

CHAPTER 4

Research findings

4.1 INTRODUCTION

This chapter discusses the findings from the data analysis. The presentation and discussion of results are a crucial part of any research project. It is essential that the presentation be systematic, logical, concise and drawn from all the analysed data. Furthermore, results should be discussed in detail to reflect clearly on the problem being investigated (Woods & Catanzaro 1988:44). In this study, the data were derived from a limited sample (12 VCT nurses), not to produce statistically significant or generalisable findings. Rather the aim was to highlight certain aspects of the phenomenon under study and to develop an understanding thereof. The researcher was concerned with exploring VCT nurses' perceptions of educating HIV-positive people about ARV drugs.

4.2 SAMPLE DESCRIPTION

A sample is “a subset of the population that participates in a study” (Depoy & Gitlin 1994:304). Although the researcher initially planned to use two VCT centres in Swaziland, only one centre was used due to financial and logistical reasons.

This centre was selected purposely because of convenience. It was convenient because it is attached to the Raleigh Fitkin Memorial Hospital where the researcher works. The sample used for the study consisted of qualified nurses who had received VCT education and work in the Raleigh Fitkin Memorial VCT Centre. The sample consisted of twelve respondents, ten female and two male nurses, aged between 20 and 40. Of the respondents, two were nursing assistants and ten were diploma qualified nurses (while one of them had a degree in nursing). All the respondents had worked in the VCT centre for less than a year since this service was still new at the hospital.

Although all the nurses working at the VCT centre met the criteria for inclusion in the study, the respondents' selection was subject to availability.

4.3 FIELD WORK EXPERIENCE

Due to financial and logistical reasons, the researcher spent a month in fieldwork. Initial contact was made with the Sister-in-Charge of the VCT Centre. The sister in charge permitted the study to move ahead with all the nurses to be involved being fully informed.

Initially, the respondents were sceptical about the researcher's motives and questioned how the findings would be used by the researcher. They were reluctant and uncomfortable to share anything. Some even avoided the researcher. The first week was mostly spent on observation, touring the institution, talking to the secretary, patients and some nurses who sometimes purposely avoided the researcher.

In the second week the participants were slightly relaxed and communicated with the researcher more openly. There was less questioning of the researcher's motives and most were willing to be interviewed. Intensive interviewing and continuous observations were done in the second, third and fourth week.

Due to the increase in HIV/AIDS patients, the VCT centre is very busy on Mondays, Tuesdays and Wednesdays therefore interviews were done mainly on Thursdays and Fridays, which were not so busy. Only a maximum of three interviews were done per day to allow the respondents to continue with their daily routine. On the other days the researcher did observations and assisted in other nursing duties besides counselling.

The researcher used Leininger (2001:82) to facilitate moving from mainly a distrusted stranger to a trusted friend in order to obtain authentic, credible and dependable data. Furthermore, it assisted the researcher to understand what happened the first time she came into contact with the participants in their working environment. According to Leininger (2001:82), it is common on first contact for participants to be sceptical, protective, and uncomfortable and tend to offer inaccurate information, but this will change with continuous interaction.

What happened in the field is also supported by Leininger's (2001:93) ethnonursing observation-participation-reflection model. The Observation-Participation-Reflection model has four phases. The first phase is for observation and active listening only. The second phase is for observation with limited participation. The third phase is for participation including data collection. The fourth phase is for reflection and reconfirmation. This is exactly what the researcher did, not because she had the model in mind but things happened naturally.

Conducting this study totally changed the researcher's mind-set about research. It gave the researcher an idea that sitting in office and interviewing is totally different from immersing yourself in the situation to get credible findings. Immersing oneself in a situation means getting firsthand information. In this case, the researcher not only "talked the talk" of the people but "walked the walk" and learned the respondents' roles and responsibilities in the centre. The researcher also learned the routine, that is, how the patients are received, given files and eventually see the counsellors.

4.4 THEMES IDENTIFIED

The data was collected using semi-structured in-depth interviews in English with the following open-ended question: What are your perceptions of educating HIV-positive people about ARVs?

Data was analysed using Tesch's eight-step model (in Creswell 1994:154) (see chapter 2). The data analysis identified five themes. These themes will be discussed and substantiated by the respondents' responses.

4.4.1 Need to educate HIV-positive people about ARVs

The respondents perceived that there is increased need to educate HIV-positive patients about ARVs. All the respondents regarded it as their duty to educate HIV-positive patients about ARVs and asserted that the patients had a right to information about this treatment. According to the respondents, this would ensure that patients chose whether to use the

drugs or not and if they chose to use the drugs, they were able to use them properly through being educated. The right to this information is confirmed by the American Patient Bill of Rights of 1972, which states that patients have a right to receive the right information concerning their treatment (Davis & Aroskar 1991:79). This information, according to the American Bill of Rights, must be relevant and current since “as they are HIV-positive, they deserve to know what is now available for them” (Davis & Aroskar 1991:79). One of the respondents stated,

We are living in times of patients' rights, we have to observe these rights and this include the right to information.

According to Walsh (2002:21), patient education has become “part of the total comprehensive patient care”. Rankin and Stallings (1996) (in Walsh 2002:21) view education as “an integral part of the nurse’s role”.

King (1971:22) maintains that patients have a right to obtain information, to participate in decisions that may influence their life and health, and to accept or reject care. According to King, it is the responsibility of health care members (nurses) to inform individuals of all aspects of health care to help them make informed decisions.

The primary health care strategy (WHO 2000:16) also stipulates education as one of the strategies to promote health and recommends that at least education concerning prevailing health problems and methods of dealing with them be offered. In this case, it means education about ARVs.

The VCT nurses’ perceptions of the need to educate HIV-positive people about ARVs concur with the Swaziland National VCT guidelines of 2004. According to the guidelines (WHO 2002:34), VCT nurses should educate HIV-positive people about ARVs because it is important to promote adherence. A randomised study which used educative intervention at 04, 24, and 48 weeks to improve long-term adherence to ARVs found that 94% of the group who were exposed to education achieved a drop of the viral load to below 400 copies/ml after 48 weeks (Cameron 2000:44). Cameron (1992:43) also stresses that in

order to promote adherence, health care professionals should ensure that the patient has adequate information.

The respondents indicated that educating patients was their ethical responsibility:

As nurses we have a code of professional conduct requiring us to educate our clients about the available treatment, actions and benefits.

According to Potter and Perry (2001:474), nurses are the primary source of information, therefore they have a responsibility to give information that clients and their families need in order for them to make informed choices.

The respondents perceived that the education should be given to the patients before they started taking the ARVs. According to the respondents, these patients need to know the basic information about HIV, how the drugs act, the benefits, how the medication should be taken and their side effects because

knowledge is power; without knowledge you are doomed.

As part of the VCT strategy, the respondents perceived it as their duty to educate HIV-positive people about these drugs since the patients see the nurses first before the doctor and the nurses are always available whereas the doctor is not always available:

It is our job as VCT nurses to educate patients about ARVs.

The WHO (2004a:66) emphasizes that people need to be educated about the drugs in order to use them appropriately to curb the infection.

The respondents maintained that since the drugs are new (new technology), patients needed to know about them so that they could use them properly since the infection continued to rise despite the ABCs of prevention.

The drugs have just arrived in Swaziland, patients do not know much about them. We got educated about them and we have to tell our clients about them.

In order to use ARVs, people must know about them and regard them as beneficial.

It is like in any kind of business, a new product is advertised. Here at the VCT centre we use education as a form of advertising ARVS to people who need them.

Patients need to know how to use them and comply. According to the WHO (2002:33), it is every health professional's responsibility to do everything in their ability to ensure the highest level of adherence to ARVs.

4.4.2 Need to educate HIV-positive pregnant women

The respondents maintained that educating HIV-positive women was indeed necessary for the same reasons as for any other HIV-positive person with added reasons. There is an increase in the rate of mother-to-child transmission of HIV/AIDS (MTCT). The Swaziland 7th Sentinel Surveillance (2002:14) revealed that 40% of children born are infected with the virus, resulting in 6 176 new infected annually. The respondents indicated that most women are ignorant of the vertical transmission of HIV/AIDS (MTCT) therefore they need the information on vertical transmission.

Most of the women I have attended are ignorant of MTCT of HIV/AIDS and ways of reducing it.

The pregnant women need to be informed about the way to reduce MTCT of HIV by the use of these drugs.

The participants stated further that these women needed to be informed that there are ARVs that could be used to reduce the incidence of MTCT of HIV/AIDS and infant and child mortality.

We are seeing a lot of babies born HIV-positive because of MTCT and we want to educate the women on how to reduce that.

[They need to be educated in order to] *give their babies a chance to be healthy and HIV free.*

We have to conserve our future generations through educating women to use the ARVS for PMTCT.

UNAIDS (2002:22) projects that by the year 2010, AIDS will increase child mortality by more than 100% in countries most affected by the virus.

The study found that most women had uncertainties about their own HIV infection and the possibility of their child being infected. The respondents were of the opinion that through education these women could be helped to clarify their uncertainties and also recommend ARVs to prevent mother-to-child transmission of HIV/AIDS. The respondents also perceived that educating pregnant HIV-positive women was necessary in view of the increase in the HIV infection rate in women. In their study on options for PMTCT Kuhn and Peterson (2000:21) found that sero-prevalence among women of childbearing age (15-49) is significantly higher in many developing countries, including Swaziland. In Swaziland, approximately 4 out of 10 (38,6%) women attending antenatal clinics are HIV infected (Swaziland 7th Sentinel Surveillance 2002:14). The respondents indicated that pregnant women taking ARVs for PMTCT could reduce the chances of passing HIV on to their babies by 50% therefore education was a must. According to UNAIDS (2003:14), the devastating impact of HIV/AIDS on children is avoidable.

The respondents indicated that, since HIV can be transmitted from mother to child during breastfeeding, pregnant women and mothers should be informed of such transmission and should be educated on other options of infant feeding.

Since breastfeeding can increase the rate of MTCT, we have to educate the mother on other methods to feed the baby.

According to the PMTCT Strategic Plan of 2003 in (WHO 2002:23), the risk of transmission is 30% as a result of nonexclusive breastfeeding.

Moreover, the respondents felt that further education on future family planning and reproductive choices was needed for pregnant women. Since the woman is HIV-positive, it is the nurse's role to educate her on family planning methods to prevent pregnancy. Sixty percent of HIV-positive mothers wanted to have babies, irrespective of their status (WHO 2002:33).

4.4.3 Need to educate HIV-positive children about ARVs

The respondents indicated that children also needed to be educated about ARVs in order for medication to be effective. According to Bristol Myers Squibb (2003:22), it is as important for children to adhere to their medication schedule as it is for adults.

The respondents stated that education should be based on the children's developmental level because children receive and process information differently.

4.4.4 Obstacles encountered when educating HIV-positive people about ARVs

Although the respondents perceived that they should educate HIV-positive people about ARVs, they also indicated the following obstacles to doing so.

4.4.4.1 Insufficient knowledge about ARVs among nurses

All the respondents indicated insufficient current knowledge about ARVs on their part as a major problem. They perceived that they had a low level of competency in educating HIV-positive people about the drugs.

I sometimes feel uncomfortable because sometimes I am not sure of the stuff I am giving the patients.

4.4.4.2 Lack of in-service training on ARVs

Despite their working experience in the VCT centre, all the respondents felt that they lacked adequate training to deal with ARVs. They indicated that they needed additional knowledge and ongoing training to put them in a better position to give this information to the people. They stated that they were not offered current information about the drugs, such as in the case of pharmacological PMTCT.

We educate about Nevirapine, yet we receive mixed messages concerning this drug.

We are not being updated about the drugs, and this makes me feel demotivated sometimes.

The respondents indicated that they felt powerless at times because as educators they should be knowledgeable and confident about the information they gave the people. Without knowledge, there was confusion and this led to distrust by the patients. The respondents emphasised that this also reduced confidence and a feeling of lack of competence in their work. Mellish and Brink (1990:23) state that in order for nurses to offer competent care they should keep abreast of new developments.

4.4.4.3 Patients' illiteracy

The respondents acknowledged that it was difficult to educate patients who were illiterate.

It is very difficult to pass the message across to an illiterate person.

Even we, as nurses, find it hard to pronounce some of the drug names, so how can a client understand a word like Zidovudine, for an example?

Cameron (1992:245) found that poor reading skills can affect understanding and interpretation of meaning and the person's organisation of thought and perception, and vocabulary development can cause confusion and misunderstanding so that instructions are misinterpreted. Although the literacy level in Swaziland is 78% (Human Development Report 2003:32), many people cannot read properly and write. This causes problems in education according to the participants.

4.4.4.4 Poverty

The respondents reported that poverty was another problem when educating HIV-positive people about ARVs. The respondents indicated that before clients were put on drugs, a thorough assessment was done to ascertain whether they would manage with the drugs, including their financial status. Most of the clients whom the respondents had educated lived below the poverty datum line. So, according to the respondents, it was difficult to educate patients about the requirements of ARV, such as a balanced diet, proper ongoing medical check-ups and prompt treatment of opportunistic infection.

How do you educate the people that need the three food groups when taking ARVs when they are poor?

How do you successfully educate on breast milk substitute when the woman is poor?

We may educate about the benefits of drugs but financial constraints are still a problem.

The issue of poverty was also identified by UNAIDS (2003:21), indicating that two thirds of the population live on less than a dollar a day in Swaziland.

4.4.4.5 Cultural, personal and religious beliefs

Some of the respondents also indicated behavioural change as another problem they encountered when educating HIV-positive people about ARVs, including the need to

change some cultural, religious and personal beliefs that affected patients' ARV treatment. The respondents pointed out that some people had strong personal or cultural beliefs about HIV/AIDS and ARVs, how it should be treated and who they could turn to for help, so it became difficult when educating such people to change their beliefs and attitudes.

Some people define AIDS differently and ways of treating it and they don't believe in the drugs and so won't use them appropriately.

Sometimes it is difficult to educate for behaviour change because most of the time it stems from the culture and it's difficult to change the culture of the people.

Andrews and Boyle (2003:44) state that some patients have personal and cultural beliefs that are strong and when treatment conflicts with these beliefs, the patient becomes fearful, anxious or alienated from the health worker.

The respondents indicated that most Swazis were still strongly attached to their culture and had beliefs about AIDS and ARVs, which caused problems in accepting ARVs. Andrews and Boyle (2003:34) found that an important deterrent to adherence is related to patients' cultural beliefs.

4.4.4.6 Difficult drug names

Some of the respondents indicated that the difficult generic name of drugs gave them problems when educating the clients because sometimes they had to call the medications by their names.

These names are very difficult.

4.4.4.7 Quality of life associated with side effects of ARVs

Another challenge faced by the respondents was the issue of quality of life on ARVs. The respondents stated that most clients were concerned about their quality of life on ARVs.

When educating these people they usually ask if they will get better, how they should handle side effects and how they are going to live generally looking at the long-term therapy with side effects.

The patients were mostly concerned about the side effects. This was a problem for the respondents since ARVs have unpleasant side effects and yet they had to educate the patients to take them. The respondents went on to say that informing the patients that ARVs are not a cure but aimed at reducing the viral load was a problem because it did not make the ARVs palatable to the patients.

4.4.4.8 ARV education a demanding responsibility

All the respondents regarded educating HIV-positive people about ARVs as a demanding responsibility. The problem of workload was the most frequently mentioned problem. According to them, given that ARVs are a new technology and the increase in HIV/AIDS infection, more patients needed education about ARVs. The respondents viewed the increased workload as a problem in that *“there are too many other duties of VCT nurse besides education”*. The respondents felt that time constraints prevented them from really concentrating on implementing high quality education. Moreover, ARV education was also demanding because the respondents needed to be knowledgeable and confident when educating people. They perceived that this needed continuous education to keep abreast of developments.

In his study of nurse educators' work-related stress, Woods (1983:22) found that overwork causes inadequacy and burnout.

4.4.4.9 Dealing with HIV-positive people perceived as traumatic

The respondents felt that dealing with HIV-positive people was traumatic in the sense that they were still at the stage of dying. A few are who were very sick were recovering due to the ARVs.

4.4.4.10 Negative attitudes towards health care professionals

The respondents indicated that negative attitudes towards health care professionals and health care compromised adherence. The respondents felt that most people did not adhere because they had an attitude of “it’s their thing, not ours”.

4.4.5 Factors perceived as influencing adherence to ARV treatment

The respondents indicated that treatment success depended on adherence. Studies show that the virological failure rate varies from 21,7% for patients who do not miss doses to 82,1% for those who miss 32 doses (WHO 2002:33). The respondents’ perception is also supported by the WHO’s (2000:22) statement that good adherence is essential for the efficacy of ARVs. The respondents indicated that they felt that most patients did not adhere due to different reasons.

Unterhalter (1979) (in Kline 2003:120) found that non-adherence was a serious problem among Black patients in South Africa with both short- and long-term conditions. This study found that the following factors influenced ARV adherence:

4.4.5.1 Patients’ lack of knowledge on ARVs

In order to ensure adherence, the respondents indicated that education should first aim at identifying the causes of non-adherence. They perceived the lack of education as the major cause of non-adherence to the drugs.

Patients cannot adhere without being informed to do so and the reasons for doing so.

The respondents indicated that most patients knew that there were drugs available for HIV/AIDS but did not know how to take them. According to the respondents, patients did not comply because of disbelief and misunderstanding about the medications' effectiveness and the importance of adherence. Patients may not believe that they needed the treatment and the reasons for lifelong treatment. This lack of knowledge led to non-adherence. The respondents perceived that extensive ongoing education that covered the benefits, actions and side effects of the drugs and the importance of adherence was needed to combat this ignorance so that patients adhered.

Kline (2003:44) found that not fully understanding the treatment regimen, how to take the drugs, the effects of the drugs, the side effects and reasons for the long duration of treatment can lead to inability or lack of motivation to use or complete the regimen.

4.4.5.2 Side effects experienced by patients

The respondents indicated that persistent side effects, such as rash, nausea, vomiting and diarrhoea, also caused non-adherence.

They should be made aware of side effects of the different kinds of drugs.

The mere mention of side effects kills the spirit of taking these drugs in some people.

We have to stress more on the benefits of the medication so that they are motivated.

According to Dybul and Fauci (2002:22), the occurrence of side effects plays a big role in adhering to a drug regime. A study by the University of California's San Francisco's Center for AIDS Prevention Studies found that concern about the short-term and long-term side effects was a primary factor deterring people with HIV from adhering. According to the respondents, patients should be well informed about what side effects to expect and reassured that any drug has side effects. They should also be educated to come to the

clinic in cases of severe side effects to evaluate other medication options. The respondents viewed reassurance as a method of allaying anxiety and ensuring adherence. One respondent stated that education should not overemphasise the side effects because patients would avoid taking them at all out of fear of the side effects.

4.4.5.3 Perceived complex regimen

The respondents indicated that some patients failed to adhere because of the complex regimen of the drugs. According to the respondents, this included dietary restrictions, increased frequency of doses and increased number of medications.

Getting the patient to take large amounts of tablets with specified meals every day at specified times for the rest of his/her life is the biggest challenge and is not a joke.

I still fail to complete a prescription of a week, how much more difficult it is if it is lifelong.

4.4.5.4 Lack of support from social support networks

Lack of support from family and friends was also perceived to cause non-adherence. The respondents indicated that this came about because of confidentiality and secrecy in most cases. Most patients were too secretive about their diagnosis and failed even to inform their closest relatives therefore no one supported them.

HIV/AIDS is still stigmatised and thus patients fail to divulge their status to family and friends and thus no support.

Since this is a lifelong therapy, patients need support, spiritually and financially.

The nurses perceived that education had to include ongoing counselling and support. The WHO (2003:43) states that family and significant others who stigmatise illnesses and disapprove of treatment will reduce the patient's willingness to adhere. Lack of motivation was also perceived as one caused of non-adherence.

4.4.5.5 Lack of motivation on the part of the patient

The respondents indicated that most clients were not motivated to take the tablets because ARVs were not a cure, of severe side effects, no improvement after some time on medication and also sudden improvement on the medication. Furthermore, some clients did not adhere because of lack of motivation related to mixed messages from other health care members and the general public. According to the respondents, some nurses still did not believe in the efficacy of ARVs and advised people against them. The general public also had mixed views on the treatment of HIV/AIDS.

Some patients receive mixed messages from health personnel.

Some are against these drugs and thus patients are confused and lose motivation.

We nurses need to have one voice to avoid confusing patients.

Some of the drugs are not palatable to take and this requires motivation.

The WHO (2002:45) states that some patients fail to adhere because of lack of motivation due to many competing priorities like poverty.

4.4.5.6 Accessibility of ARVs to clients

A few of the respondents indicated that some patients failed to adhere because of poor access to the drugs. This is still a problem in Swaziland.

Because the service is still new, office space is limited yet we have a large number of patients, and we cannot attend them very fast.

We are short-staffed and thus patients have to wait for long periods before being attended.

According to the WHO (2000:12), health care should be made available to the people.

4.4.5.7 Patients' depression associated with diagnosis of HIV/AIDS

The respondents indicated that depression was another cause of non-adherence. Depression was perceived to stem from the fact that HIV/AIDS was incurable for now and was still stigmatised.

People are not always killed by the infection but by the depression brought by the stigma and this depression can cause the patient to refuse the drugs.

4.4.6 Need for capacity building for VCT nurses

The respondents perceived a need for continuous education for all nurses about ARVs. According to the respondents, all nurses need information and ongoing in-service education because as nurses "*we have to speak with one voice*".

With regard to the AIDS epidemic in Sub-Saharan Africa, Akinsola (2000:18-22) stresses that "the knowledge that we need is greater than what we have". This includes knowledge of ARVs. The Code of Professional Nursing Conduct for Swaziland upholds continuous education for nurses to "maintain and improve professional knowledge and competence through continuous education".

According to Potter and Perry (2001:385), the nurse "acquires and maintains current knowledge and competency in nursing practice. She/He participates in ongoing educational activities related to clinical knowledge and professional issues. There is a

need to keep abreast with the changing world.” Mavuso (1993:6) points out that ongoing education is essential for nurses because nursing is experiencing a knowledge explosion, technological changes, expanding roles of nurses and ever-changing health care delivery systems.

It is clear from the respondents’ responses that nurses need to take every available opportunity to maintain and improve their professional knowledge and competency. The need for continuous education was also recognised by the Alma Ata Declaration of 1978, which stipulated that governments should undertake or support ongoing education for health workers to be competent and motivated to serve the people and due attention should be paid to their continuing education.

One of the respondents stated that if nurses did not engage in continuous education, they were at risk of becoming “*strangers in their own field*”. She went on to say that by this she meant that they needed current knowledge about ARVs in order to be comfortable working as VCT nurses with the accurate and latest information about ARVs and confident in their practice.

Woods (1983:42) contends that in order for nurses to function or practice adequately in their job, they require the latest knowledge, skill and attitudes. Tobin (cited in Mellish & Brink 1990:13) ongoing education is a must to keep updated”. Stryker (cited in Mellish & Brink1990:44) points out that “the body of knowledge of the world doubles every six to seven years and this fact makes continuing education a must”.

Sebanyoni (2003:10), an AIDS activist in South Africa, asserts that it is important that nurses and other health professionals keep abreast of the HIV/AIDS situation and treatment. She goes on to say that health professionals need more knowledge in order to promote a continuum of care.

4.4.7 Challenges for continuous education

Although the respondents stressed the need for continuous education, they also foresaw challenges based on what they perceived would cause problems. The respondents felt that

the current shortage of nurses hindered nurses from engaging in continuous education. According to the respondents, the shortage was due to nurses leaving for overseas because in Swaziland there were poor working conditions, no incentives and low pay.

In Swaziland salaries are low, with no incentives and poor working conditions and thus nurses are leaving and there is a shortage and no time for any form of continuous education.

The shortage of nurses is recognised internationally and the Ministry of Health and Social Welfare of the Government of Swaziland (2004:6) acknowledges that the human resources shortage is a crisis in Swaziland. The shortage of nurses was also recognised by the WHO situational analysis of the health workforce in Swaziland done in April 2004. In the researcher's view, this is an indication that Swaziland is not following the Alma Ata Declaration (1978) and the WHO (2004a) recommendations. The Alma Ata Declaration (1978:6-12) recommends that governments provide incentives to health personnel. These incentives may take such forms as living and working conditions. According to the WHO (2004a:23), it is widely recognised that a health workforce crisis now exists throughout the developing world which is characterised by the shortage and mal-distribution of trained health workers. This crisis existed well before HIV/AIDS.

The respondents cited the negative attitudes of some nurses towards ongoing education as another major problem hindering continuous education. The respondents pointed out that some nurses did not value continued education and were therefore opposed to it, claiming that they had no time for it. The respondents gave the following example of such comments: *"I used to hate in-service education, I expect the same from other nurses"*.

According to Rowland and Rowland (1992:17), a lack of continued education is a problem since the "health industry is dynamic with changes in technology, legislation, research, economics and public demands, all of which affect what nursing personnel need to know to give effective and comprehensive nursing care".

Demotivation was also perceived as another problem hindering continued education. One respondent said,

We do love our job but we are demotivated and demoralised. What do we get afterwards - no incentive, poor pay - then why bother?

A situational analysis of the health workforce in Swaziland in April 2004 (WHO 2004b:54) found that nurses are no longer valued and are demotivated about attending continuing education.

4.4.8 Measures to ensure that the public is well educated about the drugs

The respondents stressed that there was a need to ensure that the public, and not only those who came to the clinic, were well informed about ARVs. The WHO (2004a:22) states that there is a need to increase public awareness on ARVs through the media and other communication channels.

The World Health Report (WHO 2004a) emphasises that providing information about the availability and benefits of ARVs (treatment literacy) is vital to generating and sustaining demand.

The participants indicated that not only HIV-positive people needed education, but it should extend even to HIV-negative people. The respondents also indicated that as a new technology, they had to sell the product to the public to reduce the death rate.

The respondents identified measures to be taken in educating the public, such as having educational programmes in all the media; having HIV-positive people educate the public; strengthening VCT services; having campaigns, and disseminating brochures, pamphlets and newsletters.

4.5 COMMENTS ABOUT THE STUDY

The respondents frequently commented about the study itself. Typical comments included that it was good that the researcher was interested in the area of ARVs and nurses; ARVs are new and should be studied; the results should not appear to devalue them, and that the research results should assist them but should not “kill them”.

4.6 CONCLUSION

This chapter discussed the findings with reference to the literature review. Themes and categories were interpreted and clarified by means of respondents' direct responses. Chapter 5 discusses the limitations of the study, presents guidelines for the support of nurses in educating HIV-positive people, and makes recommendations for nursing education, practice and further research.