as a valuable resource in the health care team, they will be able to develop a sense of personal worth and respect as individuals and as professionals (Stoter 1997:64).

Respondents were asked in question 4.3 whether they found it easy to share emotional problems with colleagues. The majority of respondents 32 (36.8%) indicated ‘sometimes’ followed by 27 (31%) who indicated ‘always’ (refer to Figure 4.6).

![Figure 4.6](image_url)

*Figure 4.6 Respondents report as to whether they found it easy to share emotional problems with colleagues (question 4.3)*
Reasons given by respondents who indicated ‘never’

- No time to share or listen to colleagues due to lack of time.
- No one can be trusted.
- No confidentiality among colleagues— it is better to share with friends outside work.
- Colleagues would not understand due to cultural differences.
- Supervisors never listen to nurses’ problems.

Reasons for indicating ‘sometimes’

- Lack of confidentiality among colleagues
- Can only share work related problems
- It is difficult to open up to colleagues
- Because colleagues face similar problems
- It depends on what the problem is
- Only when the relationship is good or close

Reasons for indicating ‘always’

- More time spent at work
- Colleagues are supportive
- Colleagues are good listeners
- Colleagues understand the situation as they face similar problems.
Table 4.12 Whether respondents find it easy to share emotional problems in relation to race

<table>
<thead>
<tr>
<th>SHARE EMOTIONAL PROBLEMS</th>
<th>RACE</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>BLACK</td>
<td>WHITE</td>
</tr>
<tr>
<td>Never</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Sometimes</td>
<td>23</td>
<td>5</td>
</tr>
<tr>
<td>Often</td>
<td>9</td>
<td>5</td>
</tr>
<tr>
<td>Always</td>
<td>24</td>
<td>2</td>
</tr>
<tr>
<td>TOTAL</td>
<td>63 (72.4%)</td>
<td>16 (18.4%)</td>
</tr>
</tbody>
</table>

Table 4.12 indicates that relatively more blacks (38.1%) than whites (12.5%) or coloureds (12.5%) always found it easy to share emotional problems with colleagues. Relatively less blacks (11.1%) than whites (25%) or coloureds (37.5%) indicated that they never found it easy to share emotional problems with colleagues.

These results suggest the influence of culture on preferred support needs of nurses. The finding that more blacks found it easy to share emotional problems with colleagues may be attributed to the value they place on group solidarity. Black people are generally collectivists and tend to rally around each other when problems arise. On the other hand, whites tend to be individualists and value autonomy (Andrews & Boyle 2003:366).

With regard to sharing problems concerning clinical knowledge and skills (question 4.4) the majority of respondents 43 (49.4%) indicated that they always found it easy to share with colleagues, 22 (25.3%) reported often, 18 (20.7%) sometimes and only 4 (4.6%) indicated never.
Ability to cope with work was rated, in question 4.5, as good by 37 (42.5%), average by 24 (27.6%), very good by 23 (26.4%) and poor by only 3 (3.4%) respondents.

In question 4.6 respondents were asked to indicate where they seek help to enable them cope, and how often. In order to help them cope, the majority of respondents (82.8%) seek help from family members, followed by fellow nurses (78.2%), religious leaders (63.2%), and supervisors (55.2%). The least utilized source of help was psychologist (32.2%). Given the choice, the majority of respondents 47 (54%) would prefer to receive emotional support from both within and outside work, 24 (27.6%) from the workplace while 16 (18.4%) indicated from outside the work environment only.

Reasons given for choosing to receive support from the workplace include:-

- Support will be readily available as more time is spent at work than outside.
- Stress is from work

Reasons for preferring outside work environment:

- It is more relaxing
- Outsiders care and listen more than people at work
- No confidentiality at work because of too much gossip
- Have no confidence in employers.

Reasons for preferring both at work and outside:

- Problems can be either work or domestic related.
- It is easier to open up to a friend.
- There is not enough time to talk to someone at work.
- Insiders know the situation better and it gives the feeling that one is alone.
Question 4.8 requested respondents to indicate from whom they would like to receive support at the workplace, the majority of respondents (33.3%) indicated they would prefer to receive emotional support from psychologists, followed by nurse managers (31.5%), then spiritual leader (18.5%) and fellow nurses (16.7%). Those who preferred psychologists gave reasons of confidentiality and that psychologists are better qualified to give emotional support. Respondents who chose nursing managers gave the reasons that their nurse managers were friendly, readily available, had more knowledge and it would make the nurses feel appreciated. Choices of where respondents prefer to receive support from are contrary to the findings by both Miller et al and the UK MOMS study in which the majority of respondents preferred support from outside the organization. However, reasons given for choosing inside or outside workplace are similar to reasons given by respondents in both Miller et al (2000 cited in Miller 2000:152-155) and the UK MOMS study (cited in Miller 2000:167).

Respondents were asked in question 4.9 to give suggestions on how nurse managers could create a more caring and supportive work environment. The following responses were obtained (percentage of respondents is indicated in brackets):

- Improve communication with nurses- especially listening to nurses (21.8%).
- Ensure that wards are adequately staffed (21.3%).
- Be available for nurses (“be there for us”) (17.2%).
- Provide in-service education to update nurses on HIV/AIDS issues (17.2%).
- Facilitate formation of support groups for nurses (14.9).
- Provide counseling/ debriefing services for nurses in wards with high death rates (12.6%).
• Use leadership styles that allow nurses to be innovative and participate in decision-making (12.6%).
• They should experience personal involvement with patients and not just sit comfortably in their offices (8%).
• Provide adequate equipment/materials so that nurses do not spend time begging from other departments as it is tiring (8%).
• Maintain confidentiality, especially regarding HIV positive nurses (8%).
• Recognize and appreciate good performance instead of just complaining (5.7%).
• Treat nurse with dignity and respect especially in front of patients (5.7%).
• Nurse Managers must have a good understanding of HIV/AIDS and issues surrounding HIV management (5.7%).
• Lobby for the provision of anti-retroviral drugs for nurses who are living with HIV infection (4.6%).
• Be approachable (3.4%).
• Allocate nurses according to interest and ability (3.4%).
• Should be firm but fair, no favouritism (3.4%).
• Solve problems- not just ignore them (2.3%).
• Attend funerals of nurses and nurses' immediate family (2.3%).
• Organise motivational talks for nurses (1.1%).
### 4.2.5 Availability of support systems (Section 5: questions 5.1 to 5.15 in questionnaire – factors related to the organisation and management)

**Table 4.13 Availability of emotional support services according to hospital (question 5.1)**

<table>
<thead>
<tr>
<th>Support service availability</th>
<th>HOSPITAL</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A</td>
<td>B</td>
</tr>
<tr>
<td>Yes</td>
<td>13</td>
<td>20</td>
</tr>
<tr>
<td>No</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Don’t know</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>TOTAL</td>
<td>23</td>
<td>30</td>
</tr>
</tbody>
</table>

The majority of respondents 50 (57.5%) indicated in table 4.13 that emotional support services were available in their hospitals. All the 8 respondents from hospital C indicated that there were no emotional support services in the hospital.

Types of emotional support services available included: counseling, pastoral care, debriefing, sessions and both formal and informal support groups (question 5.2).

The majority of respondents in hospitals where support services were available (38.9%) indicated that they were able to access the services sometimes, 15 (29.8%) always, 12 (22.2%) often and 6 (11.1%) never.

Reasons given for not being able to access the support services included:

- Being too busy because of heavy workload and shortage of staff
- Issues of confidentiality
Table 4.14 Quality of emotional support offered according to hospital (n=50)

<table>
<thead>
<tr>
<th>QUALITY OF SUPPORT</th>
<th>HOSPITAL</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A</td>
<td>B</td>
</tr>
<tr>
<td>Poor</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Unsatisfactory</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Satisfactory</td>
<td>8</td>
<td>12</td>
</tr>
<tr>
<td>Excellent</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>TOTAL</td>
<td>13</td>
<td>20</td>
</tr>
</tbody>
</table>

Table 4.14 indicates that the quality of emotional support was rated as satisfactory by the majority (64%) of respondents (question 5.3).

It is clear from the findings that some form of emotional support services for nurses do exist in hospitals A, B, D and E. However the coverage of these services may not be adequate to meet the needs of nurses who care for patients with HIV/AIDS or the services have not been made known to all the intended users. Hospital C does not appear to have any form of emotional support for nurses as all the respondents from that hospital gave a negative response.

In response to question 5.6, the majority of respondents indicated that they did not have any knowledge/skill-based support at their workplace. Fifty five (63.2%) respondents reported not having a library, while 15 (17.2%) reported having adequate library service. All the respondents from hospital C indicated that they did not have a library. In hospital B, though a library was geographically accessible, respondents reported that they were not able to use it because they were required to pay in order to use it. Forty (46%) respondents reported that they did not have any HIV/AIDS theory update
while 16 (18.4%) reported having adequate theory updates, 34 (39.1%) reported having no clinical supervision with 24 (27.6%) indicating that they had adequate clinical supervision. These results suggest that knowledge/skill-based support was inadequate.

The majority of respondents 59 (67.8%) had access to HIV testing at their workplace. Sixty three (72.4%) knew their HIV status, 12 (13.8%) indicated they did not know their HIV status, 7 (8.1%) had never been tested and 5 (5.8%) did not want to know their HIV status. Most of the respondents in this study knew their HIV status unlike results of the KTCC et al (2002:107) study in which most of the respondents did not want to know their HIV status.

In response to question 5.10, thirty-eight (43.7%) respondents indicated that nurses who are HIV positive had access to psychosocial counseling within the workplace, 37 (42.5%) indicated that they did not know, while 12 (13.8%) indicated that HIV positive nurses did not have access to psychosocial counseling. Where counseling exists, it is provided by HIV/AIDS counselors (89.5%), nurse managers (5.3%) and hospital chaplain (5.3%). With regard to whether HIV positive nurses had access to anti-retroviral medication, quite a number of respondents (44.8%) indicated they did not know. Results further suggest that anti-retroviral drugs were made available only to nurses who have had accidental HIV exposure while on duty.
Table 4.15 Quality of support given to nurses who are HIV positive (question 5.14)

<table>
<thead>
<tr>
<th>QUALITY OF SUPPORT</th>
<th>HOSPITAL</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A</td>
<td>B</td>
</tr>
<tr>
<td>Poor</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Inadequate</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Satisfactory</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Excellent</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Don’t know</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>TOTAL</td>
<td>23</td>
<td>20</td>
</tr>
</tbody>
</table>

The quality of support given to nurses who are HIV positive was rated as poor by 23 (26.4%) of the respondents, an equal amount 23 (26.4%) indicated they did not know followed by 20 (23%) inadequate, 12 (13.8%) satisfactory and 9 (10.3%) excellent (refer to Table 4.15). Hospital C had a relatively high proportion of respondents 5 (62.5%) who rated the support as poor. Of those who rated support to nurses living with HIV/AIDS as excellent, the majority (55.6%) were from hospital A. The reason given by 60% of respondents from hospital C who indicated that the support was poor was that there was no confidentiality, especially by supervisors. Reasons given by respondents who indicated inadequate support include:

- HIV positive nurses were treated like any other HIV patient at the hospital (10%).
- No follow up care except when a nurse is very ill (10%)
- Nurses with HIV infection were discriminated against by colleagues (5%).
- HIV positive nurses were expected to cope on their own because they should understand the condition (5%).
• There were very few trained counselors to offer support to nurses. Counselors concentrated on patients (5%).

Handling of needle stick injuries involved testing for HIV and follow up (47.1%), giving post-exposure prophylaxis (42.5%). Only 8 (9.2%) respondents did not know how needle stick injuries were handled. It is clear from the results that all the sampled hospitals had guidelines on how to deal with needle-stick injuries. However there is need to find means of ensuring that there is 100% awareness of the guidelines.

4.2.6 Personal coping strategies (Section 6: questions 6.1 to 6.2 in questionnaire – factors related to nurses)

Personal coping strategies commonly used by respondents include:

- Spending time with family
- Prayer
- Going to church
- Reading religious books
- Having fun with friends
- Listening to music/gospel music
- Watching movies

Coping strategies rarely used include:

- Taking alcohol
- Smoking
- Participating in sports
- Relaxation techniques

In order to maintain their physical health, the respondents mainly used the following strategies:

- Having adequate rest/sleep
- Good nutrition
- Precautions to prevent infections
Physical exercise, taking vacations and vitamin supplements were not often used. The coping strategies reported by respondents in this study are recognized emotion focused coping strategies similar to those reported by participants in studies by Harding (1996b: 29) and UNAIDS (2000b:40).

4.3 Summary

The findings suggest that both job preparation and support for nurses who care for HIV/AIDS patients were inadequate. The major problems faced by nurses included extreme suffering and frequent deaths of patients and shortage of staff. Nurses preferred support from both within and outside the workplace. These findings suggest that there is need to improve provision of support for nurses who care for patients with HIV/AIDS.
CHAPTER 5

CONCLUSIONS, IMPLICATIONS, LIMITATIONS AND RECOMMENDATIONS

5.1 Introduction

The aim of this study was to describe the support available for nurses who care for HIV/AIDS patients in Pretoria urban public hospitals. In this chapter, the conclusions made from the findings of this study will be put into perspective and implications to the health system outlined. Research findings indicate the need for several aspects to be addressed. Hence recommendations for improvement of support to nurses who care for patients with HIV/AIDS will be suggested.

5.2 Conclusions

The following conclusions were made from the research findings of this study:

5.2.1 What preparation was given to nurses for HIV/AIDS care-giving roles?

Job preparation for nurses who care for patients with HIV/AIDS in Pretoria urban public hospitals was inadequate both in terms of coverage of topics and coverage of nurses.
5.2.2 What problems did nurses experience while providing care to patients with HIV/AIDS?
The major problems experienced by respondents were fear of HIV exposure, coping with the extreme suffering of patients and high death rate, inadequate staffing, lack of teamwork and poor working relationships among nurses as well as between nurses and medical staff.

5.2.3 How did nurses caring for patients with HIV/AIDS perceive their support needs?
The majority of respondents preferred to receive support from both within the organization and outside the organization. Nurse Managers, psychologists and religious leaders were identified as the most preferred personnel to provide support.

5.2.4 What were the support systems available for nurses who care for patients with HIV/AIDS in Pretoria urban public hospitals?
Both emotional and knowledge/skill based support, though available in some hospitals, was inadequate in terms of both quality and coverage of nurses. Support for nurses living with HIV infection was also generally inadequate.

5.2.5 What were the personal coping strategies used by nurses who care for patients with HIV/AIDS?
The nurses used emotion focused forms of coping to deal with emotional stress. To maintain their physical health, the nurses took adequate rest, good nutrition and precautions to prevent infections.
5.3 Implications to the health system

The results of this study have the following implications:

This study reveals that support for nurses who care for patients with HIV/AIDS in Pretoria urban public hospitals is generally inadequate. The problems and shortcomings identified by this study need to be addressed in order for the DOH to achieve its objective of providing quality of care to people with HIV/AIDS (DOH 2000:4). If this is not done, absenteeism, sickness, low productivity and increased turnover among nursing staff will lower the quality of care to patients and increase the cost of care provision by hospitals.

In view of the above, the DOH needs to prioritise provision of support for nurses who care for patients with HIV/AIDS and work with hospital managements to develop, implement and evaluate relevant policies. Hence, the following recommendations might be helpful in addressing some of the apparent inadequacies in provision of support to nurses who care for patients with HIV/AIDS identified by this study.

5.4 Recommendations for improvement of support services

Recommendations for improvement of support services are made as follows:

5.4.1 Recommendations for management

Recommendations for management are as follows:

- Before designing support strategies, there is need to find out from the nurses what problems and stressors they face as well as the
causes and origins of those problems from the nurse’s point of view. Some stressors are inherent in the job and working environment, some arise from internal responses of individual nurses while others are caused by home and family pressures (Stoter 1997:33-35).

- **Management needs to take action** eliminate stressors inherent in the job and working environment that can be removed by creating a safe, healthy and responsive work environment. Specific examples include increasing staffing to needy areas, providing adequate equipment and supplies for basic patient care and using appropriate management styles.

- **For stressors that are inherent in the job situation and are unavoidable** such as high death rate of patients, specific support strategies should be put in place to help nurses cope. For example, counseling and debriefing sessions by qualified facilitators.

- **For stressors created by the person’s own lifestyle, understanding or attitudes**, education is needed to empower nurses with skill to recognize and manage stress effectively. Nurses should be encouraged to practice self-care activities.

- **The types of support on offer and what they aim to achieve** should be clarified with the recipients so that resources are not wasted on systems that will not be accepted or utilised. Interventions need to match the identified problems / needs.

- **Support should be accessible both geographically and logistically.** Hence, hindrances to access and effective utilisation of support services need to be addressed and built into the system. Fear of inappropriate disclosure of information has been identified by this study as a major hindrance to seeking support. Managers need to decide upon appropriate confidentiality mechanisms and have clear statements regarding how confidentiality will be observed.
Any feedback from counselors or debriefing facilitators to management should be general and not contain issues attributable to individual nurses. To overcome the identified problem of time, nurse managers need to arrange for staff cover to enable nurses have regular and reliable support sessions available at place of work.

- Nurses need to be recognised and rewarded for outstanding performance and contribution to the organisation. Such rewards need not be big, even just letters of commendation go a long way in motivating staff and addressing their personal esteem and professional worth. Other ways of recognizing nurse’s good performance include giving them important tasks or something new to do as well as responsibility and power to make important decisions in their areas of work. Such strategies also work to increase nurses’ satisfaction.

- Results of this study reveal that nurse managers are key persons with regard to provision of support within the workplace. Hence nurse managers at all levels need to work at improving relationships with nurses, be approachable and available for nurses. They should be well versed in issues of HIV/AIDS management and stress management so that they are able to offer guidance to nurses. Nurse Managers need to adopt leadership styles which include trusting, honouring, inspiring and sharing power with subordinates. They should set clear standards of practice and evaluation criteria. Giving and receiving of feedback and positive re-enforcement should be regular to reduce nurses’ anxiety and improve performance. Managers should learn to listen to staff complaints, problems and ideas, work together to find solutions and above all keep confidences. Nurses should be treated with respect and dignity. Whenever possible, nurses need to be allowed to work in their areas of interest and skill to suit
their personal needs and professional aspirations. This makes nurses love their work and feel competent and challenged to do their best.

- Managers need to foster a spirit of teamwork and encourage good relationships among staff to enhance the ability of nurses to support each other. One way of enhancing collegiality is by encouraging group social activities such as sports, fitness training or parties within the work place.

- To provide support with regard to knowledge and skills of nurses, clinical supervision is one approach that would improve and develop clinical skills and contribute to the life-long need to update nurses’ performance. Clinical supervision needs to be carried out by senior nurses with sufficient experience in HIV/AIDS management and skills in group facilitation and clinical supervision (Bond & Holland 1998:18-19). A library with current material on HIV/AIDS issues should be provided and made accessible to nurses. Efforts should be made to hold clinical meetings, research presentations and interest group meetings to enable nurses update their knowledge and share information with colleagues.

### 5.4.2 Recommendations for Nursing Education

The following recommendations for nursing education are made:

- Care and support for nurses who care for patients with HIV/AIDS should be part of the curriculum for all workshops, seminars and courses for nurse managers.

- Pre-service nurse training should have a comprehensive coverage of issues related to HIV/AIDS including stress management and self-care

- In-service training should be given to all nurses who care for patients with HIV/AIDS. The curriculum for such courses needs to
be reviewed to ensure that pertinent topics are not omitted. Management should ensure that opportunities for training are increased, especially for enrolled nurses.

5.4.3 Recommendations for nurses

Recommendations for nurses are as follows:

- **Nurses need to take an active role in looking after their own health.** It is important to adopt healthy lifestyles, and avoid behaviours that may expose them to HIV, Hepatitis B or other infections both at work and outside work.

- **All nurses should take the initiative to update their knowledge and develop themselves professionally by reading, attending seminars and interest group meetings or participating in research studies related to HIV/AIDS.** They should have an interest of finding out important information related to their areas of practice, for example, policy on occupational exposure to HIV, and what resources are available for their benefit.

- **For nurses living with HIV infection, it is important to have a healthy diet and lifestyle, treat any infections promptly and seek relevant support whenever necessary.**

5.5 Recommendations for further studies

The following recommendations for further study are made:

- **Research targeted at nurses who are HIV positive to assess the care and support that they are receiving.**

- **A study to determine the knowledge and attitudes of nursing staff towards clinical supervision for nurses.**

- **A study to investigate the influence of nurses’ spirituality on the experience of stress.**
• Replication of this study in other parts of the country, and Sub-Saharan region, utilising qualitative methods.
• There is need to develop a staff support model for nurses caring for people with HIV/AIDS in the Sub-Saharan region.

5.6 Limitations of the study

The scope of this study was limited to five hospitals in the Pretoria urban area, in the Gauteng Province of the RSA. The findings of this research are based on data obtained from a sample consisting of 87 respondents. These findings cannot be generalized to the total nursing profession population in Gauteng, nor the rest of the RSA.

5.7 Summary

This study aimed at describing the support available for nurses who care for patients with HIV/AIDS in Pretoria urban public hospitals. The researcher concludes that the support available was generally inadequate. Unless the identified inadequacies are addressed, hospitals will not be able to retain existing staff and provision of quality care to patients with HIV/AIDS will not be achieved. Recommendations have been for management, nurse education and nurses on how nurse support services could be improved. Finally, recommendations for further research have been given.
**LIST OF REFERENCES**

AHRTAG see Appropriate Health Resources and Technologies Action Group.


DOH see Department of Health.


KCTT see Kara Counseling and Training Trust.


SADC see Southern African Development Community

SANC see South African Nursing Council.


UNAIDS see Joint United Nations Program on HIV/AIDS.


Van Tonder, S. 1996. Religious and cultural forces in trans cultural nursing (universality and diversity), in *Ethics in nursing practice*, edited by Pera, SA and Van Tonder, S. Kenwyn: Juta


WHO see World Health Organization.

QUESTIONNAIRE

TOPIC: A description of support services available for nurses who care for patients with HIV/AIDS in Pretoria Urban public hospitals.

DATE:  
CODE OF HOSPITAL:  
SERIAL NUMBER:  

INSTRUCTIONS FOR PARTICIPANT:

1. This research project is conducted by a post-graduate student in the department of Advanced Nursing Sciences at UNISA.
2. You are kindly requested to participate in this research by answering all the questions and returning the questionnaire within a given time limit.
3. Please answer the questions by making a cross in the appropriate box or boxes and providing a motivation where required.
4. Do not write your name. The study is completely anonymous; names of participants or hospitals will not be included in the final report.
5. All the information will be treated as strictly confidential.
6. The success of this research will depend, to a great extent, on your contribution. You are therefore encouraged to answer as sincerely as possible.

Thank you for taking your time to participate.
### SECTION 1: DEMOGRAPHIC DATA

1.1 Gender:  
- Female [ ]
- Male [ ]

1.2 Age group:  
- 20-29 [ ]
- 30-39 [ ]
- 40-49 [ ]
- 50-59 [ ]
- 60-69 [ ]

1.3 Rank:  
- Registered Nurse [ ]
- Enrolled Nurse [ ]
- Nursing Assistant [ ]

1.4 Duration of nursing service in years:  
- 1-5 [ ]
- 6-10 [ ]
- 11-15 [ ]
- 16-20 [ ]
- 21-25 [ ]
- 26-30 [ ]
- 31-35 [ ]
- 36-40 [ ]

1.5 Marital status:  
- Married [ ]
- Divorced [ ]
- Separated [ ]
- Widowed [ ]
- Never married [ ]

1.6 Number of children:  
- None [ ]
- 1-2 [ ]
- 3-4 [ ]
- 5-6 [ ]
- 7 and above [ ]

1.7 Race:  
- Black [ ]
- White [ ]
- Asian [ ]
- Coloured [ ]

1.8 How long have you been caring for HIV/AIDS patients?  
- 1-3 years [ ]
- 4-6 years [ ]
- 7-9 years [ ]
- 10-12 years [ ]
- 13-15 years [ ]
- 16-18 years [ ]

1.9 Highest level of nursing education:  
- Certificate [ ]
- Diploma [ ]
- Bachelor’s degree [ ]
- Master’s degree [ ]
- Honour’s degree [ ]
- Doctor’s degree [ ]
- Other (specify) [ ]

1.10 What category of HIV/AIDS patients do you care for?  
- Children [ ]
- Adult males [ ]
- Females and children [ ]
- Adult females [ ]
- Females and males [ ]

### SECTION 2: JOB PREPARATION

2.1 Did you receive any in-service training to prepare you for HIV/AIDS caregiving role?  
- Yes [ ]
- No [ ]
If you attended in-service training, indicate by a tick which topics were covered and the amount of information given on each topic.

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2.3 Whether you did or did not attend in-service training, indicate your level of understanding for each of the topics listed below

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SECTION 3: PROBLEMS EXPERIENCED IN THE CARE OF PATIENTS WITH HIV/AIDS

3.1 Do you consider caring for HIV/AIDS patients to be more stressful than working in other departments?
   Yes [ ]
   No [ ]
   Sometimes [ ]

Please give reasons for your answer…………………………………………………………………………………………

3.2 How are HIV/AIDS patients identified in your hospital?
   From signs and symptoms [ ]
   By blood test for HIV [ ]
   Both [ ]

3.3 In your hospital HIV/AIDS patients are:
   Nursed in separate wards [ ]
   Mixed with other patients [ ]

3.4 If HIV/AIDS patients are nursed in general wards, what is the average percentage of patients with HIV infection?
   Less than 25% [ ]
   25-49% [ ]
   50-74% [ ]
   Above 75% [ ]
   Do not know [ ]

3.5 What is the mode of HIV transmission for the majority of patients whom you nurse?
   Intravenous drug use [ ]
   Blood transfusion [ ]
   Heterosexual [ ]
   Homosexual [ ]
   Mother-to-child [ ]
   Unknown [ ]
   Unknown [ ]
3.6 If you discover the patient’s mode of HIV infection, how does it influence your feelings regarding nursing that patient? Please indicate your feelings below.

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</tr>
<tr>
<td>AVOID PATIENT</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>BLAME PATIENT</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>EMPATHETIC</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3.6.6 Mother-to-child</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>CONFORTABLE</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UN CONFORTABLE</td>
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</tr>
<tr>
<td>AVOID PATIENT</td>
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</tr>
<tr>
<td>BLAME PATIENT</td>
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<tr>
<td>EMPATHETIC</td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3.6.7 Unknown</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>CONFORTABLE</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>UN CONFORTABLE</td>
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</tr>
<tr>
<td>AVOID PATIENT</td>
<td></td>
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<td></td>
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<tr>
<td>BLAME PATIENT</td>
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<td></td>
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<tr>
<td>EMPATHETIC</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

3.7 How does your family feel about you nursing patients with HIV infection?

- They resent it [ ]
- They are supportive [ ]
- Fear that I may get infected [ ]
- They do not know what work I do [ ]
- Fear that they may get infected [ ]

Other: ........................................................................................................

3.8 What effect does caring for patients with HIV/AIDS have on your social interaction with friends?

- No effect [ ]
- Some friends avoid me [ ]
- They help me cope with my work [ ]

3.9 What AIDS related condition(s) do you find to be emotionally distressful and to what extent? (Tick your responses in the table below).

<table>
<thead>
<tr>
<th>CONDITION</th>
<th>NO DISTRESS</th>
<th>MILD DISTRESS</th>
<th>DISTRESSFUL</th>
<th>EXTREMELY DISTRESSFUL</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.9.1 Herpes zoster (shingles)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.9.2 Kaposi’s sarcoma (skin cancer)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.9.3 Oral candidiasis (oral thrush)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.9.4 Pneumocystic carinii pneumonia (PCP)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.9.5 Chronic diarrhoea</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.9.6 Tuberculosis</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.9.7 Cryptococcal meningitis</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.9.8 Loss of sight</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Other conditions
…………………………………………………………………………………………
Give reasons for your
answer……………………………………………………………………………………

3.10 How would you rate your risk of being infected with HIV while performing the following duties?

<table>
<thead>
<tr>
<th>DUTY</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.10.1 Drawing blood</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.10.2 Giving injections</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.10.3 Dressing wounds</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.10.4 Bathing patients</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.10.5 Changing soiled linen</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.10.6 Oral toilet</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3.11 How would you rate the availability of equipment and supplies necessary for basic nursing care in your ward / department?

<table>
<thead>
<tr>
<th>ITEM</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.11.1 Gloves</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.11.2 Medicines</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.11.3 Bowls/receivers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.11.4 Bath soap</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.11.5 Bed linen</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.11.6 Beds</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.11.7 Cotton wool</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Other (specify)
……………………………………………………………………………………………………

3.12 Do you consider shortage of nursing staff to be a major problem in your workplace?
No [ ]
Yes [ ]
3.13 If yes to question 3.12, how does shortage of nursing staff affect your work? (Tick your responses in the table below).

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NO EFFECT</strong></td>
<td><strong>SLIGHT EFFECT</strong></td>
<td><strong>MODERATE EFFECT</strong></td>
<td><strong>VERY MUCH AFFECTED</strong></td>
</tr>
<tr>
<td>3.13.1 Time for emotional care to patients</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.13.2 Time for basic patient care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.13.3 Time to deal with relatives</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.13.4 Time for break</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Other………………………………………………………………………………………………

3.14 How would you rate the level of confidence in the following situations?

3.14.1 Providing emotional care to a dying patient
- Not confident [ ]
- Confident [ ]
- Unsure [ ]
- Very confident [ ]

3.14.2 Providing spiritual care to patients
- Not confident [ ]
- Confident [ ]
- Unsure [ ]
- Very confident [ ]

3.14.3 Providing emotional support to patients’ relatives.
- Not confident [ ]
- Confident [ ]
- Unsure [ ]
- Very confident [ ]

3.14.4 Separating your work from your personal life
- Not confident [ ]
- Confident [ ]
- Unsure [ ]
- Very confident [ ]

3.15 How would you rate the level of your job satisfaction on this scale? (Mark your answer on the line)

Very poor poor moderate satisfactory very satisfactory

3.16 Given the choice, would you choose to work in the same department?
- Yes [ ]
- No [ ]
- Unsure [ ]
Give reasons for your answer
.................................................................................................................................
.................................................................................................................................

3.17 How would you rate the level of teamwork among professionals caring for HIV/AIDS patients?

3.17.1 Between nurses and physicians:

Poor [ ] High [ ]
Average [ ] Very high [ ]

Give reasons for your answer
.................................................................................................................................
.................................................................................................................................

3.17.2 Among nursing staff:

Poor [ ] High [ ]
Average [ ] Very high [ ]

Give reasons for your answer
.................................................................................................................................
.................................................................................................................................

3.18 Do you consider any of the following to be a problem among nurses who care for HIV/AIDS patients? (You may tick more than one answer).

<table>
<thead>
<tr>
<th></th>
<th>NEVER</th>
<th>SELDOM</th>
<th>OFTEN</th>
<th>ALWAYS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Low morale</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Decreased productivity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Poor time keeping</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Requests to change departments</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Increased frequency of sick leave</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Increased mortality due to HIV/AIDS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Departure for non-medical jobs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Departure for jobs in other countries</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SECTION 4: PERCEIVED SUPPORT NEEDS

4.1 Do you find it easy to ask colleagues for help with work?

Never [ ] Often [ ]
Sometime [ ] Always [ ]

(Please give reasons for your answer).
.................................................................................................................................
.................................................................................................................................
4.2 Do you feel that your work is appreciated?

<table>
<thead>
<tr>
<th>4.2.1 by patients:</th>
<th>Never [ ]</th>
<th>Often [ ]</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sometimes [ ]</td>
<td>Always [ ]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4.2.2 by colleagues:</th>
<th>Never [ ]</th>
<th>Often [ ]</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sometimes [ ]</td>
<td>Always [ ]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4.2.3 by supervisor:</th>
<th>Never [ ]</th>
<th>Often [ ]</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sometimes [ ]</td>
<td>Always [ ]</td>
</tr>
</tbody>
</table>

4.3 Do you find it easy to share emotional problems with your colleagues?

<table>
<thead>
<tr>
<th>Never [ ]</th>
<th>Often [ ]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sometimes [ ]</td>
<td>Always [ ]</td>
</tr>
</tbody>
</table>

(Please give reasons for your answer).

……………………………………………………………………………………………………………………………………………………………………

………………………………………………………………………………………………………………………………………………………………

4.4 Do you find it easy to share your problems concerning clinical knowledge and skills with your colleagues?

<table>
<thead>
<tr>
<th>Never [ ]</th>
<th>Often [ ]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sometimes [ ]</td>
<td>Always [ ]</td>
</tr>
</tbody>
</table>

(Please give reasons for your answers)

……………………………………………………………………………………………………………………………………………………………………

……………………………………………………………………………………………………………………………………………………………………

4.5 How do you rate your ability to cope with your work?

| Poor [ ] |
| Average [ ] |
| Good [ ] |
| Very good [ ] |
4.6 If necessary, where do you seek help to enable you to cope and how often? (You may tick more than one answer).

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NEVER</td>
<td>SOMETIMES</td>
<td>OFTEN</td>
<td>ALWAYS</td>
</tr>
<tr>
<td>4.6.1 Psychologist</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.6.2 Social worker</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.6.3 Fellow nurses</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.6.4 Supervisor</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.6.5 Family member</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.6.6 Religious leader</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Other (Specify)

4.7 Given the choice, where would you prefer to receive emotional support?

<table>
<thead>
<tr>
<th>At place of work</th>
<th>Both</th>
<th>Outside work environment</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

(Please give reason for your answer)

4.8 If you would like to receive support at your place of work, from whom would you prefer to receive support?

<table>
<thead>
<tr>
<th>Nurse Manager</th>
<th>Fellow nurses</th>
<th>Spiritual leader</th>
<th>Psychologist</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

Other (Please specify)………………………………………………………………
Give reasons for your answer………………………………………………………………

4.9 What do think Nursing Service Managers can do to create a more caring and supportive work environment?

…………………………………………………………………………………………...
## SECTION 5: AVAILABILITY OF SUPPORT SYSTEM

5.1 Are there any emotional support services at your workplace?
- Yes [ ]
- No [ ]
- Don’t know [ ]

5.2 If yes to question 5.1, indicate the types of emotional support services that are available and how often.

<table>
<thead>
<tr>
<th>TYPE OF SERVICE</th>
<th>NEVER</th>
<th>SELDOM</th>
<th>OFTEN</th>
<th>ALWAYS</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.2.1 Debriefing sessions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.2.2 Counseling services</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.2.3 Informal support</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.2.4 Formal support groups</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.2.5 Pastoral care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.2.6 Peer support</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Other (please specify)

5.3 If yes to question 5.1, how would you rate the quality of emotional support offered?
- Poor [ ]
- Satisfactory [ ]
- Unsatisfactory [ ]
- Excellent [ ]

5.4 Are you able to successfully access the available emotional support?
- Never [ ]
- Often [ ]
- Sometimes [ ]
- Always [ ]

Give reasons for your answer

5.6 Indicate what form and quality of knowledge / skill-based support is available at your workplace.

<table>
<thead>
<tr>
<th>FORM OF SUPPORT</th>
<th>NONE</th>
<th>INADEQUATE</th>
<th>ADEQUATE</th>
<th>EXCELLENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.6.1 Clinical skills teaching</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.6.2 HIV/AIDS theory update</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.6.3 Library service</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Other (specify)
<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.7 Do you have access to HIV testing at your place of work?</td>
<td>Yes [ ] No [ ] Do not know [ ]</td>
</tr>
<tr>
<td>5.8 If yes to question 5.7, how often is testing done for staff caring for HIV/AIDS patients?</td>
<td>Annually [ ] Individual preference [ ] After a needle stick injury [ ] Do not know [ ]</td>
</tr>
<tr>
<td>5.9 Do you know your own HIV status?</td>
<td>Yes [ ] Never been tested [ ]</td>
</tr>
<tr>
<td></td>
<td>No [ ] Would not like to know [ ]</td>
</tr>
<tr>
<td>5.10 Do nurses who are HIV positive have access to psychosocial counseling at your work place?</td>
<td>Yes [ ] No [ ] Do not know [ ]</td>
</tr>
<tr>
<td>5.11 If yes to question 5.10, who provides the counseling?</td>
<td>Nurse Manager [ ] HIV/AIDS counselor [ ]</td>
</tr>
<tr>
<td></td>
<td>Hospital Chaplain [ ] Other [ ]</td>
</tr>
<tr>
<td>5.12 Do HIV positive nurses have access to anti-retroviral medication?</td>
<td>Yes [ ] No [ ] Do not know [ ]</td>
</tr>
<tr>
<td>5.13 If yes to question 5.12, what type of anti-retroviral medication?</td>
<td>.........................................................................................................</td>
</tr>
<tr>
<td>5.14 On the whole, how would you rate the quality of support given to nurses who are HIV positive?</td>
<td>Poor [ ] Satisfactory [ ] Inadequate [ ] Excellent [ ] Do not know [ ]</td>
</tr>
<tr>
<td></td>
<td>Give reasons for your answer ................................................................</td>
</tr>
<tr>
<td>5.15 How are needle prick injuries handled in your hospital?</td>
<td>Counseling is offered [ ] Testing for HIV and follow up [ ]</td>
</tr>
<tr>
<td></td>
<td>Post exposure prophylaxis is offered [ ]</td>
</tr>
<tr>
<td></td>
<td>Policy not available [ ] Do not know [ ]</td>
</tr>
<tr>
<td></td>
<td>Other (Specify) ..............................................................................</td>
</tr>
</tbody>
</table>
SECTION 6: PERSONAL COPING STRATEGIES

6.1 How are you as an individual dealing with emotional stress? (You may tick more than one answer).

<table>
<thead>
<tr>
<th>ACTIVITY</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1.1 Relaxation techniques</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.1.2 Participate in sports</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.1.3 Have fun with friends</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.1.4 Spend time with friends</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.1.5 Retreat for time of reflection</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.1.6 Take alcohol</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.1.7 Smoke</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.1.8 Prayer</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.1.9 Go to church</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.1.10 Read religious books</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Other (Specify).................................................................

6.2 How do you maintain your physical health? (You may tick more than one answer).

<table>
<thead>
<tr>
<th>ACTIVITY</th>
<th>1</th>
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<tr>
<td>6.2.1 Adequate rest</td>
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<td>6.2.2 Good nutrition</td>
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<td>6.2.3 Adequate sleep</td>
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<td>6.2.4 Physical exercise</td>
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<td>6.2.5 Take vacation when possible</td>
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<td>6.2.6 Vitamin supplements</td>
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<td>6.2.7 Take precautions to prevent infections</td>
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</table>

Other (Specify).................................................................

THANK YOU VERY MUCH FOR YOUR PARTICIPATION.