

CHAPTER 1

INTRODUCTION AND RESEARCH METHOD

1.1 INTRODUCTION

While there is evidence of growing Human Immunodeficiency Virus (HIV) infection rates and an Acquired Immunodeficiency Syndrome (AIDS) epidemic in South Africa, most registered nurses struggle to visualise how the disease is going to affect them. Registered nurses are expected to nurse all patients, including HIV/AIDS victims. Nursing HIV/AIDS patients becomes a problem as the disease may be contracted through handling the body fluids with which nurses come into contact on a daily basis. This problem may instil fear or cause confusion in nurses and this may influence their therapeutic relationship with their clients. The researcher therefore identified a need to investigate registered nurses' experiences of working in a high-risk environment for contracting HIV/AIDS and the influence of such experiences on the therapeutic relationship.

A phenomenological inquiry was carried out in order to explore registered nurses' experiences of working in this kind of high-risk environment. The steps of descriptive phenomenology, phenomenology of essences, phenomenology of appearances, constitutive phenomenology and reductive phenomenology were employed. The study was conducted among registered nurses of one hospital in the Vhembe district of the Limpopo Province of South Africa. Informants were selected using a purposive sampling method. Focus group interviews were conducted and qualitative data-analysis was performed.

The findings indicated that registered nurses are exposed to unintentional and intentional risk factors. The research results will enable health service managers and caregivers to devise strategies so as to meaningfully engage in health care delivery in the midst of the challenges brought about by the risk of HIV-infection.

1.2. THE RESEARCH PROBLEM

1.2.1 Background to the research problem

South Africa is considered to be a country with one of the highest rates of HIV-infection in the world, and those infected are often dying in the hands of nurses. The government is obliged to cope with between 4.7 and 6.6 million South Africans who are living with this infection. This figure means that more than 10% of the global population of HIV-positive persons live in South Africa, and the number rises daily. There are 40 million people living with HIV globally. As the pandemic bites further into the lives and livelihoods of South African people it will gradually erode the ability of health professionals to cope with their health care needs and demands (Department of Health 2004:11).

Due to the stigma attached to the illness, HIV/AIDS patients may feel unable to discuss their diagnosis with family and friends, making them more dependent on registered nurses. South Africans are not legally compelled to disclose their HIV-status to anyone or to represent it truthfully (Maelane 2001/ 2002:26). Patients are not all open about their HIV-positive status. Furthermore, nurses are bound by professional secrecy to keep a patient's HIV-status confidential. The result is that nurses are identified as a group at risk of contracting HIV in their work setting. The risk of contracting HIV from infected patients is possible through repeated exposure to contaminated blood and body fluids (Van Dyk 2002:26). Many known cases of HIV transmission in healthcare settings have occurred through accidental exposure to infected blood and other body fluids. Examples of such accidents are needle stick injuries from an infected needle, scalpel cuts or cuts from other sharp instruments contaminated with blood, and the explosion of a vacutainer tube when too much pressure is used to fill the tube (Maelane 2001/ 2002:26).

During the researcher's personal encounters with nurse practitioners, they verbalised the fear of being infected with HIV, since those who had been infected were often not certain about how they contracted the virus. According to Van Dyk (2002:59) registered nurses are advised to keep in mind that every patient who enters a hospital or clinic may be a carrier of HIV. Because there is no way of telling whether or not patients are infected with HIV, universal blood and body fluids precautions should therefore always be observed for all patients. This results in nurses spending time taking

precautionary measures against contracting HIV. Examples include washing of hands if the nurse feels uncomfortable about the contact, covering skin lesions, ensuring a clean and safe working environment, wearing protective clothing and taking precautions concerning injections and invasive procedures. The measures may be time consuming and may drive the focus away from maintaining a therapeutic relationship. The morale and efficiency of registered nurses may be negatively affected by working with patients who are HIV-infected and suffering from AIDS, especially in light of the risk of infection.

The nursing profession in South Africa expects registered nurses to practise their profession in an ethical manner. The registered nurses are expected to maintain a trusting relationship and provide care that promotes the well-being of their patients at all stages of their illnesses, particularly those who are vulnerable. However, the public are generally mistrustful of the nursing profession with respect to the caring and the support that the latter render to those affected by HIV/AIDS. People do not know whom to trust or who is a truthful client advocate. Nurses are perceived as non-supportive and devaluing of their patients' personhood and needs. One of the fundamentals in the caring practice of nursing includes the obligation of applying a non-judgemental approach towards persons living with HIV/AIDS. However, there is a perception that the opposite is happening (Maelane 2001/2002:26). There is an outcry that nurses have become judgemental in terms of the AIDS pandemic. Affected patients are made to feel shameful and stigmatised. Nurses are faced by a major challenge: to earn the respect and the trust they deserve from patients (Van Dyk 2002:26).

The researcher identified the need to investigate nurses' experiences of working in a high-risk environment for contracting HIV/AIDS and to determine how their experiences influence the therapeutic relationship with their clients. These insights should contribute towards understanding the life-worlds of nurses who work in this kind of high-risk environment. Such understanding could pave the way for devising strategies to assist them in engaging in meaningful care practices, despite the challenges that they face, thus earning the respect of patients and the public alike.

1.2.2 The research problem

Registered nurses are identified as a risk group in terms of contracting HIV from infected patients because, as noted above, accidents may lead to HIV transmission in the health care setting. The

South African Nursing Council (SANC) and the Democratic Nurses Organization of South Africa (DENOSA) advocate the viewpoint that nurses may not refuse to nurse patients with HIV or those suffering from AIDS (Van Dyk 2002: 86). Working in a high-risk environment and being professionally compelled to render care to those in need will necessarily have an impact on the registered nurses' experience of the situation. The perception that there is a lack of support and protection for nurses who work in high-risk settings may give rise to negative experiences and an impaired ability to maintain a therapeutic relationship with their patients. If the nature of nurses' exposure to HIV-infection and their experiences are unknown, it is virtually impossible to provide relevant and effective support to them. The researcher therefore conducted a study with the following problem statement (stated in interrogative form) in mind:

How do registered nurses' experiences of working in a high-risk environment for contracting HIV/AIDS influence the therapeutic relationship with patients under their care?

The research questions were:

- *What are registered nurses' experiences of the risk of contracting HIV/AIDS in the workplace?*
- *How do registered nurses perceive the therapeutic relationship in caring for HIV-infected and AIDS patients?*

1.3 RESEARCH PURPOSE

The purpose of the research was to contribute towards the knowledge base of the nursing profession by explicating and contextualising nurses' experiences and the nature of the therapeutic relationship in the high-risk settings described.

1.4 SIGNIFICANCE OF THE STUDY

This study contributes to an understanding of the life-world of nurses who work in a high-risk environment for contracting HIV/AIDS, and points to ways of caring for HIV-infected patients or those suffering from AIDS. The research findings could be used to develop a support system for the nurses caring for such patients. This should ultimately lead to improved patient care.

1.5 DEFINITIONS OF CONCEPTS

1.5.1 Experience

Experience denotes to undergo personally; feel (*Funk & Wagnalls Standard Dictionary* 1974:447). It constitutes the process of meaning construction whereby people think about themselves and their position in relation to others and the world around them (Coetzee 1986:110).

1.5.2 Registered nurse

Registered nurse refers to a person who is registered as a nurse under Section 16 of the Nursing Act no 50 of 1978 as amended (Searle 2000:123; South Africa 1978:5).

1.5.3 High-risk environment

Risk is a possibility of danger, injury or other adverse consequences (*The Concise Oxford English Dictionary* 1995:1189). *Environment* refers to the physical surroundings, conditions or circumstances in which a person lives (*The Concise Oxford English Dictionary* 1995:452). Applied to this study, *high-risk environment* denotes any working conditions which pose a high probability of contracting HIV/AIDS.

1.5.4 Contracting

Contracting means catching an illness or being at risk of being infected by an infectious communicable disease, due to direct or indirect contact with the source of infection (Nzimande 1998:2).

1.5.5 Human Immunodeficiency Virus (HIV)

HIV refers to a virus which attacks infection-fighting blood cells, the CD4 cells, and other cells of the body's immune system (Uys 2000:20).

1.5.6 Acquired Immunodeficiency Syndrome (AIDS)

AIDS is an advanced infection with HIV, marked by certain conditions that do not occur in people with a healthy immune system due to a decrease in CD4 cells to below 200 copies per ml of blood (Uys 2000:20).

1.5.7 Therapeutic relationship

Therapeutic denotes contributing to the cure of a disease or solving the problem (*The Concise Oxford English Dictionary* 1995:550). *Relationship* refers to how people get on with each other (*The School Oxford English Dictionary* 1998:369). For the purposes of this study, *therapeutic relationship* refers to the interactions that influence the healing or improvement of a patient's condition.

1.5.8 Caring

Caring refers to assisting, supporting and facilitating acts toward, or for, another individual or group with evident or anticipated needs (Kozier, Glenora, Berman & Burke 2000:429).

1.6 FOUNDATIONS OF THE STUDY

1.6.1 Assumptions

Assumptions are basic principles that are assumed to be true, without proof or verification (Polit & Hungler 1999:18). Sources of assumptions include universally accepted truths such as theories, previous research and nursing practice. In research studies, assumptions are embedded in the philosophical base, study design and interpretation of findings (Burns & Grove 2001:46).

The ontological assumptions, namely assumptions regarding reality underlying this research were:

- The presence of HIV/AIDS results in a high-risk working environment for nurses.
- HIV/AIDS has an influence on the registered nurse-patient relationship.

The epistemological assumptions, namely assumptions concerning knowledge were:

- Personal experiences and the construction of meaning, by individuals, are rich sources of knowledge.
- Personal experiences and meanings are communicated through language.
- To understand peoples' experiences and the meanings that they assign to the experiences it is necessary to generate narrative data.

The methodological assumption, namely assumption regarding research was:

- Phenomenological qualitative research supports narrative data collection, in order to capture the life-world of people from an emic or insider perspective.

1.6.2 Theoretical framework

The researcher approached the study with an open mind. A decision on which theory to utilise, to assist in interpretation of the research results, was taken after data collection and analysis. The theory selected was Victor Frankl's theory of meaning in life (refer to chapter 4).

1.7 THE RESEARCH DESIGN

Through the use of his/her research design, a researcher establishes an overall plan for obtaining answers to research questions. It spells out the strategies that the researcher has adopted to develop information that is objective, accurate and meaningful (Polit & Hungler 1999:92). Exploratory, qualitative research was carried out to answer the research questions. Exploratory research identifies and describes the concepts related to the phenomenon under study. It is used in instances where little is known about a topic. From exploratory designs researchers gain the necessary insight to develop new ideas, concepts and theories regarding a problem under review. To capture meaning, narrative data are collected about feelings, behaviours, thoughts, insights and actions (Brink & Wood 1998:308-309; Streubert & Carpenter 1999:55). The experiences of registered nurses regarding working in a high-risk environment for contracting HIV/AIDS have not been documented before in the Vhembe district. The researcher therefore opted for exploratory research.

A qualitative research paradigm was chosen because of its systematic approach towards capturing people's experiences and interpretation of events and circumstances. It attempts to capitalise on the subjective as a means for understanding and interpreting human experiences. Qualitative research involves fieldwork in which the researcher physically goes to the people or institution to interview informants or observe behaviour in a natural setting. No attempt is made to impose control or restrictions (Streubert & Carpenter 1999:21-22). A holistic approach is adopted, which describes the individual as a whole in relation to his or her social setting. Furthermore, qualitative research usually focuses on specific individuals, rather than on groups or types of individuals. The researcher must become enmeshed and integral with the people being studied (Hicks 1999:6). Burns and Grove (2001:594) state that the researcher's personality is a key factor in qualitative research because he/she becomes closely involved in the informants' experiences in order to interpret them. In this study, the researcher conducted interviews in the hospital in which the informants worked. An attempt was made to interact closely with informants in order to understand their experiences and perspectives.

Qualitative research is effective in investigating human life experiences, for example fear and happiness, and therefore it is phenomenological (see below) (Streubert & Carpenter 1999:55). Lincoln and Guba (1985:150) state that qualitative researchers are interested in meanings, how people make sense of their lives, their experiences and their structures of the world. Qualitative research allows the ideas to arise from data rather than imposing a pre-existing framework on the data. This approach allows the researcher to discover new phenomena and to reveal the story behind the numbers. It explores the experiences of people in their everyday lives. The process of qualitative research is inductive in that the researcher builds abstractions and theories from details. Data is analysed in an organised but intuitive fashion to make sense of informants' experiences of everyday life (Lincoln & Guba 1985:145). In this study, the researcher conducted a literature review and selected a theoretical framework for interpreting the research results after her data collection and analysis were completed. This enabled her to perform data collection and analysis with an open mind and to obtain accurate descriptions of the informants' experiences and perceptions of working in a high-risk area for contracting HIV/AIDS.

Qualitative research is allied with a phenomenological perspective. Phenomenology emphasises the individual's constitution of a life-world, in other words how the person experiences his or her existence (Rice & Ezzy 1999:15). A phenomenological research method was used to conduct this study. Phenomenology is a suitable method if the research topic is fundamental to the life experiences of humans for investigation. The goal of phenomenology is to study and describe the essences of the lived human experiences. It emphasises that people's actions should be explained with reference to their conscious intentions (Streubert & Carpenter 1999:44; Polit & Hungler 1999:115). The researcher maintains therefore that phenomenological research is suitable to capture the essence of how registered nurses experience working in a high risk environment and of how these experiences and their views influence their relationships with those whom they care for.

Phenomenological research requires that the integrated whole be explored. It investigates subjective phenomena in the belief that the truth is grounded in lived experience (Streubert & Carpenter 1999:56). In this research the researcher also tried to capture the context in which health care is rendered. She ensured that the phenomenon was described from the emic perspective.

1.8 POPULATION AND SAMPLING

1.8.1 Research population

Research population refers to all elements (individuals, events, or circumstances) that meet the sample criteria for inclusion in a study. It is sometimes referred to as the target population (Burns & Grove 2001:806) The research population for this research project comprised registered nurses working in clinical units of a particular hospital in the Vhembe district of the Limpopo Province, where HIV-infected patients and AIDS patients are cared for.

To be eligible for inclusion in the study, individuals had to comply with the following criteria – they needed to:

- be accessible to the researcher
- have had at least two years of working experience
- be involved in caring for HIV-infected and AIDS patients on a daily basis
- be registered with the South African Nursing Council.

1.8.2 Sampling

Sampling is a process during which decisions are made on what and how to sample (Kuzu in Talbot 1995:468). This involves selecting a group of people with which to conduct a study. A non-probability sampling approach, using the purposive sampling method, was employed to obtain a sample of informants. In this method not every element of the population has an equal opportunity to be included in the sample (Polit & Hungler 1999:235).

The purposive sampling method is used most commonly in phenomenological inquiry (Streubert & Carpenter 1999:48). Lincoln and Guba (1985:118) state that the idea of qualitative research is to purposefully select the informants that will best answer the research question. The qualitative researcher may decide to seek informants with particular characteristics to increase the theoretical understanding of some facets of the phenomenon being studied (Burns & Grove 2001:376). In this study, purposive sampling was applied because information-rich informants were required. This entailed selecting informants who were experienced in working in a high-risk environment for contracting HIV/AIDS. The registered nurses working in the male and female wards rendering care to HIV-infected patients and AIDS patients were hand-picked for participation in the study.

1.8.3 Sample

Fifteen registered nurses participated in the study. The sample size was not predetermined. The researcher conducted focus group interviews until no new data emerged. Sampling was terminated when this data saturation had occurred. This is in accordance with methods applied for qualitative research involving a small sample, and the principle of conducting sampling and data collection until data saturation has occurred (Streubert & Carpenter 1999:22-23; Cormack 1996:140).

Of the fifteen registered nurses who participated, three of the informants were males and twelve females. Their years of experience ranged between five and ten years. The participants worked in the Maternity, Medical and Intensive Care Units. All the informants were registered as nurses (general, psychiatric, community) and in midwifery. Three of the informants had completed the BA (Cur) degree and had therefore obtained additional qualifications. One of the informants was a

registered intensive care nurse. All informants worked in clinical settings where HIV/AIDS patients are admitted and cared for.

Informants' average years of experience in caring for HIV/AIDS patients amounted to five years. Two informants were trained HIV/AIDS counsellors. Seven of the informants had attended several courses related to HIV/AIDS counselling. One of them had also attended a *train the counsellor* workshop, while one had completed a module in HIV/AIDS counselling at UNISA and one of them did voluntary counselling.

1.9 OVERVIEW OF THE PHENOMENOLOGICAL METHOD

The researcher followed the steps as explained in (Streubert & Carpenter 1999:49-57), and depicted in table 1.1. The steps comprise descriptive phenomenology, phenomenology of essences, phenomenology of appearances, constitutive phenomenology and reductive phenomenology.

Table 1.1 Application of the phenomenological method

Step	Research activities
Descriptive phenomenology	Intuiting: Data collection and management. Analysing: Coding and categorising of data. Describing: Identifying the main ideas that emerged from the coded data.
Phenomenology of essences	Data reduction: Linking of related ideas to discover the meanings emerging from the coded data.
Phenomenology of appearances	Data synthesis: Identifying and describing the main themes, using Frankl's theory.
Constitutive phenomenology	Arriving at conclusions and recommendations based on insight into the structure and substance of the phenomenon.
Reductive phenomenology	Bracketing: Setting aside preconceived ideas, personal assumptions and biases throughout the phenomenological study.

1.10 DESCRIPTIVE PHENOMENOLOGY: DATA COLLECTION, MANAGEMENT AND ANALYSIS

Descriptive phenomenology involves “direct exploration, analysis, and description of a particular phenomenon, as free as possible from unexamined presuppositions, aiming at maximum intuitive

presentation” (Streubert & Carpenter 1999:49). It constitutes three activities, as explained below.

1.10.1 Intuiting: Data collection and management

Intuiting requires the researcher to become totally immersed in the phenomenon under investigation. It is the process whereby the researcher begins to know about the phenomenon as described by the informants, by being involved in the data collection and data management processes (Streubert & Carpenter 1999:49).

- *Data collection approach and method*

It is through imagination that new knowledge is discovered (Streubert & Carpenter 1999:49). Intuiting occurs when the researcher remains open to the meanings that informants attribute to a phenomenon and views it from an emic perspective (Polit & Hungler 1999:272). Intuiting requires the researcher to become totally immersed in the phenomenon under investigation, by means of which the researcher begins to know about the phenomenon as described by the informants (Polit & Hungler 1997:204). Streubert and Carpenter (1999:49) state that data collection involves the researcher as an instrument for data collection. The informants are allowed to talk freely about their experiences, feelings, attitudes and perceptions (Polit & Hungler 1999:272).

Semi-structured focus group interviews were conducted to enable registered nurses to verbalise their experiences and perceptions of caring for HIV/AIDS patients in a high-risk environment. Focus group interviews are distinguished from any other form of interview by the use of group discussions to generate the data, as opposed to individual interviews (Morgan & Kruger, in De Vos 1998:317). Focus group interviews allow the researcher some control over the line of questioning. While open-ended questions are asked, some structure is imposed on the subsequent discussions to ensure that these remain within the parameters of the problem statement. Questions were asked to enable the informants to explain and fully discuss their experiences, actions and interpretations. Focus group interviews stress the interviewee’s definition of the situation under study (Lincoln & Guba 1985:268). The researcher had an interest in “going to the people” and a willingness to see the researcher-informants relationship as a partnership. The researcher viewed each informant’s perspective as equal to any other’s. She encouraged the informants to focus on the questions being

asked. Questions were rephrased and further explained to those informants who did not understand what was asked. This was done so as to enable the researcher to elicit data that were directly relevant to the research questions. Within the parameters of the research questions, repeated focus group interviews were conducted until data saturation occurred.

Focus group interviews create a process of sharing and comparing among the informants. Focus group interviews are suitable for achieving a well-defined purpose and they produce large amounts of concentrated data in a short period of time.

- *Data collection instrument*

An interview guide (Annexure D) was used as a data collection instrument. It comprised two open-ended questions, namely:

1. Tell me about your experiences of working in a high-risk environment for contracting HIV/AIDS.
2. Tell me how your experiences influence the therapeutic relationship with the HIV-infected and AIDS patients that you care for.

The interview guide was pre-tested by means of posing questions to the Thohoyandou campus nurse educators. These educators provided inputs and the researcher then made some changes by refining the interview questions.

Probing questions were also asked during the interviews. These questions were derived from the responses made by the informants, and asked the following:

- Tell me more about the risks that you are exposed to.
- Tell me more about your feelings.
- Tell me more about the support available to HIV/AIDS patients.
- Tell me more about the support available to nurses who work in a high-risk environment for contracting HIV/AIDS.
- If you had a chance to choose between nursing HIV-positive and AIDS patients and those not infected, what would you prefer and why?
- In spite of all the problems experienced, what is your way forward pertaining to HIV/AIDS

patient care?

- *Data collection process*

The researcher followed a data collection process as suggested by Marshall and Rossman (1989:89), Polit and Hungler (1999:270), and Rice and Ezzy (1999:72). Eight interview sessions were conducted. Informants were asked to attend two sessions, accommodating time for questions.

The researcher identified a quiet, comfortable venue in order to ensure comfort and privacy. This venue was prepared before the commencement of the interviews. The chairs were arranged in a circle. The tape recorder was tested beforehand.

Before the commencement of each interview, the informants were welcomed and thanked for being present. The researcher explained that they had been chosen because of their expertise on the topic. The informants were requested to sign consent forms (Annexure C), after the researcher had explained the purpose of the study and informed them of their right to withdraw at any point. The purpose of recording the interviews on audiotape was explained to them, after which permission was obtained to capture their responses on audiotape. The researcher promised to respect informants' wishes if they desired to retract information given.

Ninety minutes were allocated for each interview and the researcher therefore asked someone to help with time management. During the initial stages of each interview, the researcher introduced the informants to one another to establish a therapeutic environment. An experienced moderator facilitated the discussion to ensure its flow and to guide informants in responding to the questions posed. The researcher asked the questions, listened to the discussions, observed non-verbal communications and attentively focused on the data that arose. She made field notes about the setting and the nonverbal behaviour of the informants, and tried to gain an understanding of informants' emotions and the explanations of their behaviours in the clinical setting.

At the end of the interview, informants were thanked. The researcher allocated time for individual conversations with informants in order to maintain a trusting relationship. Repeated focus interviews were continued until no new or relevant data emerged and all leads had been followed.

- *Data management*

After data collection, the researcher transcribed the data that were captured on audiotape. The transcriptions were typed and saved in ASCII text format. Text units were specified by placing a hard carriage return after each sentence. By doing so, the researcher converted data into small, manageable and manipulative units that could easily be imported into QSR NUD*IST 4.0 and coded. Burns and Grove (2001:468) suggest that a researcher should carefully check data and correct problems before data entry is initiated. The researcher, consequently, carefully read and reread the transcriptions to obtain a general sense of the data. She reviewed the transcripts in order to uncover essences and familiarise herself with phrases frequently used by the respondents

1.10.2 Analysing: Coding and categorising of data

Analysing data involves identifying the essence of the phenomenon under investigation, based on the data obtained and on how data are presented (Streubert & Carpenter 1999:52). Qualitative analysis is a process of fitting data together, of making the invisible obvious and of linking and attributing consequences to antecedents. In qualitative analysis several simultaneous activities are performed, namely collecting information from the field, sorting the information into categories, formatting the information into a story or picture and writing a narrative description of the results (Polit & Hungler 1999:576).

In this study the researcher selected one interview and reflected on the underlying meanings in the data. The researcher wrote down the thoughts that emerged while she was reading the interview record. She made a list of all the topics that she identified, and clustered similar topics together. By doing so, she identified preliminary nodes under which data could be coded. This only served as a preliminary guideline, since nodes were created and revised when new insights emerged during data analysis.

Nodes were created in QSR NUD*IST and node definitions were formulated. Each text unit was then coded under a relevant node or nodes. The researcher then developed categories and subcategories for coded data. She identified the most descriptive wording for topics and turned them

into categories by grouping together topics that related to each other. Subcategories that reflected narrower topical areas within major categories were identified. After data analysis was performed, node reports were printed.

1.10.3 Describing: Identifying emerging meanings and recoding

The aim of the describing operation is to communicate the distinct, critical elements of a phenomenon. The researcher should avoid attempting to describe the phenomenon under study prematurely (Streubert & Carpenter 1999:52). In this study, the researcher read the printed node reports and identified the meanings that emerged from each. She identified the different ideas that emerged from the data of each node. She noted each idea and marked all text units that related to a particular idea. This paved the way for the recoding and re-categorising of data, thus obtaining a refined coding system.

1.11 PHENOMENOLOGY OF ESSENCES: DATA REDUCTION

Phenomenology of essences involves probing through data to search for common themes or essences and thus to establish patterns of relationships shared by a particular phenomenon (Streubert & Carpenter 1999:52). In this study the researcher carefully studied the node reports in order to identify interrelationships among the meanings that emerged from the reports. She identified the emergence of the following preliminary themes and reorganised the data to fit the themes identified:

- factors that inhibit meaningful care for HIV/AIDS patients
- factors that enhance meaningful care for HIV/AIDS patients
- ethical issues involved in working in a high-risk environment for contracting HIV/AIDS
- therapeutic relationship in a high-risk health care setting.

1.12 PHENOMENOLOGY OF APPEARANCES AND CONSTITUTIVE PHENOMENOLOGY: DATA SYNTHESIS

Phenomenology of appearances involves giving attention to the ways in which phenomena appear. A researcher pays particular attention to the nature in which the phenomenon unfolds, through dwelling on the data (Streubert & Carpenter 1999:53). Synthesising involves “sifting” the data and

putting pieces together. This gives a researcher a sense of what is “typical” with regard to the phenomenon under study and of what the range and variation are like (Polit & Hungler 1999:575). In this study the researcher identified a suitable theory to guide her in data synthesis. Frankl’s theory of the meaning of life promised to capture all the preliminary themes that were identified during the process of data reduction. The themes that emerged, after the data were interpreted within the framework of Frankl’s work, comprised:

- Theme 1: Factors that pose challenges to discovering the meaning of life in a HIV/AIDS high-risk environment.
- Theme 2: Factors enhancing the discovering of the meaning of life in a HIV/AIDS high-risk environment.

These themes formed the basis for arriving at conclusions and recommendations.

1.13 REDUCTIVE PHENOMENOLOGY

Reductive phenomenology occurs concurrently throughout phenomenological research, and entails bracketing. Bracketing is employed by qualitative researchers to meet the ethical dictum of portraying accurately the reality of the phenomenon as it is lived and described by the informants. It requires that the researcher sets aside any preconceived beliefs and opinions about the research phenomenon. The informants’ viewpoints were seen as neither “true nor false or good nor bad” (Streubert & Carpenter 1999:47, 53; Talbot 1995:467).

Prior to undertaking this study the researcher regularly came into contact with registered nurses who work in a high-risk environment for contracting HIV/AIDS. This could have influenced the researcher’s stance towards the study. While conducting the study, the researcher set aside these preconceived ideas by telling herself that those working with HIV-infected and AIDS patients have had different experiences from what she might be thinking. The researcher avoided voicing any opinions, criticism or judgements during data collection.

1.14 TRUSTWORTHINESS OF THE RESEARCH

In qualitative research, researchers are concerned with enhancing its trustworthiness.

Trustworthiness refers to ensuring that the research study is worth paying attention to, worth taking account of, and that the findings are to be trusted. Lincoln and Guba (1985:289) have identified the following criteria for trustworthiness, namely credibility, confirmability, transferability and dependability.

1.14.1 Credibility

Credibility refers to the extent to which those who read a research report can believe and accept the research findings to be true. One strategy to establish credibility is through prolonged engagement with the informants during data collection and with the data during data analysis. Another strategy is to determine whether the informants recognise the findings to be true to their life-worlds as revealed by them. These activities are called a membership check (Lincoln & Guba 1985:290-291; Streubert & Carpenter 1999:29).

To enhance credibility, the researcher invested much time in data collection and analysis. Data was collected and analysed in such a way that the findings reflected the exact state of affairs regarding the phenomenon. The interviews were recorded on audiotapes to capture the original responses and transcribed to maintain the original meanings (Refer to Section 1.10.1). Bracketing was employed as explained in section 1.13. The registered nurses who participated in the study were given an opportunity to validate that the reported findings represented their life-worlds that they had shared with the researcher. The informants were given an opportunity to determine whether the themes were true reflections of the data that had emerged during the interview.

The interviews were conducted in English. No interpreter was needed during data collection and there was no need of translations during the stage of data-management.

1.14.2 Dependability

Dependability of qualitative data refers to the stability of data over time and over conditions (Polit & Hungler, 1997:306). The researcher ensured that this was achieved by applying strategies to enhance the credibility of the study. The raw data and the data analysis process were scrutinised by an external reviewer, namely the supervisor. An audit trail was established to enable others to judge

this study for its dependability.

1.14.3 Confirmability

Confirmability refers to the objectivity or neutrality of data, namely the extent to which the research results are a product of the focus of the study and not the biases of the researcher. This strategy allows an external auditor to try to understand how and why decisions were made and to determine whether another researcher would arrive at comparable conclusions (Lincoln & Guba 1985:318-319; Streubert & Carpenter 1999:29). Bracketing by the researcher and the audit trial served to enhance the confirmability of this study.

1.14.4 Transferability

Transferability refers to whether the findings of a qualitative study can be transferred to another similar context or situation. Transferability of the findings rests with potential users and not with the researcher (Polit & Hungler 1999:430; Streubert & Carpenter 1999:29). The researcher asked one of the unit managers to help select the informants, trusting that this would lead to the selection of informative individuals. The researcher gave rich descriptions when reporting on the research results, in order to enable potential users of the research results to judge the applicability of these to other contexts.

1.15 ETHICAL CONSIDERATIONS

1.15.1 Rights of the institution

The Research and Ethical Committee of the Department of Health Studies, Unisa, approved this research (Annexure A). This project was also referred to the Limpopo Provincial Ethical Research Committee for consideration prior to data collection. Permission to conduct the research in the particular hospital was obtained (Annexure B). The researcher promised the institutional managers not to publish the name of the institution and to disseminate the research results to the managers of the institution.

1.15.2 Protecting the rights of informants

Research involving humans requires a careful consideration of the procedures to be used in order to protect the rights of human subjects (Hicks 1999:74). The researcher considered three major principles, namely beneficence, respect for human dignity and justice.

1.15.2.1 *Beneficence*

Informants should be protected from discomfort and harm. *Beneficence* involves the protection of informants from physiological, social and economic harm, and protection from exploitation.

Categories of levels of discomfort and harm are:

- no anticipated effects
- temporary discomfort
- unusual levels of temporary discomfort
- risk of permanent damage, and
- certainty of permanent damage (Burns & Grove 2001:203; Polit & Hungler 1999:32).

The researcher weighed the risks to the informants against the potential benefits to society and the cost and benefits to individual informants. She anticipated the risk to be minimal, while the study promised to enhance patient care and to result in improved support to registered nurses. The informants-researcher relationship was not exploited in any way. Participants were not exposed to serious or permanent harm. Because being exposed to the risk of contracting HIV-infection on a daily basis is potentially emotionally disturbing, the researcher ensured that the interviews were held in a comfortable venue. She avoided inflicting psychological harm by carefully considering the phrasing of questions and by providing debriefing sessions following interview sessions. This gave informants an opportunity to ask questions, raise concerns and to obtain the researcher's contact details.

1.15.2.2 *Human dignity*

A researcher has an ethical responsibility to recognise and protect the dignity of human research informants. This is achieved by ensuring their autonomy and obtaining informed consent (Polit &

Hungler 1999:33). *Informing* comprises the transmission of essential ideas and content from the investigator to the prospective informants. *Consent* is the prospective informants' agreement to participate in a study as informants, which is reached after the assimilation of essential information. *Voluntary* consent means that informants decide to take part in a study of their own volition, without coercion or any undue influence (Burns & Grove 2001:206, 210). Informants voluntarily decided to participate in the study and were allowed to terminate their participation at any point. No informant was coerced to participate in the study. Prior to obtaining informed consent, the researcher fully described the nature of the study, the informant's right to refuse participation, the researcher's responsibilities and the likely risks and benefits of the study. The researcher promised to give summaries of the research findings to the informants.

1.15.2.3 Justice

The principle of justice is applied by treating informants fairly and equitably before, during and after their participation in the study. This entails ensuring their privacy, confidentiality and anonymity (Burns & Grove 2001:200; Polit & Hungler 1999:36). The researcher promised the informants not to share, with anybody, private information without their knowledge or against their will. The confidentiality of the information divulged to the researcher was secured. Anonymity was maintained by making no attempt to link an informant with specific information.

1.16 SCOPE OF THE STUDY

A small sample of registered nurses working in one hospital was involved. The findings of the research are therefore not generalisable. However, in a qualitative research study generalisability is not intended (Streubert & Carpenter 1999:22). This study succeeded in obtaining an in-depth, contextualised understanding of the life-worlds of those working in a high-risk environment for contracting HIV-infection and AIDS.

1.17 STRUCTURE OF THE DISSERTATION

The structure of the dissertation is as follows:

Chapter 1: Introduction, research design and research method

Chapter 2: Research findings and literature control

Chapter 3: Literature review

Chapter 4: Theoretical framework: Frankl's meaning of life

Chapter 5: Conclusion and recommendations

1.18 CONCLUSION

Many registered nurses work in a high-risk environment for contracting HIV. HIV/AIDS exerts a devastating impact on the lives of registered nurses, patients and their significant others. The morale and efficiency of registered nurses may be affected by working in a high-risk environment and this may negatively impact on the therapeutic relationship. Qualitative phenomenological research was therefore conducted to determine registered nurses' experiences of working in a high-risk environment for contacting HIV/AIDS and the effect of these experiences on the therapeutic relationship. A phenomenological method was applied. Focus group interviews were conducted involving fifteen informants and the data was submitted to qualitative data analysis.

CHAPTER 2

RESEARCH FINDINGS

2.1 INTRODUCTION

In the previous chapter, the research problem, design and method were discussed. In this chapter the research findings are discussed. The researcher followed the data collection approach, method and process as explained in chapter one (Sections 1.7-1.10). Data was collected involving fifteen registered nurses working at a hospital in the Vhembe district of the Limpopo Province. The objective of the study was to answer the following research questions:

- *What are the registered nurses' experiences of the risk of contracting HIV/ AIDS in the workplace?*
- *How do registered nurses perceive the therapeutic relationship in caring for HIV-infected and AIDS patients?*

The questions posed to informants are included in annexure D.

2.2 DATA ANALYSIS STRATEGY

Data analysis represents the second activity involved in descriptive phenomenology and was carried out as explained in section 1.10 (Also refer to table 1.1). Data coding was done electronically using QSR NUD*IST 4.0. The coding system that the researcher developed is outlined in table 2.1. An example of a node report that comprises the coded data is attached as annexure E.

Table 2.1 Coding system

CATEGORY	NODES/SUB-NODES	DEFINITIONS
/Biographical data		Biographical data refers to data pertaining to a person's personal profile.
/Risk		Risk refers to possibility or chance of meeting danger, suffering or injury.
	/Risk factors/Exposure to risk	Exposure to risk is the possibility or chance of meeting danger, suffering, loss or injury whilst caring for the HIV/AIDS patients.
	/Risk factors /Increased workload	Increased workload refers to the increased number of activities required to care for a HIV/AIDS patient.
/Experiences		Experience refers to undergo personally; feel. It is the process of meaning construction by means of which people think about themselves and their position in relation to others and the world around them.
	/Experiences/Depression	Depression is a mood state characterised by a feeling of sadness, dejection, despair, discouragement or hopelessness.
	/Experiences/Fear	Fear is an unpleasant emotion caused by exposure to danger.
	/Experiences/Worry	Worry refers to allowing one's mind to dwell on difficulty or trouble.
	/Experiences/Uncertainty	Uncertainty refers to the condition of experiencing doubt.
	/Experiences/Experiences of reward	Reward is a return or recompense for a service.
/Consequences		Consequences are what naturally flow from a preceding action or condition.
	/Consequences/Ethical	Ethical relates to morals, especially in human conduct.
	/Consequences/Therapeutic relationship	Therapeutic relationship refers to the interactions that influence healing or improvement of a patient's condition.
	/Consequences/Coping mechanisms	Coping mechanisms refer to strategies to manage a condition or circumstance.
/Support		Support refers to keeping from failing.
	/Support/Patient support	Patient support is support given to patients by registered nurses to enhance their well-being.

CATEGORY	NODES/SUB-NODES	DEFINITIONS
	/Support/Peer support	Peer support is support given to co-workers to enhance their well-being.
	/Support/Possible solutions	Possible solutions refer to ways of dealing with difficulty.

2.3 RESEARCH FINDINGS

This section represents the results of completing the third activity of descriptive phenomenology, namely describing (Refer to Table 1.1; Section 1.10). The researcher identified the meanings that emerged from the coded data. The findings are presented below by discussing the experiences of registered nurses working in a high-risk environment for contracting HIV/AIDS and the influence of these experiences on maintaining a therapeutic relationship with their clients. The informants explained that their experiences are mainly negative but a few informants verbalised positive experiences. The therapeutic relationship appears to be compromised by registered nurses' fears and their resultant behaviour. This is complicated by the risk factors to which registered nurses are exposed.

The discussions of the research findings are supplemented with quotations to indicate how the informants revealed their life-worlds with the researcher. Some of the quotations are verbatim, while others have been slightly edited to ensure that the reader would understand the meanings that the informants tried to convey.

2.3.1 Risk

Risk refers to the possibility or chance of meeting danger, suffering, loss or injury (*The School Oxford English Dictionary* 1998:1189). The research findings highlighted the intentional and unintentional risk factors that informants are exposed to.

2.3.1.1 Exposure to risk

For the purposes of this study, *exposure to risk* is the possibility or chance of meeting danger,

suffering, loss or injury whilst caring for HIV/AIDS patients. The responses by informants indicated that the phenomenon of AIDS is devastating and frightening, and that they are exposed to intentional and unintentional risks of contracting HIV-infection. A complicating factor is the fact that HIV and AIDS sufferers are being stigmatised and nurses therefore run the risk of being stigmatised themselves. An informant explained: *“I am at risk of contracting HIV/AIDS. My main problem is that people will think I contracted it from somewhere else (other than by being infected by a patient) because of the stigma attached to it”*.

- ***Unintentional risk factors***

Unintentional risk factors in this study refer to circumstances in which registered nurses are accidentally exposed to danger, suffering, loss or injury whilst caring for HIV/AIDS patients. The informants indicated that they are exposed to the risk of HIV-infection due to needle stick injuries, by pricking themselves with HIV-contaminated needles. In the words of an informant: *“When you are suturing an episiotomy of an uncooperative primigravida you find that she is doing all sorts of things that put you in a vulnerable state of pricking yourself”*.

Another risk factor is being exposed to direct contact with the body fluids or blood of an HIV-infected person. The informants explained that they are at risk of contracting HIV-infection as they nurse AIDS patients with continuous diarrhoea and oozing wounds that need to be dressed. An informant said the infected body fluids of AIDS patients might accidentally splash into the registered nurse’s eyes or other part of the body: *“I remember one day when I was suctioning the patient, the secretions got into my eyes as they were not protected”*. Another said: *“Sometimes when you change the linen of a patient who have messed himself up you may contract HIV”*.

Informants indicated that they might also be exposed to the mycobacterium bacilli, as they often admit AIDS patients who are also suffering from undiagnosed pulmonary tuberculosis (TB). The TB bacilli are spread as droplet infection. Messmer, Jones, Moore, Taggart, Parchment, Holloman and Quintero (1998:118) indicate that the TB bacilli are spread through the air every time a person sneezes, coughs, talks or sings. Nurses may be exposed to TB and not realise the risk of becoming infected.

Being exposed to the risk of contracting HIV-infection is a traumatic experience, as explained by an informant: *“One day after delivering a baby, I wanted to administer Konakion to the baby. When I was breaking a vial with gloves on, it broke and cut my finger. There was blood on my finger. I was traumatised by that experience. I was afraid to go for a HIV test”*.

The informants explained that they employ precautionary measures but that the gloves and masks that they use are often torn. They are therefore exposed to HIV-infection irrespective of the precautionary measures. It is often necessary to put on two pairs of gloves to overcome the dangers inherent in wearing low quality gloves: *“Many patients admitted to the ward need bathing and frequent changing of bed linen because of continuous diarrhoea and vomiting. I put on two pairs of gloves when attending to full-blown AIDS patients who have got sores all over the body”*. An informant explained that precautionary measures against tuberculosis are not necessarily effective because it is not feasible to maintain these measures constantly: *“The TB bacilli may remain in the air for several hours and we may breathe them in as we cannot put on the mask for the whole day”*.

The response by one informant captured the risks to which they are exposed due to ineffective precautionary measures: *“I am also at risk of contracting the mycobacterium tuberculosis because we sometimes admit full-blown AIDS patients who are also suffering from undiagnosed pulmonary tuberculosis. These patients may be coughing, and I can contract tuberculosis or even HIV from the contaminated sputum. I may contract HIV through using gloves or masks that are not intact. I sometimes come across the whole box of gloves with holes except for only two to three. In that case I am then forced to put on almost two to three gloves at a time”*. Registered nurses often have to contend with shortages of medical supplies and equipment, including the most basic necessities for protecting against hospital-acquired infection, such as rubber gloves, gowns and masks (Mahatelo 2003:7).

- ***Intentional risk factors***

These factors are circumstances, created on purpose, which may cause danger, suffering and loss or injury to the registered nurses whilst caring for the HIV/AIDS patients. It is apparent from the responses that some HIV-positive patients try to infect the registered nurses intentionally.

It appears as if some patients may try to infect others intentionally because the former do not want to die alone. Informants indicated that, when they insert an intravenous infusion, some patients might remove it, with the idea of spreading blood on the nurse. An informant explained: *“My experience happened in male medical ward. There was a guy who did not accept that he was HIV-positive. He wanted to infect many people. When you insert an intravenous infusion, he would remove it so that blood should splash on you. If you have a cut and you have one pair of gloves on that is torn, you may contract HIV”*. Another said: *“You may find that they have told themselves that they cannot die alone; they will die with many”*.

Patients who try to infect nurses do so by trying to bring nurses into contact with their faeces or blood and this results in nurses putting a distance between them and their patients. For instance, informants said: *“The fact that these people smear faeces all over, increases the risk of infection and makes you not to want to get next to that patient because he will be trying his best to infect you”*. *“Most of the patients who do not accept that they are HIV-positive, do not cooperate. When you change their messed up linen they may smear you with the faeces. They will make sure that at the end of the day you end up touching those faeces with the idea that you get infected. There was also another guy in the male medical ward, who denied that he was suffering from this disease. He was having diarrhoea. He would scoop his faeces and smear that on you trying to infect you. Sometimes this diarrhoea may contain blood. At the end of the day you feel it is not OK as you may contract HIV”*.

An informant indicated that some patients go to the extent of even trying to infect their relatives. As one informant remarked, *“You can imagine when they try to infect their parents”*.

2.3.1.2 Increased workload

Increased workload refers to the increased number of activities required to care for HIV/AIDS patients. Caring for these patients can be physically and psychologically exhausting. Moetlo (1998:15), Sminoff, Erlen and Sereika (1998:148), Mahatelo (2003:7) and Kemppainen (1996:296) support the idea that nursing AIDS patients requires more nursing care than other patients because the majority of them are very weak, bed-ridden and need everything done for them. An increased workload as a result of HIV/AIDS could increase the risk of contracting HIV-infection. Working

under pressure, being exposed to intentional and unintentional risk factors and having to deal with their emotions could potentially lead to nurses being careless with regard to adhering to precautionary measures. The number of patients admitted to wards suffering from AIDS is apparently increasing daily and they require intensive nurse engagement in meeting their health needs. One informant said: *“Out of forty patients who are admitted in the ward, thirty of them are suffering from AIDS. Ten to fifteen patients might be having continuous diarrhoea and ten of them might be critically ill and on top of that there are other patients to be cared for. It is difficult to work in the ward in which there are almost five patients presenting with continuous diarrhoea and other patients in need of care. There may be other patients who need attention like those who suffer from cardiac disease. When one has finished helping an AIDS patient with continuous diarrhoea, the next patient might be waiting for a nurse to fix a messed up bed. Above all there is shortage of nurses”*.

2.3.2 Experiences of informants

Experience refers to undergo personally; feel (*Funk & Wagnalls Standard Dictionary* 1974:447). It is the process of meaning construction by means of which people think about themselves and their position in relation to others and the world around them (Coetzee 1986:110). Informants indicated that they experience depression, fear, worry, uncertainty, stress and enjoyment when caring for HIV/AIDS patients.

- ***Depression***

Depression is defined as a mood state characterised by feelings of sadness, dejection, despair, discouragement or hopelessness (Uys & Middleton 2004:319). According to informants it is difficult to work in an environment in which they may contract HIV/AIDS. However, their focus is not only on their own well-being but also on the well-being of the next of kin of HIV/AIDS patients.

Informants indicated that the risks to which they are exposed result in experiences of depression. An informant stated that she experienced depression after an episode during which the secretions of a critically ill AIDS patient splashed into her eyes: *“I felt depressed for the whole day and I prayed to God that I must not contract HIV as I was trying to help the patient. I asked God to protect me. After two to three days the depression was gone”*. Catalan, Burgess, Pergami, Hulme, Gezzard & Phillips

(1996:427) supported the idea that emotional distress and psychological morbidity can occur.

The informants also experience depression due to the devastating implications of HIV/AIDS for the significant others of an AIDS sufferer. An informant explained the consequences of a male patient failing to disclose his HIV-positive status to his wife: *“He (the patient) did not want her (his wife) to be depressed. The issue of denying the wife information about the husband’s positive HIV-status was so depressing. The husband died without disclosing his HIV-status. When I met the deceased’s wife I became worried, hoping that she might have done something to improve her health status. I could not tell her about her husband’s HIV-positive status. I felt depressed when nursing that patient particularly when thinking that according to Venda culture, the woman should remarry the deceased husband’s brother”*.

The informants highlighted the fact that they become depressed when counselling patients who are HIV-positive or suffer from AIDS, in view of the socio-economic implications of AIDS for the family. One of the informants explained it this way: *“I felt depressed when the AIDS patient, who is a breadwinner, showed concern about how the kids will survive without him after his death”*.

- **Fear**

Fear is defined as an unpleasant emotion caused by exposure to danger (*The Concise Oxford English Dictionary* 1995:492). Informants verbalised fear of contracting an HIV-infection and this appears to directly influence their therapeutic relationship with their patients, as well as their sexual relationships with their husbands.

Informants fear contact with AIDS patients, as stated by an informant: *“The registered nurses have got fear of nursing the AIDS patients. Taking blood from the patients every four hours and also turning them becomes a problem if the patient is HIV-positive”*. However, it appears that informants’ fear can be counteracted if reliable precautionary measures are intact, as depicted in the following response: *“I do not have fear of contracting HIV even when I am nursing a full-blown AIDS patient who might be having sores all over the body. The only thing that gives me fear is the holes that are sometimes found on the gloves”*. Nurses are frightened to care for HIV/AIDS people. If the nurse suffers fear and prejudice towards the patient, he or she does not experience any job

satisfaction and this is demotivating. Everyone is unnerved by the silence surrounding HIV/AIDS, and front-line health workers are frequently exposed to aggression from scared and overwrought patients and their relatives (Munsaka 2003:8; Ng'andu 2003:11; Maxwell 1996:21).

According to the informants, the fear of HIV-infection also affects their own sexual relationships: *“They (registered nurses) lose interest in doing coitus with their husbands because they always think of those men lying in beds critically ill suffering from AIDS”*. *“Sexual relationships of the registered nurses allocated to care for full-blown AIDS is affected. They lose interest in doing coitus with their husbands”*.

- **Worry**

Worry refers to allowing one's mind to dwell on difficulty or trouble (*The Concise Oxford English Dictionary* 1995: 1616). Informants' responses brought to light that they experience emotions of worry, which are directed to the families of those suffering from AIDS. They specifically verbalised worry about the dependants of a breadwinner who died of AIDS, and about HIV-positive babies being born. Two responses explicate these worries: *“I become worried when thinking of how the dependants of patients that are known to me will survive without the breadwinner”*. *“I am worried sick thinking that the baby's parents might be now busy making another baby, who may also be born HIV-positive. The parents may not even go for antiretroviral drugs as the wife may not disclose her positive status to the husband”*.

- **Uncertainty**

Uncertainty refers to the condition of having doubt (*The Concise Oxford English Dictionary* 1995:1516). An informant verbalised that she experienced uncertainty, which was associated with not knowing whether she had been infected with HIV. She said: *“I still do not know whether I am negative or positive because the window period can be prolonged”*.

- ***Experience of reward***

Reward is defined as something given in return for a useful action or a merit (*The School Oxford English Dictionary* 1998:377). One of the informants highlighted the fact that serving the needs of HIV/AIDS patients can be a rewarding experience: “*My experience of working in a high risk environment for contracting HIV is also good because AIDS patients come to the hospital when they are really in need of care. I enjoy helping AIDS patients because they are in need of us*”.

2.3.3 Consequences of informants’ experiences of working in HIV/AIDS high-risk environment

2.3.3.1 Ethical consequences

Ethical relates to morals, especially in human conduct (*The Concise Oxford English Dictionary* 1995:463). *Consequences* refer to something that happens as a result of an event or action (*The School Oxford English Dictionary* 1998:95). For the purposes of this study, ethical consequences are occurrences judged by the principles of morality underlying human interaction. Working in a high-risk environment for contracting HIV infection poses ethical problems in the clinical settings where informants work.

- ***Confidentiality***

The ethical principle of confidentiality emerged from the data. *Confidentiality* refers to keeping a secret (*The School Oxford English Dictionary* 1998:94). Although confidentiality is officially maintained in the health care settings where informants work, informants have a way of secretly communicating a patient’s HIV-status among themselves and even among them and other patients: “*My experience as a registered nurse allocated in a HIV ward is that HIV patients are identified in a way that is only known to the staff members*”. “*The negative part of the nurses is that, once they see there is a positive patient, we would try to check to see if she has all signs we read about in the book. Some of us will make sure that patients must know about her status using nonverbal cues. The HIV-positive patient will later realise that she is not treated like others*”. This clearly indicates a breach of the ethical principle of confidentiality.

Confidentiality regarding the HIV-status of patients poses problems for registered nurses as this may hamper them in performing their clinical functions. For example, registered nurses cannot render appropriate health education to patients if they are unaware of his/her HIV-status. Informants said: *“The fact that the diagnosis of the AIDS patients should be kept confidential makes it difficult for the registered nurses to communicate with patients about the disease”*. *“I think the issue that is making people to be negligent, is because of the confidentiality that is so highly maintained. If this is not so highly confidential, the husband would have been told”*.

The informants also referred to the consequences of confidentiality for the intimate partners of those who are HIV-positive or are suffering from AIDS: *“The husband died without disclosing his HIV-status. When I met the deceased's wife I become worried, hoping that she might have done something to improve her health status. I could not tell her about her husband's HIV-positive status. I felt depressed when nursing that patient particularly when thinking that according to Venda culture, the woman should remarry the deceased husband's brother”*. This quotation was included elsewhere to indicate that informants experience depression when confronted with the implications of HIV/AIDS. Here the consequences for the significant others of HIV/AIDS sufferers become apparent.

- ***Informed consent***

The ethical principle of informed consent emerged from the data. *Informed consent* refers to agreement with what someone wishes, after being given an explanation about the issue. There appear to be instances of registered nurses conducting blood tests without a patient's knowledge or consent. Informants explained that registered nurses in the intensive care unit (ICU) secretly take blood for HIV-testing, particularly involving patients who refuse to be tested. If the results are positive the nurses retrospectively persuade the patient to give consent to be tested. They cannot counsel an HIV-positive patient or tell the doctor about his/her HIV-status if consent was not obtained. HIV-testing is also done if a patient does not respond to treatment. This is captured by the following response: *“In case where the critical patient is not responding to treatment in the ICU, we take blood for HIV testing without the patient's consent so that we give care knowing why the patient is not responding to treatment”*.

- ***Neglect***

The ethical principle of neglecting to render care to patients in need of it emerged from the data. *Neglect* refers to not giving care (*The Concise Oxford English Dictionary* 1995:912). In some instances informants tend to protect themselves against HIV-infection by neglecting the HIV-positive patient. From the perspective of one informant: *“I sometimes experience an ethical dilemma especially when working in the labour ward. Sometimes midwives are unaware that the second stage of labour is approaching. In the olden days we used to deliver babies with our bare hands. Nowadays you may consider not delivering the baby bare handed if the baby is delivered unexpectedly. What should I do in this circumstance? Should I go and grab the baby or should I leave the mother to deliver alone? I really do not know how to handle such situation but it pains me”*. Another informant said: *“It also reminds me of a certain case where an HIV-positive woman was in labour. Monitoring of first stage was difficult. When she entered second stage, every nurse ran away from that woman and she delivered the baby alone, as they would not help her”*.

- ***Commitment to render care***

Commitment refers to what one has to undertake (*The Concise Oxford English Dictionary* 1995:266). One of the informants, in spite of being fearful, however acknowledged the duty of registered nurses to nurse those in their care: *“I sometimes experience fear but there is not much we can do as we have to nurse these HIV/AIDS patients”*.

2.3.3.2 The therapeutic relationship

Therapeutic connotes contributing to the cure of a disease or solving the problem (*The Concise Oxford English Dictionary* 1995:550). *Relationship* means how people get on with each other (*The School Oxford English Dictionary* 1998:369). For the purposes of this study, *the therapeutic relationship* refers to the interactions that influence the healing or improvement of a patient's condition. The informants' ability to establish a therapeutic environment is being compromised by ethical constraints, the emotions that they experience and their reactions to their emotions.

- **Communication**

The fact that the HIV-status of a patient is kept confidential contributes to an impaired therapeutic relationship. It hampers open communication between informants and their patients, as stated by an informant: *“The issue of keeping the positive HIV-status of the patient confidential is affecting the nurse-patient therapeutic relationship because we cannot communicate openly with the patient about the disease”*.

- **Care and caring**

HIV-positive patients' insistence on confidentiality results in a negative attitude, on the part of informants, towards such a patient. Informants regard such patients as being uncaring persons. As a result of this, informants themselves become uncaring caregivers to those patients and may even neglect their patients. One informant explained: *“A pregnant woman did not want to divulge her positive HIV-status to the husband and I thought that woman was not good. I sometimes neglect HIV/AIDS patients because of being uncertain of my safety when giving them care”*. *“There was a HIV-positive patient admitted in the ward. The lady wouldn't divulge her positive status to the husband and she continued having a sexual relationship with the husband without using a condom. It was obvious because she was pregnant. These HIV patients do not have feelings for their partners. They prefer to spread it. The husband never knew that the wife was HIV-positive. I think you can as well neglect them because they also don't care for others”*.

Informants' fears influence the therapeutic relationship in the sense that they do not want to nurse an HIV/AIDS patient. Discrimination against patients also appears to occur. An informant said: *“If I was to be given a chance to choose between those who are HIV-positive and those who are negative, I would choose to nurse those who are negative”*. This situation is aggravated by the fear that some patients might want to deliberately infect nurses: *“I feel uncomfortable to build a relationship with the patient who wants to infect me”*. *“With good behaviour you might find that the relationship is good between the patient and the nurse - nurses will not go next to the patient who is infecting them”*. *“You cannot go to somebody whom you know she wants to hurt you”*.

An informant indicated that HIV/AIDS has an inhibitory effect on physical touch between registered nurses and patients: *“I do not want to touch or massage them (those who are HIV-positive) because of fear of contracting the virus. When the patient is not HIV-positive, the registered nurse massages them in order to build good relationship”*. Even if physical touch occurs, the presence of gloves may contribute towards a distance between nurse and patient: *“The therapeutic relationship between the nurse and the patient is negatively affected. We put on gloves whilst making AIDS patients’ beds and also when feeding them thinking that the patient might at anytime vomit”*.

- ***Responding to the calling of caring for those in need***

On the positive side, there are informants who acknowledged the calling of registered nurses to care for those in need: *“I don't have any problem with nursing AIDS patients. I am always having a good relationship with them”*. *“It is not a matter of choosing between nursing the HIV/AIDS-patients and those who are negative. What matters is that they are patients who need care. At the end of the day, you may contract HIV and who must nurse you. Some of the patients contracted HIV through blood transfusion and they also need care”*.

2.3.4 The supportive environment

Support means to keep from failing (*The Concise Oxford English Dictionary* 1995:1400). *Environment* refers to the surroundings that affect people’s lives. For the purposes of this study a *supportive environment* refers to the extent to which registered nurses are supported in their efforts to maintain therapeutic relationships despite the challenges that they face. Informants indicated that institutional support for registered nurses working in a high-risk environment for contracting HIV-infection is available in some instances and lacking in others.

- ***Areas of support to informants***

The informants indicated that they do receive institutional support in the event of being in contact with the bodily fluids of patients. An occupational nurse advised one informant whose blouse was

contaminated with the faeces of an AIDS patient to take it to the laundry for washing. Informants appear to have access to follow-up care. An informant indicated that, after exposure to a patient's blood, both her blood and that of the patient were tested for HIV. An informant indicated that she was given an anti-D drug within 72 hours. Blood tests were done every month for three consecutive months. The blood tested negative for HIV.

There appears to be peer group support available. An informant explained: *"The nurse to nurse relationship is very good. They cling to each other. They usually have good cohesion. They usually support each other"*.

An informant explained that she relies on God for comfort and strength. She remarked: *"I pray every morning that God should give me strength to nurse HIV/AIDS patients"*.

- ***Areas of inadequate support to informants***

Although the quality of protective gloves is suspect, it appears as if the infection control department does not allow nurses to put on two or more pairs of gloves, as this is perceived to be uneconomical. This indicates that economic restrictions result in inadequate support for informants. An informant explained: *"You would be having one pair of gloves on, as the infection control group does not allow nurses to put on more than one pair. At the end of the day you will be told about the economy of the hospital"*. Considering the apparently poor quality of the gloves that are available, as explained in section 2.3.1.1, informants are unnecessarily exposed to the risk of contracting an HIV-infection.

Informants explained that they are being held responsible for the safety of HIV/AIDS patients, although they may not have control over the situation in the light of their increased workload. They commented that some HIV/AIDS patients are confused and demonstrate suicidal tendencies. These patients escape from the ward and commit suicide by hanging themselves. An informant said: *"The therapeutic relationship is sometimes affected by nursing the confused patient. Sometimes when working in the ward, there might be two to three patients who are confused. These patients may get out of the ward and go to the bush, hang themselves or may go out through the window. The management often query the nurses when patients are missing"*. Institutional support in ensuring a

manageable workload, which would enable informants to give due consideration to patient safety, is therefore lacking.

- ***Areas of adequate patient support***

Patients are supported by a number of people in different ways. Nurses refer them to appropriate health professionals such as social workers who provide them with food parcels. Psychologists (for those who can pay), pastors, and nurses render counselling services. Nurses also provide the relevant health education.

Patients receive help with informing their families and with accepting their HIV-positive status. They are also assisted in disclosing the diagnosis to their friends, partners and relatives. They receive health education on diet and safe sexual practices, and on the consequences of behaviour that put others at risk. An informant said: *“I counsel them even if they deny their positive status. I give them health education on diet and advise them to be retested so that they get convinced. Patients are told that they should use condoms when doing coitus”*.

- ***Areas of inadequate patient support***

Sometimes patients are not approached with compassion and this translates into inadequate patient support. An informant explained: *“When the HIV/AIDS patients are counselled, some of them deny that they were unfaithful to their partners. Some of them cry and they are left crying”*.

One of the informants made recommendations on how to improve patient care: *“I would recommend that the ward staff be increased and AIDS patients be nursed in a specialised ward where they may be cared for by nurses and volunteers who are willing so that they do not limit other patients’ time to be cared for. Some patients are kept in the hospital unnecessarily. I recommend that the family members be given advice and health education on how to care for AIDS patients because most of them only need basic nursing care and medicines”*.

2.4 CONCLUSION

The findings indicated that registered nurses are exposed to danger, suffering, loss, or injury whilst caring for HIV/AIDS patients. They commented that they are exposed to intentional and unintentional risks of contracting HIV-infection. They are also in danger of contracting mycobacterium TB, as they sometimes care for full-blown AIDS patients who are also suffering from pulmonary TB. Ethical restrictions lead to increased exposure to risk. As a result, informants experience negative emotions, which result in unethical practice and an impaired therapeutic relationship. On the other hand, instances of experiencing positive emotions and of a positive attitude towards caring for HIV/AIDS patients also emerged from the data.

CHAPTER 3

LITERATURE REVIEW

3.1 INTRODUCTION

In many countries, there is discrimination against people living with HIV/AIDS, as well as against their friends, partners, families and persons who care for them. Studies have shown that registered nurses reported high levels of discomfort and stress while caring for HIV/AIDS patients and that they harbour significant concerns about their personal safety. Studies also indicated that the attitudes of nurses are often negative and characterised by reluctance to provide care to the HIV/AIDS patients, which are determined by their experiences of working with such patients. In this chapter information from various researchers and authors, which is related to the study findings, will be discussed. The information to be discussed will include the pathophysiology of HIV-infection, treatment, mode of transmission, epidemiology and implications of HIV/AIDS.

3.2 HIV AND AIDS

3.2.1 Definitions of concepts

The Human Immunodeficiency Virus (HIV) is a virus that attacks and hijacks the most important body defensive cells (CD4), macrophages of the human immune system (Van Dyk 2001:7). Acquired Immunodeficiency Syndrome (AIDS) is the late and most advanced stage of HIV-disease and is characterised by signs and symptoms of severe immune-deficiency. The body loses its ability to fight against infections because the immune system is weakened (Department of Health [Sa]:32).

HIV/AIDS is a disease much like the Trojan horse, which defeated the ancient Greeks. It breaks down one's defences from the inside, and allows all kinds of diseases and infections to reign (Uys 2000:20).

3.2.2 Epidemiology of HIV/AIDS

Epidemiology is the science which studies pattern of health and disease in communities and factors which determine this patterns (De Haan 2001:30).

3.2.2.1 Prevalence and incidence

HIV/AIDS is a global issue that affects the whole world. It is a significant health problem in South Africa, which has a high incidence and prevalence of HIV/AIDS. This epidemic is a crisis that threatens South Africa's reconstruction and development. There are alarming statistics regarding people infected with HIV. Statistics show a yearly increase. Of the estimated 44 million South African citizens, five million people are HIV-infected, despite the intense HIV programmes that are in place. It is postulated that the numbers will increase as the epidemic has yet to plateau, possibly somewhere between 2005 and 2010 (DENOSA 2002:44; Mzolo 2003:50). Fifty (50) to 60 percent of the bed occupancy in the public hospitals of Gauteng province is due to HIV-infection (Spencer 2003:17). It is estimated that not less than 1500 people are infected daily. In some parts of this country, one in four women is believed to be carrying HIV.

These high frequency and prevalence rates indicate that AIDS and associated diseases will continue to place a burden on the health system in coping with the demand for adequate care and support facilities. It is estimated that, in Gauteng province where a substantial proportion of medical beds is already utilised for HIV/AIDS care, the required beds available for HIV/AIDS related diseases will increase by up to 600% over the next ten years unless more efficient ways of caring for people with HIV/AIDS are implemented (DENOSA 2002:44; Moetlo 1998:15).

3.2.2.2 Modes of transmission

Three modes of transmission of HIV exist: unprotected sex, contact between the blood of a person who is not infected and the infected blood or body fluids of another person, and mother to child transmission.

HIV-infection is sexually transmitted primarily through unprotected vaginal or anal intercourse and

possibly through oral sexual contact under certain conditions. HIV is transmitted when the virus enters a person's bloodstream via the body fluids of an infected individual. Women are more likely than men to become infected with HIV during unprotected vaginal intercourse. HIV-positive women are highly contagious during menstruation because of the presence of HIV-infected blood. The recipient of semen during anal sex runs a greater risk of infection than the active partner because the inflexible mucous membrane that lines the anal-rectal area is easily torn during anal intercourse. Women are physically more vulnerable to HIV than men because the vagina has a large area of exposed and sensitive skin which can be cut during sex. Semen also remains in the vagina after sex, increasing the risk of transmission. The penis has a small surface area, which is in contact with the vaginal fluid for a shorter time. This means that a man's risk of contracting HIV is lower than that of a woman (Department of Health 2001a:38; Department of Health 2004:15; Van Dyk 2002:19).

HIV is also transmitted following the transfusion of whole blood, blood components and plasma products. Individuals who misuse injectable drugs account for the largest group of individuals who have contracted the HIV-infection, since contaminated needles are often reused. Donor organs (kidneys, corneas, and hearts) of the individuals whose previous behaviour has put them at risk of acquiring HIV-infection, increase the risk of HIV-transmission.

Mother to child transmission can take place while the baby is still in the uterus, during childbirth or after birth during breastfeeding. HIV-infection may be transmitted in utero, at birth or in the neonatal period. Most cases result from prenatal transmission of HIV. Without antiviral treatment, the rate of transmission of HIV from mothers to babies varies from about 20 to 30 percent. Epidemiological data indicates that breast-feeding is associated with a high HIV transmission risk (Ferris & Kabaabetswe 2003:3).

HIV cannot be transmitted through casual contact like working with someone who is HIV-positive, or sharing the same space in a bus, school, party or home with an infected person. It cannot be transmitted by toilet seats, swimming together in a swimming pool, through telephones, sharing clothing, and eating utensils. One cannot be infected by eating food prepared by an infected person. It is also not possible to contract HIV through a mosquito bite (Department of Health 2001a:36).

3.2.2.3 Risk to health practitioners

HIV may be transmitted in the health care setting from patient to health care practitioner (DENOSA, Department of health, UNAIDS & WHO 2000: 11-1). The average risk of HIV-infection from all types of reported percutaneous exposure to HIV-infected blood is 0.3%. The risk of infection increases if the injury is deep, there is visible blood on the device causing the injury, if the device was previously placed in the source patient's vein or artery and the source patient has advanced HIV-disease (AIDS) (Department of Health 2000c:4).

Health practitioners are at a low risk of becoming infected with HIV if they follow normal precautionary measures. The occupational risk of becoming HIV-infected from patients in health care settings is low (approximately 0.3%, as noted above) and in most cases is associated with needle stick injuries stemming from a patient with HIV. The estimated risk of becoming infected with HIV after a puncture with a contaminated needle is less than 1%. For a needle-stick accident to lead to HIV-infection a sufficient amount of infected blood must be injected into the nurse's body. It has been argued that the seropositive nurses are more likely to become infected in their personal lives than by working with AIDS patients (Berkowitz & Nuttal 1996:464). This view is contradicted by the results of this study, which revealed that registered nurses are exposed to various intentional and unintentional risk factors in the workplace, as explained in section 2.3.1.

The risk of transmitting HIV is dependent upon the practices of health care personnel, the prevalence of illness, and the amount and frequency of exposure (DENOSA *et al* 2000:11-1). The risk after mucous membrane (via the mouth) or skin exposure (without any injury) depends on the volume of blood and load of HIV in the blood (HIV viral load). However these risks are much lower, and are reported to be approximately 0.1% and less than 0.1% respectively. The risk of skin exposure (e.g. skin splash, not an injury) is likely to be higher if there is prolonged contact with the skin, the contact involves a large area of the skin, the skin is unhealthy (i.e. open wounds, diseased, inflamed) and if there is a high viral load in the source patient's blood (Evian 2000:308).

Factors that increase the risk of occupational HIV-infection are shortages of plastic gloves, protective aprons and proper disposal facilities (Knussen & Niven 1999:367). Simpson's (2003:53) study in Scotland revealed that nurses are unnecessarily at risk of HIV-infection because of an

insufficient supply of protective gloves. This study on nurses' experiences of working in a high-risk environment for contracting HIV/AIDS, revealed that nurses perceive that they are exposed to risk due to faulty gloves.

3.2.3 Pathophysiology of HIV-infection

3.2.3.1 HIV life cycle

In order for infection to occur, the virus has to enter the body and attach itself to the host cells. HIV attacks CD4 cells, which organise the body's overall immune response to foreign bodies and infections. HIV attacks T-helper cells and macrophages. In order for a person to become infected, the viruses attach themselves to the CD4 cells and macrophages. Once the virus attaches itself to the cell's surface, it penetrates the wall. After penetration the virus cannot be destroyed by the body's defence mechanisms. Inside the cell, it copies its RNA into DNA in order for the door into the nucleus to be opened. The copied DNA integrates easily into the company of the host genes and, by manipulating the proceedings of the nucleus, causes the cell to churn out new HIV viral proteins. These viruses break out of the cell. In the process the cell is destroyed and the viremia goes on to infect more CD4 cells (Whiteside & Sunter 2001:7).

3.2.3.2 Stages in the progress of AIDS

HIV affects the immune system of the infected person. Various stages of progression of HIV/AIDS occur: acute retroviral syndrome, clinical latency, early signs and symptoms of HIV-infection and late signs and symptoms of HIV-infection (Calles 2003:11-13).

3.2.4 HIV/AIDS and tuberculosis (TB)

DENOSA *et al* (2000:13) state that HIV/AIDS is the most powerful factor known to increase the risk of TB: that is, HIV-infection increases the person's susceptibility to infection with the mycobacterium tuberculosis. The presence of TB may allow HIV to multiply more quickly. Moetlo (1998:16) stated that South Africa's TB rates are already among the world's highest. TB is curable

but very common in people with HIV. It is estimated that up to 50% of HIV-infected persons may develop TB.

Messmer, *et al* (1998:118) stated that the TB bacilli are spread through the air any time the patient sneezes, coughs, talks or sings. The bacilli may remain in the air for a prolonged period. Nurses may be exposed to TB and not realise the risk of becoming infected, as indicated in an above discussion. Many hospitals are not aggressive about conducting employee skin testing for TB exposure.

- ***Prevention and treatment of TB/HIV/AIDS***

HIV-positive health practitioners should avoid contact with TB patients. They should seek care if they develop TB symptoms. The best way to prevent TB transmission is to rapidly diagnose and treat infectious TB patients. Isolation of TB patients prevents TB transmission to other patients. TB wards should have large windows with ventilation and sunlight. If available, masks should be worn by health care practitioners in high risk situations (Department of Health 2000a:60).

- ***Continuity of care of patients with TB/HIV/AIDS***

Continuity of care with adequate follow up of TB patients will prevent transmission, improve TB cure rates and prevent the development of multi-drug resistant TB. Patients should learn the symptoms of HIV/AIDS/TB, seek care if they develop them, and follow health care practitioners' recommendations on when to come for appointments and go to the referral facilities. Standard short course treatment also effectively cures TB in HIV-infected individuals and the standard national TB control programme protocols should be followed (Department of Health 2000a:61; Department of Health 2000d:27).

3.2.5 Treatment of HIV/AIDS

AIDS cannot be cured but one can survive for more than twenty years (Christesen [Sa]:2). Developments in the treatment have resulted in a decline in the mortality rates resulting from HIV/AIDS in the developed countries. There are three stages in the treatment of HIV-positive

people. The first occurs when they are infected and the CD4 cell counts are high. At this point, the emphasis is on “positive living” – staying healthy, eating the correct food and so on. The second stage takes place when the CD4 cell count begins to drop. At this stage, prophylactic treatment to prevent TB and other common diseases is normally begun. The third stage comprises the use of antiretroviral drugs to fight HIV directly. This can start when the CD4 cell count drops below 350 (Whiteside & Sunter 2001:21). Antiretroviral treatment is a special combination of medicines that stop the HIV from multiplying in a person’s body. Treatment is indicated when AIDS has developed because in a person who does not yet have AIDS, the side-effects can be worse than the benefits. The purpose of antiretroviral treatment is to achieve viral suppression and reduce the viral level of HIV-RNA to as low as possible, for as long as possible. This stops the virus from killing the immune system cells, which defend the human body against infection. Antiretroviral treatment is effective in keeping people with AIDS fairly healthy by reducing any continued decline in the health status of the patient. This treatment is expensive and though it is available in some of the South African public sector hospitals, the vast majority of South Africans do not currently have adequate access to antiretroviral treatment.

Antiretroviral treatment drugs used to treat people who are already HIV-infected are effective in slowing down the development of AIDS. The new advanced drug therapies make it possible for people to move back from a state of AIDS, when they are very sick, to being HIV-positive and leading normal lives again (Whiteside & Sunter 2001:2). Many people who are on antiretroviral treatment continue to work normally for a long time. In countries that have been using antiretroviral treatment for many years, as in Brazil, the USA and elsewhere, people with HIV live longer and healthier. The HIV situation has changed since antiretroviral treatment became available: deaths from AIDS-related illnesses have been reduced by 75%. Once a person commences taking antiretroviral treatment, it should be taken lifelong. Antiretroviral treatment medicines are very strong, however, and they do have many side effects, a number of which can be recognised and treated if they are reported early. People die from AIDS, but the medicines, if used properly, don’t kill a patient. Considering that for people with AIDS the alternative is death, the benefits of antiretroviral treatment far outweigh the risks (Department of Health 2001a:40).

A study in Cape Town revealed that antiretroviral treatment has been shown to reduce the incidence of TB in HIV-infected patients by more than 80%. These patients require intensive adherence

support as they are likely to develop side-effects, such as gastro-intestinal intolerance resulting from taking a large number of tablets every day (Cohen & Maartens 2004:8; Department of Health 2000c:26; Evian 2000:79; Xudu & Karstaed 2001:36; Department of Health 2004:5).

Participation in drug trials is often the only way of gaining access to antiretroviral treatment. HIV/AIDS related clinical trials refer to trials of antiretroviral drugs and to trials with medications such as immune modulators, and drugs for the treatment and prevention of HIV-related opportunistic infections. Drug trials are conducted to determine various outcomes such as the drug's impact on the health status of the individual and survival benefits. Comparisons are made with other therapeutic options. The side effects, and compliance with therapy, are also monitored. A programme of antiretroviral treatment also has to grapple with the challenge of ensuring that people take drugs several times a day, every day, for the rest of their lives. Poor adherence rapidly leads to the emergence of drug resistance and treatment failure at the individual level. People need support from someone who will ensure they take their medicine even when they have no appetite and don't feel up to it (Barnardt & Georgiev 2003:31; Hirschfeld 2003:47; Scheneider & McIntyre 2003:19).

AIDS patients present with a number of opportunistic infections such as Cryptococcal Meningitis, Oesophageal Candidiasis and respiratory infections, which should be specifically treated. Patients also present with symptoms such as fever, diarrhoea, nausea and vomiting, and fluid and electrolyte imbalances. Other symptoms that require prompt treatment include oedema, constipation, skin problems, problems of the oral mucus membrane, anorexia, pain, impaired vision and general fatigue (Van Dyk 2002:375-393).

3.2.6 Precautionary measures

The principle of successful HIV-infection prevention is ensuring that people are not exposed to the disease and, if they are, that they are not susceptible to infection. Vaccines provide the latter form of protection, but they are not available for HIV yet. Precautionary measures are threefold. Firstly, it is necessary to stop transmission through behaviour change. This can be achieved when people gain *knowledge*, then change their *attitude* and finally alter their *behaviour*. People ought to adhere to one sexual partner and delay the first experience of sexual intercourse. This is the classic ABC message: A-*abstain*; B- *be faithful*; C- *use a condom if necessary*. Secondly, those infected with

HIV ought to be identified at an early stage so that treatment, counselling and health education can commence. Thirdly, precautionary measures to prevent HIV transmission in the care delivery setting should be maintained (Ferris & Kabaabetswe 2003:4; Whiteside & Sunter 2001:17-19)

An essential strategy is health education, aimed at possible alteration of human behaviour which increases the risk of HIV-transmission. Such an education programme implicitly involves publicity regarding the avoidance of shared needles for drug addicts and maintaining safe sexual practices. The presence of sexually transmitted illnesses such as gonorrhoea or syphilis greatly increases the risk of HIV-infection through sexual intercourse. Anything that will reduce the extent of sexually transmitted diseases in a society will help reduce the spread of HIV/AIDS. The most important way to prevent the spread of HIV is to ensure that sexual behaviour does not put individuals at risk. Health education programmes should therefore propagate changes in sexual behaviour, namely a reduction in the number of partners and the move from high-risk to low-risk sexual activities. The most effective way of ensuring that partners have not contracted HIV is for each of them to take an antibody test (Uys 2000:20; Department of Health 2004:7; Ferris & Kabaabetswe 2003:5). The problem highlighted in this study is that the confidentiality of the HIV-status of individuals hampers nurses in their efforts to render health education.

Those at risk of HIV-infection and their sexual partners should be tested. Voluntary HIV-testing may form part of health care for suspected HIV-related illness and may also be provided in conjunction with information, education and counselling and other support services to help promote sustained behavioural change. A safe sex standard for discordant couples (one HIV-positive and one HIV-negative) must be very stringent, with sexual activity limited to masturbation. Married couples may possibly not adhere to such advice and the use of condoms for every vaginal or oral contact should be advocated (Department of health 2001a:62).

The health care setting also poses the risk of HIV-transmission. A preventative strategy is to increase control over blood and blood products, which are utilised in the treatment of various diseases and conditions. Testing of donated blood and blood products for HIV greatly reduces the possibility of the spread of HIV. To minimise the risk of occupational transmission of HIV, all health practitioners should adopt appropriate risk infection, risk assessment and accident prevention procedures. Precautions by health practitioners to prevent HIV transmission include taking

measures to: protect existing wounds and prevent new wounds; prevent direct contact with infected material; safely dispose of spillages, contaminated materials and wastes. This includes provision of appropriate disinfectants to clean up spills of blood and other body fluids, and ensuring that universal precautions are implemented, monitored and evaluated (DENOSA *et al* 2000:11-3). Wang (1997:36-38) explains that nurses must take specific actions such as complying with standard and airborne precautions to protect themselves from nosocomial infections in caring for HIV/AIDS patients diagnosed with TB (DENOSA *et al.* 2000:11-1)

Pregnant women who attend clinics are informed about the Prevention of Mother to Child Transmission Expansion Programme. HIV-infected pregnant women are then admitted to the programme. Interventions to reduce mother to child HIV transmission include vaginal disinfection with virucide before delivery, and performing caesarean sections. A single dose of Nevirapine is administered at the onset of labour and the baby is also provided with a single dose of Nevirapine within 72 hours after birth. Vitamin A supplements are also administered to improve the immune status of an individual. Mothers are advised on the safe use of breast milk substitutes. Babies are followed up with further health care and HIV tests. Counselling, education and support are provided (Urassa, Walraven & Boerma [Sa]:337).

3.2.7 Management of HIV/AIDS

- *Principles of care*

Holistic care is central to caring for people living with HIV and AIDS. It reduces the burden on hospitals. Clinicians must be trained in basic HIV counselling and empowered to decide where and how to best manage their patients at different stages of the infection and the disease (Xudu & Karstaed 2001:7)

- *Strategies to reduce the morbidity and mortality rates*

The morbidity rate can be reduced by reducing transmission from mother to child through the provision of short-course antiretroviral treatment to pregnant HIV-positive women. The treatment of sexually transmitted infections and access to voluntary counselling and testing services are also essential. Antiretroviral treatment, improved nutrition and immune boosters are rendered to improve patients' quality of life and delay their death (Bekker 2003:38-39).

- *Providing quality care*

Providing quality care requires consultation with and the active participation of all stakeholders in the fight against HIV/AIDS. AIDS, like any other disease, can be managed. Cristesen ([Sa]:3) remarked that it is just another factor in life to deal with. Simpson (2003:53) stated that the stage at which HIV is diagnosed can make a significant difference to the prognosis. The choice rests with the individual: HIV/AIDS can be a chronic, manageable condition or a life threatening disease.

People who are HIV-infected should be motivated to prevent the spread of HIV; protect themselves from re-infection with new strains of HIV and an increasing viral load; prevent and/or treat other sexually transmitted infections, opportunistic infections and other chronic illness that could accelerate disease progression and complicate treatment; and make informed choices about lifestyle, treatment and compliance (Simpson 2003:53).

Management differs according to the stages of infection and problems experienced by the patient. Some patients experience a sense of social isolation. Patients with HIV-infection and AIDS face many problems and stressors which often cause them to withdraw both physically and emotionally. They are forced to reveal hidden life-styles to family, friends and co-practitioners. The current normal levels of social interaction should be assessed as early as possible so as to provide a baseline for monitoring changes in behaviour. Patients should be given confidence by providing them with information on protecting themselves and others from HIV-infection (Van Dyk 2002; Raphuti 2003:34).

- ***Management of occupational exposure to blood or body fluids***

For all the exposures, the affected area is immediately cleaned with an antiseptic agent and irrigated with water. Mucous membrane and eye exposures should be rinsed and flushed extensively with water. An exposure level is evaluated, the HIV-status of the exposure source should be determined and post exposure prophylaxis is recommended (Department of Health 2000a:9).

- ***The importance of a healthy lifestyle for people living with HIV/AIDS***

Some HIV-infected individuals have attributed their delayed onset of AIDS diagnosis to regular exercise, a healthy diet and stress management. Science is beginning to support this conclusion. Good nutrition contributes to the wellness and sense of well-being of the person with HIV/AIDS. An HIV-infected person should adhere to a well-balanced diet and drink ample amounts of water. A review article has reported that HIV-infected persons who exercised had improved their cardiovascular fitness and muscle function, weight gain, mood and coping skills. Progressive-resistance training increases muscle tissue in HIV-infected patients (Department of Health 2001b:1-4).

- ***Palliative care of patients with AIDS***

Palliative or terminal care is active, compassionate and comprehensive care that comforts individuals and families who are living with life threatening illness. The purpose is to meet the physical, psychological, social and emotional needs of the patient (Van Dyk 2001:397).

3.3 IMPLICATIONS OF HIV/AIDS

3.3.1 Psychosocial impact

HIV can exert a social, mental and physical impact on an individual and his/her environment. Levels of psychological distress are highest at the early stages of diagnosis of HIV-infection. This is caused by anxiety about the repercussions of being HIV-positive. Coping with the knowledge of being HIV-positive is difficult. People fear being stigmatised and rejected by family and friends

(Xudu & Karstaed 2001:8). This result is congruent with the findings of this study, which indicated that informants fear being stigmatised even if they contract HIV in the workplace.

3.3.2 Ethical considerations

Ethical guidelines comprise a set of moral rules or principles used to guide the work of professionals. They protect people served by professionals against abuse. Various ethical considerations must be taken into account when dealing with HIV/AIDS in health care. On the other hand, people with HIV/AIDS have the duty to respect the rights, health and physical integrity of those who are HIV-negative and to take appropriate steps to ensure that this respect is accorded when necessary (Van Dyk 2002:411; Department of health 2000b:12; Geyer 2004:30-31).

The AIDS Law Project is a pioneering organisation that helps combat HIV/AIDS by protecting the rights of millions affected by the disease in South Africa. It gives the world a model for combating AIDS by fighting stigma, discrimination, sexual violence and other gender-related abuses that fuel the epidemic (Jurgens 2003:46).

3.3.2.1 The dilemma of confidentiality and privacy of information versus the right to receive optimal care

People with HIV and those who suffer from AIDS have the right to confidentiality and privacy about their personal data, health profile and HIV-status. Health professionals are ethically and legally required to keep information about clients or patients confidential (Van Dyk 2002:408). On the other hand, HIV/AIDS sufferers have the right to receive optimal health care. To achieve this, health practitioners require access to the information necessary for meeting the unique needs of individuals.

A multidisciplinary health care team renders health care and this entails the exchange of ideas among health practitioners. Information concerning a patient's health, including information concerning treatment, can only be given to another health practitioner if informed consent has been obtained from the patient. This may not be necessary when information is needed legally or as a result of any court order. Other health care practitioners may need to know a patient's HIV-status if

that person needs special treatment related to their HIV-infection. If disclosing the patient's HIV-status is going to be important to the future care of the patient, this must be explained to the patient. If a person refuses to agree to this information being given to other health care practitioners, then this decision must be respected (Achmat, Barrett, Cohen, Fine, Gots, Grant, Heywood, Kekana, Richardson, Stone & Strode 1997:49-53). The findings of this study revealed, however, that informants breach the principle of confidentiality through non-verbal cues that a particular patient is HIV-positive.

With the rapid rise of reliance on electronic storage and transfer of sensitive personal information, concerns about the rights and abilities of citizens to control third-party access to private information are voiced. This is particularly acute for people living with HIV/AIDS, due to the continuing stigma and punitive reactions that their status engenders (Hansen 2000:59). It is imperative to secure the safety of medical records, especially in a health care dispensation that utilises electronic health information systems.

3.3.2.2 The dilemma of confidentiality of information versus the rights of a sexual partner or caregiver

Caregivers (including health practitioners) and sexual partners of HIV-positive persons are at risk of contracting HIV-infection, especially if they are unaware of the person's HIV-status. Those caregivers and sexual partners can, in turn, become sources of contamination. In this sense, confidentiality is seen as beneficial for HIV-positive patients but potentially detrimental to those who are in close contact with such patients (Berkowitz & Nuttal 1996:463). While confidentiality of information should be maintained, a health care practitioner can be sued for not telling the sexual partners of an HIV-positive person that they are at risk of contracting HIV-infection. If the person says that his or her sexual partner is not in danger as they are practicing safer sex, the health practitioner must accept this (Achmat *et al* 1997:49-53).

3.3.2.3 The dilemma of self-determination versus HIV testing

Individuals are responsible for determining the conduct of their own life and the management of their illness. The nurse supports such self-determination, while understanding that frightened or ill

people often feel anger, sorrow, guilt and shame. The nurse must always help such people to take decisions, encouraging them to do so for as long as possible and providing the information necessary to make sound decisions. Voluntary counselling and testing has emerged as a major strategy for the prevention of HIV-infection and AIDS in Africa. Apart from raising awareness about HIV/AIDS, being aware of one's HIV-status is instrumental in affecting behavioural change. Registered nurses should motivate people regarding the advantages of knowing their HIV-status. This can be achieved through volunteer counselling and testing (VCT) as a new HIV-prevention strategy (Department of Health 2000b:9).

3.3.2.4 The dilemma of the right to treatment and care versus the rights of health professionals

Any person who approaches a health service, doctor or nurse for assistance has the right to expect that he or she will be given treatment. Once HIV/AIDS patients are accepted by nurses, the latter have certain obligations and the patient obtains specific rights. No one may be refused emergency medical treatment. Health care practitioners cannot refuse to treat a person with HIV or AIDS (Achmat *et al* 1997:43; Pera & Van Tonder 1996:173). The rights of HIV-positive patients are, however, considered to be in conflict with the rights of health professionals (Deetlefs, Greef & Koen 2003:26).

Moetlo (1998:15) explains that AIDS which is progressing results in an increasing need for hospitalisation, not only for acute, treatable illnesses but also for terminal conditions. There is a concern that nurses tend to view AIDS patients as more demanding or requiring more nursing care than other patients because the majority are very weak (Sminoff *et al* 1998:148). Kemppainen (1996:296) in his research reported that caring for AIDS patients can be physically and psychologically exhausting. Some investigators have found that nurses and other health practitioners express the intention of avoiding AIDS patient care and have even considered changing occupations if faced with an increased workload. Health practitioners who choose to work with AIDS patients are subject to stress and burnout. Cushman, Evans, Namerow, Davidson, Foster, Janz, Wren and Israel as quoted by Demmer (1999:433-442) stated that health care givers need to be supported and cared for as they provide terminal care to terminally ill AIDS patients. During the early 1990s a number of disturbing reports in South Africa indicated that AIDS patients received

less optional care, as nurses were afraid of them. Nurses held negative attitudes towards patients suffering from AIDS and would tend to practice avoidance behaviour, resulting in providing poor quality care. This consequence is supported by the findings of this study, which revealed that informants are subjected to an increased workload and that they tend to neglect their patients, or to create a distance between them and their patients, to the detriment of a good therapeutic relationship.

A survey among Canadian dentists revealed that some Canadians are reluctant to treat persons living with HIV/AIDS and more than one in six would deny treatment to homosexuals. Of those who would refuse treatment, about six in ten are concerned for their own safety; about two thirds are afraid of losing other patients; and just under half objected to the extra costs of taking precautionary measures (Bekker 2003:38-40). In this study on the experiences of nurses working in a high-risk environment for contracting HIV/AIDS informants mentioned that, if given a choice, they would choose to care for HIV-negative rather than HIV-positive patients.

On the other hand, HIV-infected nurses have obligations towards those who are HIV-negative. Nurses with oozing lesions or weeping dermatitis should under no circumstances be allowed to perform or assist in direct patient care activities until such conditions heal. It is the responsibility of both the employer and the health care professional to make sure that safe procedures are followed at all times and to be aware of any changes in the mental and physical abilities of employees (Van Dyk 2002:414).

3.3.3 Socioeconomic consequences

HIV/AIDS is a major health and social problem facing South Africa. As noted earlier, it has the potential to threaten the goals of the Reconstruction and Development Programme (RDP) and future government strategies in every sphere. The South African Minister of Finance stated on TV, whilst giving a summary budget report, that the total expenditure on HIV/AIDS for the year 2003 was 1.1 billion Rand. He further estimated that it would increase to 2.2 billion Rand for the year 2004 and 3.3 billion Rand for the year 2005 (SABC 2, Parliament Live report. 19 Nov 2003, 14.00). This places a huge burden on the health care sector and has consequences for the broader economic development of this country. On the other hand, the prevailing inequalities in society: inequalities

of power, gender, sexual orientation, status, income, working and housing conditions, continue to contribute to the increased vulnerability to HIV-infections in the most disadvantaged groups (DENOSA 1999:37; DENOSA 1998:37).

The economic effects are first felt by the family. Almost all families with relatives dying of AIDS experience a decreased income because the affected person may no longer be able to work or another person may have to leave employment to become a caregiver. There is an increase in expenses for the family because of the need for medication and care, and the high cost of funerals. Meeting the medical costs of managing AIDS depletes household resources and has been shown to lead to indebtedness and loss of property in developing countries (Department of Education 2001:11; Marcus 2002:56).

HIV/AIDS also affects the economy on a larger scale. There is for instance, increased absenteeism from the workplace, of people who are ill or people who are caring for those who are ill. Productivity in the economy may decrease as a result of absence due to illness and attendance at funerals (Wessels 1998/1999:73). The governmental welfare approach states clearly that HIV and AIDS are disabling conditions. People living with HIV or AIDS may, in future, qualify for social security grants and other assistance. Various non-governmental organisations render support to victims (Achmat *et al* 1997:151-155). This places a huge financial burden on society.

HIV/AIDS may overload the social services of a country and put practitioners of the caring professions under tremendous pressure. Some families disintegrate and the number of homeless children increases, bringing ever-increasing demands for welfare services. The school dropout rate may also rise (Wessels 1998/1999:73).

3.4 THE THERAPEUTIC RELATIONSHIP

3.4.1 The concept therapeutic relationship

Therapeutic refers to treating or curing a disease (Doland's Dictionary 1981:1354). *Relationship* refers to how people are related (The School Oxford English Dictionary 1998: 369). A *therapeutic relationship* therefore refers to interactions between health care practitioners and HIV/AIDS

sufferers, aimed at healing or improving their condition, and assisting them to take responsibility for their own health.

3.4.2 Characteristics of a therapeutic relationship

- ***Therapeutic reciprocity***

Therapeutic reciprocity denotes the mutual exchange of feelings, ideas and conduct between nurse and patient, with the aim of strengthening the outcome of the relationship for all parties concerned. Therapeutic reciprocity can be affected negatively by mental factors such as noise, lack of privacy or time, and language and cultural differences. An attempt should be made to eliminate these interfering factors (Pera & Van Tonder 1996:60).

- ***Mutual trust***

One of the most important factors influencing the relationship between the nurse and the person being cared for is mutual trust. Trust in the nurse enhances the relationship and improves the chance that the individual will act on the counsel or an advice provided, or respond to the care given. It has long been accepted that trust is an essential ingredient of a successful health care relationship. The relationship between the nurse and the person being cared for must be built on the understanding that whatever is discussed remains a private issue between the two. A HIV-positive person needs to share his/her feelings about the diagnosis with a caregiver whom he/she trusts. People often want to share how they became infected and also to share their feelings of shock, guilt, shame, sadness, anger and regret. Due to the stigma attached to this illness they may feel unable to discuss their diagnosis with family and friends, making them more dependent on health care professionals. It is therefore important that confidentiality should be guaranteed. It is very beneficial for patients with AIDS to meet and talk to others in the same position (Pera & Van Tonder 1996:61; Uys 2000:20). However, this study revealed that informants breach the confidentiality principle and that they harbour negative attitudes towards HIV/AIDS patients. They also neglect these patients. These actions contradict the requirements of a therapeutic relationship.

- ***Compassion***

Compassion is a way of living born out of an awareness of one's relationship to all living creatures. It is a specific act in response to this knowledge. Compassion asks one to go where it hurts, to enter into places of pain, to share in brokenness, fear, confusion and anguish. Compassion is more than kindness and also more than caring. Nurses are to care for HIV/AIDS patients with compassion (Pera & Van Tonder 1996:3). However, this study revealed that, while some informants approach patients with compassion, others are judgemental and foster negative attitudes towards their patients.

- ***Mutual respect***

Differences in values and beliefs on the part of nurse and patient pose a serious threat to a therapeutic relationship. Both nurse and patient bring a variety of values, beliefs and moral points of view to their relationship. The code of nursing ethics for nurses defines, *inter alia*, the principle of respect for a patient's human dignity and uniqueness. The nurse should know what beliefs, values and moral points of view a patient subscribes to in order to respect them (Pera & Van Tonder 1996:61).

- ***Accessible health care***

Health care should be obtainable by all persons infected with HIV, or with HIV related diseases, who need it. An effort should be made to ensure that all those at risk of HIV-infection or in need of health care actually perceive the health services as being both readily available and accessible. People with HIV/AIDS have very unique difficulties. Nurses often need to be the health carer and the counsellor. They should be interested in the patient's life situation- job, family, economic situation. The nurse must be able to help HIV-infected persons and their friends face the fact of the impending death. The nurse should support and respect the patient's spiritual beliefs and facilitate the observance of traditional rituals related to terminal illness, death and bereavement. The nurse should be warm and friendly, non judgemental, easily available or contactable as possible and be able to empathise with the patient's burden (Evian 2002:58).

The sick should be supported for as long as possible in their own decision-making and their own self-care. Clients are free to discuss their concerns about medical prescriptions with counsellors, clinicians or nurses.

Nurses from various countries gathered in Durban on the 8th July 2000 for a very successful international satellite meeting prior to the 13th July 2000 International AIDS Conference. The theme of the satellite meeting dealt with nurses breaking the silence on HIV/AIDS. In her opening address, the Minister of Health, Dr Tshabalala-Msimang, highlighted the plight of the nurse and the impact of HIV/AIDS on the nurse. She said that only by forming partnerships with other nurses, the community and their own families, could the impact of HIV/AIDS be successfully managed. She expressed her concern about reports that some health care practitioners often treat patients and their families badly. She then invited nurses to join her in a partnership to ensure the delivery of humane and caring health care services to all those that are infected or affected by HIV/AIDS and all those who seek health care (DENOSA 2000:1).

- *Autonomy*

Persons with HIV/AIDS have the same rights to liberty and autonomy as the rest of the population. *Autonomy* enshrines the right to self-governance, personal freedom, and the freedom to express one's own will in a community or society. It is further defined as the individual's freedom to determine his/her own objectives and to act accordingly. This implies that a person should be free to decide for herself, on condition that her autonomy does not encroach upon the autonomy of others. Autonomy expresses respect for the unconditional worth of an individual and also respect for individual thought and action. Respect for autonomy is binding on all nurses. Persons with HIV or AIDS are entitled to autonomy in decisions regarding marriage and child bearing, although counselling regarding their decisions should be provided. Patient autonomy regarding antiretroviral treatment needs to be respected. Endeavours to promote autonomy should be pursued through seeking the opinions of representatives of vulnerable communities, including persons living with HIV (Achmat *et al* 1997:275; Pera & Van Tonder 1996:145; Spencer 2003:15).

3.5 PREVIOUS RESEARCH ON NURSES' EXPERIENCES

Registered nurses experience high levels of stress and discomfort in AIDS patient care. The study by Kemppainen, Dubbert & McWilliams (1996:296) revealed that those registered nurses who had frequent contact with HIV/AIDS experienced more stress when providing care and perceived a greater risk of contagion than those who did not have frequent contact (Knussen & Niven 1999:367).

Sherman (1996:206) found that nurses are at significant risk of contracting HIV. A study by Wang (1997:38) led to the conclusion that, fear and uncertainty regarding AIDS challenges all caregivers to provide adequate, and quality, care to patients. The study revealed a significant relationship between concern about contracting AIDS from patients, and fear of HIV-infection and AIDS. Wang (1997) found that registered nurses who thought the risk was high in their job expressed great fear of contracting HIV-infection and AIDS. The study by Sminoff *et al* (1998:156) confirmed that fear of HIV contagion continues to be high among nurses. Nurses' fears of occupational transmission of HIV have sometimes been prevalent despite limited or no experience in caring for AIDS patients (Berkowitz *et al* 1996:464). Fear leads to reluctance in giving care to AIDS patients, over-emphasis on universal precautions and little respect for HIV-positive patients (Barbour 1995:218). This study supports the above findings, since it revealed the presence of fear and unethical practices among informants, and an impaired therapeutic relationship with the patients under their care.

According to Sherman (1996:211), nurses who demonstrate spirituality or spiritual awareness are willing to care for HIV-positive patients. They actualise their nursing potential and accept their nursing responsibility. In this study, some informants indicated their willingness to care for AIDS patients and explained that they regard doing so to be a satisfactory experience.

Demmer (1999:434) indicated that many health practitioners are themselves partners of people with AIDS. Many health practitioners reported feeling uncomfortable if a dying AIDS patient talks about death. In addition, many health practitioners express discomfort talking about their own death.

3.6 CONCLUSION

The world of AIDS is a bewildering one, because everything changes so quickly. HIV/AIDS is a health problem in the entire world. The number of infected people is increasing every day. However, the onset of effective therapy has switched the perception of AIDS being a fatal disease to that of being a manageable, chronic condition. More effective treatment and management of HIV/AIDS patients positively affect the patient, caregivers and society in general. Despite this, health care practitioners experience a fear of contracting HIV/AIDS. This has ethical implications and poses a challenge for the maintenance of a therapeutic relationship.

CHAPTER 4**THEORETICAL FRAMEWORK: FRANKL'S MEANING OF LIFE****4.1 INTRODUCTION**

In this chapter Frankl's view of the human being (in his terms, "man"; the feminine pronoun or the term "human (being)" or "person" will sometimes be used below for the sake of gender inclusivity) and the meaning of life are discussed. This theory served as the basis for interpreting the research findings while implementing the step related to phenomenology of appearances (Refer to table 1.1). The foundation of Frankl's theory is existential psychology.

4.2 EXISTENTIAL PSYCHOLOGY

Existential psychology is based on existential philosophy, which maintains that an individual is autonomous and has freedom of choice. An individual defines herself through her choices and has a choice as to how to live her life. She possesses a responsibility and freedom of will to make something special of her life, irrespective of her circumstances. This philosophy is basically concerned with human longing and search for meaning within the self. An individual possesses the ability to detach himself from his physical form and can therefore rise above biological drives and instincts. What man becomes is his own responsibility. An individual is responsible for making choices and is accountable for the consequences of such choices. It is also a choice to challenge or confront conditions such as death and aloneness. An individual is constantly becoming and changing because of her choices. Courage is required to move ahead in spite of despair and is necessary in order to make being and becoming possible. Authenticity involves accepting the painful challenge and finding the courage or hardiness to persist in making choices that precipitate individuals into an unknown future. An individual must be in a purposeful relationship with physical things, herself, others and God. Existential psychology maintains that man needs to understand his own unique existence. He needs to know who he is and why he is on earth. He wants to serve his unique purpose in life. A neurotic person, therefore, is regarded as a person who evades

the question of the meaning of his existence (De Villiers 1997:277-278; Havenga Coetzer 2003:86-87).

4.3 FRANKL: MEANING OF LIFE

4.3.1 Frankl's view of man

Man is unique in essence and existence. Man is a somatic, psychic and spiritual (noological) being. The spiritual dimension of man is the integrating core of his being, as it is the existential core of his existence. The principle of becoming a mature adult is one's striving to find and fulfil one's meaning and purpose. Being human means living in the face of a meaning to fulfil and values to realise. A human being needs to find a purpose to live and is capable of embarking on fulfilling the meaning of life, of which she has been in search all along. The satisfaction of physical and psychological needs is not the ultimate aim of human striving, but the aim is rather to find the means to become free to strive towards spiritual goals (Frankl 1969:22, 41, 52, 54).

Man has freedom of will. He is free to feel guilty and to take a stand against any circumstances that may confront him (Frankl 1969:7, 16, 73). Man's freedom is counter-balanced by being responsible. Responsibility is the essence of being human and requires inner discipline (Havenga Coetzer 2003:34, 87). Each person is questioned by life, and she can only answer to life by answering for her own life; she can only respond by being responsible. An individual is responsible for her choices, how she lives her life and for her responses towards circumstances. She is therefore ultimately responsible for what she makes of herself (Frankl 1969:17; Havenga Coetzer 2003:86). Specifically, an individual is responsible to overcome guilt and to fulfil meaning; responsible for what to do, whom to love and how to suffer (Frankl 1969:7, 49, 73, 74). She cannot change her fate but has the power to change herself, her attitude and her responses to circumstances. Responsibility entails decision-making under the guidance of one's conscience (Frankl 1969:65).

4.3.2 Man's ability of self-transcendence

The essence of being is self-transcendence, and authentic living must be lived in terms of self-transcendence (Frankl 1969:50, 52). Self-transcendence means to be able to reach out beyond

oneself to encounter a higher being or other human beings and to fulfil meaning (Frankl 1969:18, 19, 31). It also denotes to be able to rise above adverse conditions and circumstances, namely suffering. It is the ability to think about and take a stand against suffering and do something about it (Frankl 1969:16, 74, 75). Self-transcendence further entails the ability to rise above one's instincts and drives, and grow beyond oneself. Man is called upon to change himself when faced with a situation that cannot be changed. This requires self-detachment, namely to be able to joke about himself, ridicule his own fears and choose his attitude in the face of adversity (Frankl 1969:88-89). Self-transcendence manifests itself in two of the most human phenomena, namely love and conscience (Frankl 1969:18).

- *Love as a manifestation of self-transcendence*

Love denotes living the experience of another person in all her uniqueness. In love the beloved person is comprehended in her very essence. Love is an intentional act. To love someone involves reaching out beyond oneself to another person and forgetting about oneself (Havenga Coetzer 2003:61).

- *Conscience as a manifestation of self-transcendence*

Conscience is the intuitive and creative capacity to find meaning in hidden situations and to distinguish between right and wrong. It awards man the power to discover meanings that contradict shared values. Through conscience one is able to judge one's deeds in moral and ethical terms. By exercising the unique responsibilities that life has entrusted to him, man feels a sense of moral integrity. Conscience is the source of personal integrity. Pure morality is to act for the sake of God, a person or a task, and not merely for the sake of a clean conscience (Frankl 1969:18, 63; Havenga Coetzer 2003:24).

4.3.3 Meaning of life

Meaning comprises the unique demands that are made upon a human by particular situations. It is neither given to her nor created by her; she must discover it. Meaning is unique to individuals and situations. The meaning of life entails an experience of fulfilment despite failure (Frankl 1969:54,

67, 69). The meaning of life differs from individual to individual, from day to day and from hour to hour. What matters, therefore, is not the meaning of life in general but rather the specific meaning of a person's life at a given moment. Everyone has her own specific vocation or mission in life to carry out a concrete assignment, which demands fulfilment (Frankl 1969:8, 11).

In his search for the meaning of life, man needs to discover the assignment that life presents to him. Man is free to answer the questions that he is asked by life. He is responsible for finding the meaning in situations and for giving the right answers to questions. He has to search conscientiously for meaning. He is guided by his conscience but is sometimes misled by it. Man often makes independent and authentic decisions in his quest for finding the meaning of life (Frankl 1969:61-65).

Shared values alleviate man's search for meaning because in typical situations he is spared decision-making. Man is, however, free to accept or reject shared values. He has the power to discover unique meanings that contradict such values (Frankl 1969:56, 57, 63).

Meaning is found through creating a work or doing a deed, through encountering someone (love) and through experiences of goodness, truth or the aesthetic. This entails a person's giving to the world, taking from the world and taking a stand to handle circumstances that prevent her from discovering meaning. Meaning can be found, even in hopeless situations, by the attitude the human being chooses. If one cannot find meaning through doing, loving or experiencing, she is free to rise above her predicament and grow beyond herself through her attitude. She can choose to suffer with dignity and to turn unavoidable suffering into human achievement, exercising virtues such as compassion, bravery, or a good sense of humour (Frankl 1969:69-75). Meaning can be found in suffering. The meaning of unavoidable suffering is the deepest possible meaning to be discovered. To choose one's attitude towards suffering is to exert human freedom (Havenga Coetzer 2003:95). Hence a meaningful attitude towards pain, guilt and death supports a meaningful life (Frankl 1969:73).

Happiness, pleasure, health and conscience cannot be pursued, but must be ensued. Happiness is the side effect of goal attainment and not the goal of human striving (Frankl 1969:34). Pursuance of pleasure, power and shallow encounters means that the person is striving to achieve what cannot be

attained, and this leads to existential frustration experienced in an existential vacuum (Frankl 1969:64).

4.3.4 Failure to find the meaning of life: The existential vacuum and existential frustration

Some amount of tension, such as tension aroused by a meaning to fulfil, is indispensable for mental well-being (Frankl 1969:531). What the human being needs is not a tensionless state but rather the striving and struggling for a worthwhile goal, a freely chosen task. It is counterproductive to try to eliminate tension from an individual's life because absence of tension leads to an existential vacuum.

The existential vacuum is a manifestation of failure to find new meaning and thus of failing to live a meaningful existence (Frankl 1969:31, 64). It is a frustration of the will to meaning. Existential frustration is characterised by experiences of boredom, apathy, aimlessness and emptiness. The aetiology of the existential vacuum is conformism (doing what others do) and totalitarianism (doing what others say should be done) (Frankl 1969:83).

The manifestations of existential frustrations are overcompensation in terms of pleasure, money and power. These are defence mechanisms which serve as substitutes for the will to meaning (Frankl 1969:83, 85, 87, 91, 96).

An individual who finds himself in an existential vacuum needs time for meditation. Centripetal leisure, namely having the courage to be lonely and making time for contemplation, would provide an opportunity for an individual to face and solve his problems. Centrifugal leisure, on the other hand, is counter-productive because it involves flight from oneself to avoid confrontation with the void in oneself. This, together with professional over-activity, allows an individual no time to finish his thoughts (Frankl 1969:97-98).

4.3.5 Logotherapy

Logotherapy is therapy during which the interaction between the therapist and the client centres on the topic of meaning. The problems that the clients experience are presented to the client as

inseparable parts of his everyday life. The client is then challenged to discover his meaning and to take responsibility in facing up to his problems. Logotherapy is aimed at helping the client to understand what his existence entails. The client is accompanied towards an understanding that life is meant to be problematic. It challenges man to overcome hardships, in order to grow and shape his life. Clients are taught to overcome fear and live triumphantly in fulfilling their purpose. Logotherapy is an optimistic approach to life, since it teaches that any tragic and negative aspects can be transmuted into positive accomplishments by the stand which one takes to them. The client is therefore challenged to combat suffering which is quite senseless. The client is taught mastery over his emotions in order to control his responses to circumstances (Frankl 1969:73).

The therapist and the client are required to self-transcend and self-detach, to see the client's life from the perspective of meaning. This entails stepping out of oneself to view one's life objectively from a distance (Frankl 1969:8). Two techniques used in logotherapy are dereflection and paradoxical intention. Dereflection involves directing the client away from her problems and encouraging her to reach towards someone or something other than herself. Through paradoxical intention the client is helped to distance herself from her problem and to address her fear, as opposed to fighting or avoiding a threat. It entails wishing for the very thing one is afraid of.

4. DISCUSSION OF RESEARCH RESULTS (Within the context of Frankl's views)

4

Registered nurses could view working in a high-risk environment for contracting HIV/AIDS in negative terms. On the other hand, it is possible for them to rise above their circumstances and change their attitudes in order to focus on the opportunities for discovering the meaning of life. Meaning of life can be achieved through rendering high quality care (work), rendering care in a caring manner (encounter or love) and experiencing the art of nursing (experiencing something aesthetic). The following discussions represent an interpretation of the research findings within the theoretical framework of meaning of life as conceptualised by Frankl. Two main themes emerged from the data and are discussed below.

Theme 1: Factors that contribute towards existential frustration in informants

Informants appear to find themselves in an existential vacuum and to experience existential frustration. The context in which they work is such that informants are exposed to unintentional and intentional risk factors for contracting HIV-infection. Unintentional risks are those that are associated with accidental exposure to HIV-infected blood or body fluids. Intentional risks are those posed by patients trying to infect informants on purpose. This is complicated by the ethical requirements of confidentiality, which further expose informants to HIV-infection. Although informants are at risk of contracting HIV-infection, institutional support is lacking. This is due to inadequate precautionary measures resulting from faulty gloves and economic restrictions. Furthermore, having to cope with a high workload increases the risk of HIV-infection.

Informants experience emotions such as fear, worry, uncertainty and depression. These emotions hamper their efforts in maintaining a therapeutic relationship with patients. Informants tend to label some patients as uncaring towards others and unconcerned with the rights of others, and therefore not worthy of care. The impaired therapeutic relationship is characterised by impaired communication, an uncaring and judgmental attitude, distance between caregiver and patient, and outright neglect. Other unethical occurrences include breaches of confidentiality about patients' HIV-status and involuntary blood testing. Instances of rationalisation of unethical behaviour emerged.

The above are indications of a lack of conscience and an inability to self-transcend, namely to rise above one's own circumstances and to reach out to those in need of care. This contributes to an inability, in informants, to discover the meaning of life in the workplace. It furthermore contributes towards the negative emotions experienced by informants.

Theme 2: Factors enhancing the discovery of the meaning of life in a high-risk HIV/AIDS environment

Many factors that enhance the discovery of the meaning of life in a high-risk environment for contracting HIV/AIDS emerged from the study. These factors can be utilised in assisting informants in transcending the existential vacuum in which they find themselves. There were instances of informants verbalising the fact that they rely on God to help them to cope with the challenges that they are faced with. Reliance on God is an indication of self-transcendence in reaching out to a higher being.

Although some informants struggle with inner conflicts associated with having to care for HIV-infected and AIDS patients, others expressed a commitment to care for those in need of care. These individuals experience a sense of fulfilment due to being needed and being able to care for HIV-infected and AIDS patients. Furthermore, many informants expressed concern for patients and their significant others, and for the many constraints that hamper their efforts in rendering high quality care. Some also verbalised the pain associated with witnessing unethical behaviour on the part of registered nurses. A positive factor is the presence of strong peer support, which means that informants rely on one another for support. These are indications of self-transcendence through love and conscience.

Institutional support to informants is available in the form of advice and follow-up care after exposure to HIV-infected blood or body fluids. Institutional support for patients is available in the form of health education, counselling and referral to the appropriate services. These strengths can serve as a basis for the establishment of a therapeutic environment for patients and caregivers.

4.5 CONCLUSION

Frankl's view of man and the meaning of life have been discussed. The research findings were interpreted within the framework of this theory. This method led to the insight that, although there are ample indications of existential frustration, some nurses are able to discover the meaning of life in the workplace.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

In chapter one the research problem was discussed. Registered nurses are exposed to a high risk of contracting HIV from infected patients, but are ethically compelled to render high quality care. Being exposed to risk while enjoying little support and protection may give rise to negative experiences amongst registered nurses. This leads to an impaired ability to maintain therapeutic relationships with their patients. If the nature of nurses' exposure to HIV-infection and their experiences are unknown, it is virtually impossible to provide relevant and effective support to them. Qualitative, phenomenological research, applying a phenomenological research method, was carried out to address the problem statement, namely:

How do registered nurses' experiences of working in a high-risk environment for contracting HIV/AIDS influence the therapeutic relationship with patients under their care?

The researcher sought to answer the following research questions:

- *What are the registered nurses' experiences of the risk of contracting HIV/ AIDS in the workplace?*
- *How do registered nurses perceive the therapeutic relationship in caring for HIV-infected and AIDS patients?*

The aim of this study was to explore and contextualise the experiences of registered nurses working in a high-risk environment for contracting HIV-infection, and to determine the effect of such experiences on the therapeutic environment. It was envisioned that the study would contribute to understanding the life-world of registered nurses who care for HIV-infected patients. The purpose was to contribute towards the establishment of a support system for registered nurses who care for HIV-infected patients. This will ultimately lead to improved patient care.

Eight semi-structured focus group interviews, involving a purposive sample of fifteen registered nurses, who were knowledgeable and experienced in rendering nursing care to HIV and AIDS patients, were conducted. Data saturation occurred after eight interviews. The data were subjected to qualitative analysis.

The research findings were discussed in chapter 2. The intentional and unintentional risk factors to which informants are exposed and their resultant emotions were discussed. The effects of these factors on the therapeutic relationship and on the ability of informants to engage in ethical practice were outlined. Chapter 3 comprised a literature review on HIV and AIDS, and the concepts *therapeutic relationship* and *experience*. This provided a conceptual framework for engaging in data reduction.

In chapter 4 the research findings were interpreted within the framework of Frankl's view of man and the meaning of life. This theory provided the researcher with a theoretical framework which assisted the researcher with data synthesis. The main themes that emerged from the study were derived from the theory.

5.2 SUMMARY OF RESEARCH FINDINGS

Informants are being exposed to intentional and unintentional factors that increase the risk of HIV-infection. The ethical obligation of keeping a patient's HIV-status confidential, and an increased workload brought about by the health care needs of AIDS sufferer, contribute towards the risk of contracting HIV-infection. These factors are in play in a context characterised by insufficient institutional support to prevent HIV-infection. As a result informants experience negative emotions such as fear, worry, uncertainty and depression. These experiences contribute towards unethical behaviour and an impaired therapeutic relationship. These findings are an indication that informants find themselves in an existential vacuum and experience existential frustration. However, evidence of being committed to render high quality care, and to rely on God and peers for support, also emerged from the study. Post-exposure institutional support appears to be available. These findings indicate an opportunity to discover the meaning of life in the workplace and ought to be utilised in

assisting informants in their search for meaning.

5.3 CONCLUSIONS

It is concluded that informants experience existential frustration due to their exposure to HIV-infection in a context that provides inadequate protection for them. They need to be assisted in transcending their circumstances, in order to find the meaning of their life through ethical practice in rendering care which is characterised by commitment and compassion. Existing post-exposure institutional support, peer support and spiritual practices can serve as a point of departure for the development of such a support system. Informants who indicated their commitment and compassion can serve as positive role models.

5.4 RECOMMENDATIONS

Based on the findings of this study, the following recommendations are made in order to enable nurses to find meaning in their professional lives and to overcome factors that contribute towards an existential vacuum in their lives.

5.4.1 Recommendations for creating a safe working environment for nurses

In order to minimise the intentional and unintentional risk factors, the researcher recommends that the employer should:

- hold regular meetings with employee representatives in order to give employees an opportunity to verbalise the risks that they are exposed to, and to propose solutions
- review and strengthen universal precautionary measures, and specifically ensure that nurses have access to high quality gloves
- provide regular in-service training concerning HIV-infection precautionary measures
- launch a health education campaign, educating patients about the dangers of trying to infect nurses intentionally.

In order to establish a working environment in which those infected with and affected by HIV/AIDS are free from stigma and prejudice, it is recommended that the employer should

consider:

- providing awareness workshops about the nature and effects of prejudice and stigmatisation
- providing counselling services to nurses who have been exposed to HIV, prejudice and stigmatisation.

5.4.2 Recommendations to assist registered nurses in finding the meaning of life in their quest for rendering high quality care in a challenging environment

It is recommended that the employer establish:

- regular workshops with the theme, *rendering high quality care in a challenging environment*.
- regular workshops on maintaining a therapeutic relationship in a challenging environment.

It is recommended that the employer utilise:

- compassionate and committed nurses to act as role models and mentors for those who struggle to come to grips with the risks involved in rendering care
- existing practices, supportive of quality patient care, as examples to those nurses who tend to neglect their duties with regard to patient care and referrals.

5.4.3 Recommendations to assist registered nurses who experience an existential vacuum due to the challenges faced while rendering care in a high-risk area for contracting HIV-infection

It is recommended that the employer establish:

- logotherapy sessions and motivate nurses to attend such sessions.
- pastoral counselling and care services and motivate nurses to utilise such services.
- an institutionalised peer support programme.

5.4.4 Recommendations with regard to nursing education

It is recommended that the following content, applied to HIV and AIDS, should be included or strengthened in the curriculum, and in in-service training programmes:

- Frankl's meaning of life theory.
- ethical obligations of nurses, applied to maintaining the lives of those suffering from HIV and AIDS.
- ethical decision making, to resolve ethical dilemmas involved in caring for HIV and AIDS patients.
- interpersonal skills, including communication and conflict management.

5.4.5 Recommendations with regard to further research

It is recommended that follow-up research be carried out to determine:

- why patients suffering from HIV and AIDS try to expose nurses to HIV-infection.
- the coping mechanisms of those nurses who succeed in rendering compassionate and committed care in a high-risk environment for contracting HIV-infection.

5.5 LIMITATIONS OF THE STUDY

This study is limited in scope because only a small sample of registered nurses working in one hospital was involved. The findings of the research are therefore not generalisable. However, in a qualitative research generalisability is not intended (Streubert & Carpenter 1999:22). The researcher anticipated that some registered nurses might be too busy in the units to make themselves available for an interview session. She minimised this risk by conducting interviews during the days on which the registered nurses were not busy and the clinical units were adequately staffed. However, some informants still could not make themselves available for an interview, as they were very busy caring for patients. Some failed to turn up for the interviews. The researcher overcame these constraints by conducting repeated interviews until data saturation occurred.

5.6 CONTRIBUTIONS OF THE STUDY

This study contributed towards greater insight into the perceived risks that nurses are exposed to, and their experiences of working in a high-risk environment for contracting HIV-infection. Insight was also gained with regard to how the perceived risks and nurses' experiences influence the therapeutic relationship with their patients. The researcher communicated the research findings and

recommendations to the health care institution's management. She stressed that the research could assist managers of health services in developing support services to enable nurses to cope with the problems that they encounter in the care of HIV/AIDS patients.

5.7 SUMMARY

This phenomenological study indicates that registered nurses are rendering care in abnormal times, owing to the devastation caused by HIV/AIDS. It was conducted to investigate the experiences of registered nurses, regarding working in a high-risk environment for contracting HIV/AIDS. Semi-structured focus group interviews were conducted in order to enable a small sample of registered nurses to verbalise their experiences. The study focused on the lived experiences of the registered nurses caring for HIV/AIDS patients. Data obtained was subjected to qualitative data-analysis. The findings can be used to assist nurses in dealing with their negative experiences and to discover the meaning of life in the workplace, according to Frankl's theory of human meaning.

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ANNEXURE A

APPROVAL FROM THE UNIVERSITY

Dr L de Villiers
Unisa
PO Box 392
Unisa
0003
20 January 2003

Ms ND Ndou
PO Box 40
TSHAKHUMA. 0951

Dear Ms Ndou

APPROVAL OF THE RESEARCH PROPOSAL

This is to certify that your research entitled , *Registered nurses' experience of working in a high risk environment for contracting HIV/AIDS*, in which you indicated your intention to investigate *how registered nurses experience the risks of contracting HIV/AIDS in the workplace, and the therapeutic relationship in caring for HIV infected and AIDS patients*, has been approved by the Research and Ethics Committee of the Department of Advanced Nursing Sciences.

The research problem is researchable and feasible. It complies with ethical principles which are applicable to the protection of the rights of the respondents and the institution in which the research will be conducted.

DR L DE VILLIERS
DEPARTMENT OF ADVANCED NURSING SCIENCES

ANNEXURE B

LETTER SEEKING CONSENT FROM THE HOSPITAL

P. BOX. 40
TSHAKHUMA
0951

I (NDOU ND) would like to be granted permission to collect data on the research topic, Registered nurses experiences of working in a high risk environment for contracting HIV/AIDS.

Data will be collected from registered nurses who are caring for HIV/AIDS patients. The study and its procedures have been approved by the provincial research committee, ethics committee at the University of South Africa. The study will provide information that will improve the quality of nursing standard.

Researcher's signature.....

Date: 20-02-2003

Contact number: (072) 0100571

ANNEXURE C

INFORMED CONSENT

Study title: Registered nurses experiences of working in a high-risk environment for contracting HIV\AIDS.

Investigator: Nthomeni Dorah Ndou, (Nurse educator)

Mrs. Ndou is a nurse educator studying the registered nurses experiences of working in a high-risk environment for contracting HIV\AIDS. The study will benefit nurses in the sense that the risks that they are exposed to, their experiences and the consequences of the experiences for patient care, will be revealed. Ultimately the results will contribute towards improves patient care.

The study and its procedures have been approved by the provincial research committee, the ethics committee of the Department of health Studies at Unisa and the hospital where you work. The study procedures involve no foreseeable risk. Data will be collected by means of focus group interviews. Interviews will be recorded to enable the researcher to capture your views. The duration of the interview in which you will participate will be approximately one hour. You are free to ask any questions about the study and you may call Mrs Ndou at 0720100571 if you have further questions.

Your participation in the study is voluntary; you are under no obligation to participate. You have the right to withdraw at any time and your relationship with the researcher will not be affected if you wish to do so. Your identity will not be revealed while confidentiality will be maintained at all times..

Researcher's signature:

Date:

Informant's signature:

Date:

ANNEXURE D**INTERVIEW GUIDE****RESEARCH QUESTIONS**

1. Tell me about your experiences of working in a high risk environment for contracting HIV/AIDS.
2. Tell me how your experiences influence the therapeutic relationship with HIV/AIDS patients that you care for.

PROBING QUESTIONS

- Tell me more about the risks that you are exposed to.
- Tell me more about your feelings.
- Tell me more about the support available to HIV/AIDS patients.
- Tell me more about the support available to nurses who work in a high risk environment for contracting HIV/AIDS.
- If you had a chance to choose between nursing HIV-positive and AIDS patients and those not infected, what would you prefer and why?
- In spite of all the problems experienced, what is your way forward pertaining to HIV/AIDS patient care?

ANNEXURE E

NODE REPORT

Q.S.R. NUD.IST Power version, revision 4.0.

Licensee: Adv Nursing.

PROJECT: Ndou, User Ms Ndou, 12:16 pm, Nov 4, 2004.

(1 1) /Risk factors/Exposure to risk

*** No Definition

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+++ ON-LINE DOCUMENT: DEPTHINTERVIEW

+++ Retrieval for this document: 9 units out of 89, = 10%

++ Text units 1-1:

Info. 1. : Experiences of working in a high risk environment for contracting HIV is good and bad. I am saying is bad because I am at risk of contracting HIV in a work place because you can find that sometimes you can even prick yourself with a needle. I can give an example of patients who are terminally ill and confused. Those patients may take a needle and prick you or you can accidentally prick yourself and get infected when injecting a restless patient. I am at risk of contacting HIV because AIDS patients may sometimes be having continuous diarrhoea. Sometimes you can find that we are using gloves that are torn or they might be having holes through which the watery stools can pass through.

1

++ Text units 3-3:

I am also at risk of contracting mycobacterium tuberculosis because we sometimes admit full-blown AIDS patients who are also suffering from undiagnosed pulmonary tuberculosis. These patients may be coughing, and I can contract tuberculosis or even HIV from the contaminated sputum. I may contract HIV through using gloves or masks that are not intact. I sometimes come across the whole box of gloves with holes except for only two to three. In that case I am then forced to put on almost two to three gloves at a time.

3

++ Text units 9-9:

Info.1. : I do not think wearing of protective clothing is wasting our time of giving care to patients.

We put on gloves and aprons except for eye protective glasses. When the ward is too busy, we put on aprons for the whole day. 9

++ Text units 30-30:

Info. 2. : I am at risk of contracting HIV/AIDS. My main problem is that if she is diagnosed with AIDS, people will think I contracted it from somewhere else because of the stigma attached to it.

30

++ Text units 33-33:

I remember one day when I was suctioning the patient, the secretions got into my eye, as they were not protected with glasses. I felt as if my eyes were itching and I quickly went to the eye department. I think they were itching because to fear. I was given a medicine for the itching eyes.

33

++ Text units 84-84:

Some of these patients are confused and often take off the intravenous infusions. I put on two gloves when attending to full-blown AIDS patients who have got sores all over the body. Some of them look very terrible. Some patients are confused and restless and they may disturb me when I give injection. 84

++ Text units 86-86:

Many patients admitted to the ward need bathing, feeding and frequent changing of bed linen because of continuous diarrhoea and vomiting. 86

++ Text units 88-89:

Most of the AIDS patients admitted are also suffering from TB and nurses contacts. 88

The TB bacilli are spread through the air any time the TB patient sneezes, coughs, talks or sings. The TB bacilli may remain in the air for several hours and we may breathe them in as we cannot put on the mask for the whole day. 89

+++++

+++ ON-LINE DOCUMENT: interviewsB

+++ Retrieval for this document: 28 units out of 145, = 19%

++ Text units 10-11:

Info. 1. : In the work place there is a risk of contracting HIV. It has been my experience one day that I delivered a baby. Then I wanted to give the konakion to the baby. When I was breaking that bottle with gloves on, it broke and cut my finger with blood on. Since that day I have been traumatize by that. I am even afraid to go and take that HIV test because I am afraid I might be

having AIDS. I was cut and my gloves were having blood on.

10

I think working there is very risky much as we have gloves because they cannot protect us enough sometimes.

11

++ Text units 13-13:

Info. 2. : The very same thing happened at labour ward. You will find that the gloves that we put on are not that much strong. We then put on two gloves at a time, but you find that after delivering a woman the top pair of gloves is torn up. What if you didn't put on two pair of gloves.

13

++ Text units 15-15:

Info. 3. : Another issue is when you are suturing an episiotomy of a primigravida who is uncooperative. When you are busy suturing, trying to calm her down, you find that she will be busy doing all sorts of things that put you in a vulnerable state of pricking yourself.

15

++ Text units 17-17:

When trying to suture that woman you may prick yourself.

17

++ Text units 20-20:

Info. 4. : My experience happened in male medical when there was a guy who was not accepting that he was HIV positive. He wanted to infect many people. When you insert a jelcon, putting an intravenous infusion, he would remove it so that blood should spread on you. If you have a cut and you HAVE one pair of gloves on that torn, you may contract HIV.

20

++ Text units 22-22:

Info.5. : Another experience happened when I was taking blood for HIV test. After taking blood I had forgotten to exert slight pressure on the injected area, then blood quickly spread all over my face. I then realized there is a possibility for me to contract HIV.

22

++ Text units 28-29:

Info. 5. : Through feeding a helpless patient one may contract HIV. Sometimes the patient may vomit when you're feeding him and the vomitus may split into the mouth as you're talking. One cannot put on the mask when feeding the patient. You cannot feed the patient without talking to her. I think one may contract HIV through talking while feeding the AIDS patient.

28

Sometimes when you are changing the linen of a patient who have messed himself up you may contract HIV. Most of the patients who do not accept that they are HIV positive, do not cooperate. When you change their messed up linen they may smear you with the faeces. They will make sure that at the end of the day you end up touching those faeces with the idea that you get infected.

29

++ Text units 31-31:

Info. 1. : I believe that the risk of contacting HIV differs with the type of fluid. I believe that with vomitus the risk of transmission of HIV is too little unlike with blood. If ever the patient is vomiting, I think it is not that much bad unlike with the patient who is bleeding or who is having diarrhoea because in that type of a situation you are much more in contact with the body fluids. 31

++ Text units 33-33:

Info. 4. : I think of a certain man who wanted to infect me HIV. When I was busy changing his messed up linen, and spread his faeces on my blouse. I ended up taking my blouse to the laundry so that it should be washed. The occupational nurse advised me to go for HIV test but I didn't. I think on that day I was at risk of contracting HIV. 33

++ Text units 35-35:

Info. 2. : There was also another guy in male medical again, who was on denial that she is having this disease. He was having diarrhoea. He would scoop his faeces and smear that on you trying to infect you. Sometimes this diarrhoea may contain blood. At the end of the day you feel it is not ok as you may contract HIV. 5

++ Text units 49-49:

Info.4. : The fact that this people smear faeces all over, increases the risk of infection and makes you not to want get next to that patient because he will be trying his means to infect you.

49

++ Text units 56-56:

but you may find that they have told themselves that they cannot die alone. I will die with many.

56

++ Text units 58-58:

Some of the patients go to an extent of infecting their relatives. You can imagine when they try to infect their parents. You can really understand that kind of situation. 58

++ Text units 96-96:

Info. 3. : In my ward I experienced some problem with professional nurses with whom I was working. A woman was diagnosed HIV positive during postpartum period. The woman became psychotic and she was admitted in psychiatric ward. She would cut herself and smear blood all over the walls. 96

++ Text units 113-113:

Info. 2 : Yes, possibilities are there. I have an experience. I was once pricked by a test tube containing blood. It fell without my notice. When I picked it up, it pricked me. When I looked at my fingers I could see a small prick. Registered nurses did not know the HIV status of the patient. Blood was for something else rather than HIV test. The blood was also tested for HIV because of the incident. I was given an anti-D drug within 72 hours. Blood was taken for ELISA test every month for three consecutive months. It tested HIV negative. 113

++ Text units 116-124:

Info. 3 : Needle pricks are common and sometimes you can't see that a needle is about to prick you, it happens accidentally. 116

117

Info. 2: especially when we suturing episiotomies. 118

119

Info. 1 : And the possibilities of torn gloves. 120

121

Res.: Nnh 122

123

Info. 3 : Sometimes the very incident that you have just shown, of a woman who has entered second stage without the notice of who ever nurse. You can't leave the baby coming out alone, you find yourself having jumped into the situation. 124

++ Text units 131-132:

131

Info. 2. : What she is saying is true, imagine a patient who went about spiting saliva all over or smear blood on the walls and chairs, with the mind of spreading the virus. If she was capable of pricking us, squeezing her blood to our open wounds, she would do that with success. To some extent it affects the caring of patients. 132

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+++ Total number of text units retrieved = 37

+++ Retrievals in 2 out of 2 documents, = 100%.

+++ The documents with retrievals have a total of 234 text units,

so text units retrieved in these documents = 16%.

+++ All documents have a total of 234 text units,

so text units found in these documents = 16%.

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