Problems Experienced by Professional Nurses Caring for HIV/AIDS Patients in Public Hospitals of Polokwane Municipality, Limpopo Province

by

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A mini dissertation submitted in partial fulfillment of the requirements for the degree of

Master of Curationis (MCur)

in the

Faculty of Health Sciences
School of Health Sciences

at the

University of Limpopo, South Africa

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2013

DECLARATION

I declare that the mini-dissertation "**Problems Experienced by Professional Nurses Caring for HIV/AIDS Patients in Public Hospitals of Polokwane Municipality, Limpopo Province**" hereby submitted to the University of Limpopo, for the degree of **Master of Curationis (MCur)** has not previously been submitted by me for a degree at this or any other university; that it is my work in design and in execution, and that all material contained herein has been duly acknowledged.

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Surname, initials (title)   **Date**

DEDICATION

This thesis is dedicated to my mother, Rachel Ledwaba, and in memory of my late father, Joseph Ledwaba. I would also like to pay tribute to my children, Matsatsi, Mabotse and Khutso, for the courage and support they always showed, my siblings and in-laws, my supervisor and co supervisor for their guidance, and the participants who willingly shared their experiences.

ACKNOWLEDGEMENTS

ABSTRACT

Background: The growing human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) pandemic continues to make a serious impact on all countries throughout the world. Globally, countries have responded to the HIV/AIDS pandemic by investing millions of dollars to help fight the disease, but the impact of HIV/AIDS is even greater in developing countries of Sub-Saharan Africa, including South Africa.

Aims: The aims of this study were to describe the perceived problems experienced by professional nurses who provide health care to patients living with HIV/AIDS in public hospitals of Polokwane municipality, Limpopo Province and to identify guidelines to support these professional nurses.

Study method: A qualitative, descriptive and contextual method was used in this study. Semi-structured, one-to-one interviews were conducted with professional nurses who participated voluntarily in the study. Tesch's open-coding method was used for data analysis.

Results: Professional nurses who provided care to people living with HIV/AIDS at Polokwane Hospital expressed feelings of frustrations and work overload, treatment delay, lack of knowledge on HIV/AIDS, lack of support systems, poor prognosis and patients presenting with confusion and mental disturbances.

Conclusion and recommendations: Despite the fact that the professional nurses expressed negative experiences as they carried out their daily activities, and they still continued rendering care to HIV/AIDS patients, notwithstanding the obstacles they encountered. Recommendations were made with regard to nursing practice and nursing education, staff support by

management, education and counselling for relatives, reaching out to the relatives and community, and further research.

KEYWORDS

- Experiences

- Professional nurses

- Problems and caring

- HIV/AIDS

- HIV-positive patients

- Public hospitals

DEFINITIONS OF CONCEPTS

Professional Nurse   Refers to a person who is qualified and competent to independently practice comprehensive nursing in the manner and to the level prescribed and who is capable of assuming responsibility and accountability for such actions (SANC, 2005). In this study, a professional nurse refers to a person who has undergone training that led to registration as a nurse as stipulated by South African Nursing Council (SANC) and provides health care to patients living with HIV/AIDS.

Patients living with HIV/AIDS   This term refers to persons who are in need of medical and nursing care as a result of being infected with HIV or is at the stage where the infection has progressed to AIDS, whereby the individual's body systems are deteriorating to a life-threatening situation.

Public hospital   Refers to a government health care facility that provides care, in-patient beds, continuous nursing services and organized medical staff (Freshwaters and Maslin-Prothere, 2005). In this study, 'public hospital' refers to the government institution that provides health care to patients living with HIV/AIDS by means of government employed care workers.

LIST OF ABBREVIATIONS

AIDS   Acquired Immunodeficiency Syndrome

ART   Anti-Retroviral Therapy/Treatment

ARVs   Anti-Retroviral Drugs

HCT   HIV Counselling and Testing

HIV   Human Immunodeficiency Virus

PHC   Primary Health Care

PMTCT   Prevention of Mother-to-Child Transmission

PLWHA   People Living with HIV/AIDS

SANC   South African Nursing Council

STI   Sexually-Transmitted Infections

VCT   Voluntary Counselling and Testing

WHO   World Health Organization

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CHAPTER 1

OVERVIEW OF THE STUDY

1.1 Introduction and Background

The growing human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) pandemic continues to cause serious health, social and financial burdens in all countries throughout the world. Globally, countries have responded to the HIV/AIDS pandemic by investing millions of dollars to help fight the disease, but the impact of HIV/AIDS is even greater in developing countries of Sub-Saharan Africa, including South Africa (National Department of Health, 2001).

The South African government has indicated that the HIV/AIDS epidemic is making it difficult for hospitals to cope with the increasing number of HIV-infected patients because hospitals are overcrowded owing to a disproportionately inadequate number of medical, nursing and allied health professionals (Mashau and Davhana-Maselesele, 2009). Health care services in South Africa are unable to manage with the large number of HIV/AIDS patients, and therefore patients are discharged much earlier from hospitals to be cared for in the family environment. Some hospitals are reported to have eventually decreased the patient's average stay from 14 days to just 3.5 days and referring them to the home-based care organizations (Mashau and Davhana-Maselesele, 2009).

The provision of health care to HIV/AIDS patients poses a challenge to health care professionals. These challenges include the identification and management of special clinical problems, counseling techniques, the administration of patient care and the ability to communicate effectively with individuals, families and community groups. Health care providers caring for HIV/AIDS patients need to acquire new attitudes, approaches, knowledge and skills as they become immersed in multi-disciplinary problems of AIDS care and prevention (Effa-Heap, 2007).

Health care workers have been overwhelmed by the impact of HIV/AIDS on the public health services, with the largest portion of resources allocated to facilities that treat people presenting with opportunistic infections or dying from AIDS-related illnesses. This has resulted in overcrowding of under-resourced hospitals where professional nurses work under challenging circumstances that might compromise patient care and increase the risk of infection. Staff morale is often low, due to the poor working conditions and the distress of being unable to treat people effectively and this leads to a number of complaints about the health system. The working conditions are made worse by lack of specialized training and staff shortages (National Department of Health, 2007).

Hall (2007) explained that HIV/AIDS are known to increase the workload of nurses because of the higher number of patients with AIDS-related diseases, the comprehensive time-consuming care that is needed by many of these patients and the lack of support that is available to them. The same author also alluded to the secrecy surrounding the disease which further reduces the

nurses' efficiency, confront them with ethical issues and hinder them from curbing the spreading of HIV/AIDS.

Effa-Heap (2007) indicated that some of the Nigerian nurses experience nightmares and increased anxiety levels while nursing patients living with HIV/AIDS. Some nurses requested to be transferred or even left the profession. Bester, Du Plessis and Greef (2006) also indicated that professional nurses experienced interpersonal discomfort and stress that can be intensified when nursing terminally ill patients living with HIV/AIDS.

According to Bester et al. (2006), nurses have experienced that medical practitioners base their treatments decisions only on the patients' HIV/AIDS diagnosis, prognosis and the availability of medication instead of the patients' presenting conditions and care needed. In this same study it was perceived by nurses as unfair and causing conflict between nurses and medical practitioners and, therefore, poor patient care (Bester et al, 2006).

1.2 Problem Statement

About half or all patients admitted to hospitals in South Africa seek care for HIV/AIDS-related illnesses, while the number of HIV-positive patients in medical wards is even higher (Palitza, 2010). According to the Joint United Nations Programme in HIV/AIDS, HIV prevalence in South Africa is 21.5% (Palitza, 2010). Professional nurses allocated to medical units in public hospitals experience problems regarding the provision of health care to patients living with HIV/AIDS. The problems experienced by professional

nurses could be based on the increasing numbers of HIV/AIDS patients in these hospitals.

1.3 Purpose of the Study

The purpose of the study was to explore the perceived problems experienced by professional nurses providing health care to patients living with HIV/AIDS in the public hospitals of Polokwane municipality, Limpopo Province.

1.4 Research Question

The following research question guided the study: "What are the problems experienced by professional nurses who provide health care to patients living with HIV/AIDS in the public hospitals of Polokwane municipality?"

1.5 Objectives of the Study

The objectives of the study were to:

* Determine the problems experienced by professional nurses providing health care to patients living with HIV/AIDS in public hospitals of Polokwane municipality, Limpopo Province,

* Develop guidelines to support these professional nurses with the problems they experience during provision of care to patients living with HIV/AIDS.

1.6 Methodology

A qualitative, descriptive and phenomenological research method was used in this study to explore and describe professional nurses' experiences when providing care to patients living with HIV/AIDS (Creswell, 2009). Phenomenology was used to understand professional nurses' experience on the provision of care to people living with HIV/AIDS. The study population involved all the professional nurses working in Limpopo hospitals. Purposive sampling was used to select the eleven professional nurses to participate in the study. Data collection was done through semi-structured interviews. Tech's open-coding was used for data analysis. Details of the research methodology will be discussed in Chapter 3 of the study.

1.7   Significance of the Study

The study is aimed at identifying guidelines to support professional nurses with the problems they experience during provision of care to patients living with HIV/AIDS, hence also contribute to the improvement of quality health care for people living with HIV/AIDS. The findings could be used in the development of the in-service education programmes for professional nurses. The study might also contribute to the development of policies that would enhance nursing practices related to HIV/AIDS.

1.8   Conclusion

This chapter presented an overview of the study, including its background, problem statement, purpose of the study, research question and objectives, research methodology and the significance of the study. The next chapter will deal with the literature review.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

This chapter discusses literature relevant to the research topic namely; problems experienced by professional nurses caring for HIV/AIDS patients in public hospitals of Polokwane Municipality, Limpopo Province. Several researchers have conducted studies on the problems experienced by the professional nurses concerning the provision of care to people living with HIV/AIDS (PLWHA) and their findings are discussed below. The review of literature involved in-depth evaluation of published scholarly literature in journals, books and book chapters. An electronic literature search was conducted in the following databases: Science-Direct, EbscoHost, and Google.

2.2 HIV/AIDS Escalation Rate and Work Overload

A review of literature revealed that the number of people living with HIV/AIDS in South Africa has escalated at an alarming rate (Smit, 2005).   Many people who are hospitalized have an HIV-positive status, and hence nurses are in regular and prolonged contact with people suffering from HIV/AIDS than is the case in other working environments (Smit, 2005). Although studies focusing on nurses' experiences of caring for patients with HIV/AIDS have been done in numerous countries, comparatively little is known about nurses' views in Africa

and, in particular, South Africa. To ensure quality care for patients with HIV/AIDS, it is important to understand nurses' experiences of caring for HIV-positive patients and how they may influence their attitudes towards these patients (Smit, 2005).

The HIV was identified in 1983 as the causative factor of AIDS which has taken on pandemic proportions, and the disease is a major problem in South Africa. The study by Deetlef, Greeff and Koen (2003) predicted that by the year 2010 the number of people in South Africa infected with HIV may be as many as 30% of the total population of 43 million. In the light of the above forecast, it is clear that AIDS will have an enormous impact on the lives of individuals, families and communities and one of these implications is that an increasing number of patients seeking care would increase pressure on health care personnel, including nurses. It is during this expected frequent contact with HIV-positive patients that the attitudes of nurses become important (Deetlefs et al 2003).

In a study conducted by Delobelle, Rawlinson, Ntuli, Decock and Depoorter (2009) it has been found out that hospital nurses reported a high frequency of care for patients with HIV/AIDS but less HIV/AIDS training as compared to primary health care (PHC) nurses. Professional nurses reported a higher workload because of HIV/AIDS, lack of training impacting negatively on their work and stigma and shared confidentiality affecting them emotionally. The attitudes towards the patients are mainly positive and knowledge is moderately adequate and associated with the professional rank. The nurses practice the universal precautions, but fear occupational HIV transmission.

For example, there are cases of needle-stick injuries, but post exposure prophylaxis was not available in all health care facilities (Delobelle et al, 2009).

2.3   Impact of HIV/AIDS on Nurses

The literature revealed that nurses feel that patients with HIV/AIDS deserve the same quality care that other patients receive, but many nurses would choose not to serve them if given a choice (Richter, Stoskopf, Samuels, Baker, Shi and Sy, 2009 [a]). Nurses who believe in the basic professional obligation to treat patients with HIV/AIDS are more likely to worry about treating such patients and even more likely to worry about their own health. Any negative attitudes or biases that nurses have concerning people with HIV/AIDS can interfere with and constitute a barrier to the provision of quality care to those patients (Richter et al, 2009 [a]).

Smit (2004) conducted a study which showed that many nurses are experiencing occupational stress, fatigue and symptoms of occupational burnout, due to the exacting and demanding nature of the care provided by health care workers to people living with HIV/AIDS. Smit (2004) also found out that the stress is escalating even more as a result of fear of HIV transmission from accidental occupational injury and exposure to HIV-infected body fluids.

2.4   Nurses' Knowledge of HIV/AIDS

A recent study by Shabani (2011) noted that almost half of the respondents felt they had a right to refuse nursing an HIV patient and believed they should

know if their client had HIV/AIDS. The same study also revealed the lack of knowledge which the nurses possessed with regard to HIV/AIDS. Therefore, nurses with a general lack of knowledge about HIV/AIDS may hinder the building of a successful nurse-patient relationship. If the patient does not trust or believe the nurse, then the efficacy of the treatment and the professionalism of nursing could also be jeopardized.

Shabani (2011) also indicated that the majority of the participant nurses were more experienced in caring for HIV/AIDS patients because they have been caring and treating such patients for more than four years. They were aware of HIV/AIDS manifestation, its transmission and prevention and they possessed some level of knowledge about HIV/AIDS. They were content with their jobs, as well as caring and treating HIV/AIDS patients, and they generally behaved positively towards such patients.

2.5 Nurses' Attitudes Towards Patient Care

Nurses are expected to give quality care to patients, regardless of their illness. Whether nurses continue to feel ethically bound to act indiscriminately towards all patients, has been called into question with increasing numbers of people living with HIV/AIDS being hospitalized (Smit, 2005). The same author further indicated that some nurses may exhibit a negative attitude towards patients suffering with HIV/AIDS. These negative attitudes may often be intensified by a nurse's perception of how the patient contracted HIV. A distinction may be made between patients perceived to be 'innocent' victims, such as those who contracted HIV through blood transfusions or birth, and 'deserving' victims

who contracted the disease because of their lack of social responsibility, such as intravenous drug users (Smit, 2005).

Bester et al. (2006) discovered that nurses are personally influenced when they nurse terminally ill patients. Professional nurses commonly experience interpersonal discomfort and stress when nursing terminally ill patients. It has been argued that the dying process of the patient confronts them with their own mortality and stress can build up when nursing a terminally ill HIV/AIDS patient, as AIDS inevitably causes death (Bester et al, 2006).

In the study conducted by Harrowing and Mill (2009), participants recognized that HIV illness and its associated costs related to the prevention, treatment and care interventions placed a huge burden on the health care system. Harrowing and Mill acknowledged the social and political factors that created the situation, and felt that they had the responsibility to compensate for deficiencies in the health care delivery. It was also suggested in the same study that nurses were caught in a vicious cycle: the lack of resources led to fatigues and despair, which in turn contributed to a growing negative attitude towards their work and their patients. The nurses' exhaustion intensified and stamina declined, the prevailing attitude changed to a "who cares" approach which became a habit and lost the essence of doing things right (Harrowing and Mill, 2009).

2.6 Fear of Occupational Exposure

A qualitative research study carried out by De Villiers and Ndou (2008) in Vhembe District, in the Limpopo Province revealed that the researcher

explored the emotions which the professional nurses experienced while caring for HIV/AIDS patients. The results strongly indicated that the participants experienced negative emotions due to the perceived risks of contracting HIV infection as a result of accidental or intentional exposure to blood or body fluids of infected patients. This impacted negatively upon the participants' ability to engage in ethical practice and maintain a therapeutic relationship with these patients (De Villiers and Ndou, 2008).

2.7 Nurses' Frustration and Emotional Effects Caused by HIV/AIDS

Hospital nurses expressed frustration over the lack of support in offering HIV/AIDS services and asked for allocation of permanent staff to ensure continuity (Delobelle et al, 2009). The professional nurses saw HIV as a national emergency that should be tackled head-on, with strategies to enable them to help curb the epidemic and improve HIV/AIDS information disseminated in their communities. They also expressed severe anxiety, reporting that they are overworked, demoralized and emotionally distressed because of seeing patients with an incurable disease deteriorate over a long period of time (Delobelle et al, 2009).

Continuous care also led patients to develop a strong attachment to their caregivers, which could turn into friendship or even make them feel like relatives. These relationships affected the nurses' lives as they hide their feelings to their families, but continue to worry about how HIV/AIDS affected their patients (Delobelle et al, 2009).

2.8 Delay of Treatment

Chirwa, Greef, Kohi, Naidoo, Makoae, Dlamini, Kaszubski, Cuba, Uys and Holzemer (2009) demonstrated that the stigma attached to HIV/AIDS contributed independently and negatively to job satisfaction, over and above variables related to personal and work setting characteristics. The perceived HIV/AIDS stigma proved to be the strongest predictor of job dissatisfaction, followed by mental health and quality of life. A patient-related stress had been described by participants - where patients refused to be tested or were tested late in the illness after being persuaded by the nurses. This frustrated the nurses as the patients were often severely ill by the time of diagnosis and they linked the delay to poor responses to medication and poor adherence (Pallangyo and Mayers, 2009).

2.9 Nurses' Willingness to Provide Care

Studies conducted in Nigeria reported that a majority of nurses were willing to care for and treat patients living with HIV/AIDS. However, some studies showed that nurses were reluctant to deal with such patients. Different background factors have been found to have an impact on whether nurses were willing to provide care, including cultural values, age, and whether nurses had been taking care of people living with HIV/AIDS. The number of working years has shown to be negatively associated with the willingness to treat people living with HIV/AIDS and the nurses' disposition to care has been found to be related to whether the HIV-positive people were homosexuals, intravenous drug users or prostitutes (Mockiene, Suominen, Välimäki, Razbadauska, Caplisnska and Martinkenas, 2010).

Reis, Heisler, Amowitz, Moreland, Mafeni, Anyamele and Iacopino (2005) conducted a study in four Nigerian states, namely, Abia, Gombe, Kano and Oyo, where it appeared that health care professionals were providing care to HIV-positive patients and complying with their ethical responsibilities, despite

the lack of training on HIV/AIDS and having insufficient supplies of materials needed for treatment and prevention in the facilities where they worked. It was also revealed in the same study that a significant number of nurses engaged in discriminatory and unethical behaviours which were deleterious to the health professions as they tainted all health professionals and eroded trust in them (Reis et al, 2005).

A study in three countries, namely, Finland, Estonia, and Lithuania revealed that the nurses were willing to perform nursing activities for a fictional patient with HIV/AIDS (Välimäki, Makkonen, Blek-Vehkaluoto, Mockiene, Istomina, Raid, Vanska and Souminen, 2008). This illustrated that these nurses' responsibility to safeguard and promote the well-being of patients can be assured on the mental level. With the arrival of HIV/AIDS in people's daily lives, nurses have to face the moral dilemma of taking care of individuals with a lethal disease and also questions about the danger of their occupation to themselves and their family members (Välimäki et al, 2008).

Grad (2011) indicated that professional nurses approached HIV-positive patients with an acute awareness of the impact of HIV/AIDS. The cases were handled in a sensitive manner in order to respect the privacy of the patients. The nurses used the term "ISS" (Immune Suppressive Syndrome) to avoid stigmatization that came along with the dreaded "HIV." Their understanding of the complex effects of HIV/AIDS on their patients allowed the nurses to also speak frankly and openly. The open dialogue between the nurses and patients seemed to maintain their dignity as a person and not being regarded as a mere diagnosis (Grad, 2011).

2.1 The Effects of Lack of Resources and Social Support

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In the study by Campbell, Scott, Madanhire, Nyamukapa and Cregson (2010), it was palpable that nurses were experiencing increased workloads. Overworked nurses who lack sufficient material and emotional support often fall back on a task rather than provide patient-oriented care. The same study also reported that the frequent violent abuse of patients can be caused by a complex interplay of concerns including organizational issues such as lack of nurse accountability, professional insecurities, a perceived need to assert control over the environment and sanctioning of the use of coercive and punitive measures to do so, and an underpinning ideology of the patent inferiority compared to the nurses' status as middle-class professionals (Campbell et al, 2010).

As a number of HIV-positive persons in any country increases, so are the chances for every health care worker in that country of becoming infected by contact with body fluids of HIV-positive patients (Ehlers, 2005). The HIV status of patients remains unknown to health care workers, unless a specific patient discloses his/her status. The policy adopted by many African countries, including South Africa that every patient must be treated as if s/he is HIV-positive, puts more strain on overburdened nurses trying to cope with shortage of staff, resources and supplies. The feasibility of carrying out this policy in daily practice depends on the number of available nurses as well as the supply of sufficient stock of good quality, protective gloves, masks, goggles and aprons (Ehlers, 2005).

2.1 Conclusion
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This chapter discussed various problems that were experienced by professional nurses as evidenced by several research studies. The experiences and main concerns were arranged and discussed under different headings - HIV/AIDS escalation rate and work overload, impact of HIV/AIDS on nurses, nurses' knowledge of HIV/AIDS, nurses' attitudes towards patient care, fear of occupational exposure, nurses' frustration and emotional effects caused by HIV/AIDS, delay of treatment, nurses' willingness to provide care and the effects of lack of resources and social support. The next chapter will describe the methodology and design applied in this study.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 Introduction

This chapter focuses on the research methodology and design applied in the study, and includes the qualitative, descriptive and phenomenological research design. The population, sampling, data collection and trustworthiness measures are also discussed.

3.2 Study Site

The study was conducted in one public hospital of the Polokwane municipality, Limpopo Province, namely, Polokwane Hospital which forms part of the Polokwane/Mankweng complex. This hospital is situated within the city of Polokwane and serves people from within the city and neighbouring farms and plots. Polokwane Hospital is a referral hospital for the district hospitals within the province, including Seshego Hospital with the exception of Mankweng Hospital as the two hospitals are regarded as tertiary institutions; hence they are referred to as Polokwane/Mankweng Complex. There are three medical units with bed capacity of 29 in the female medical unit, 32 in the male medical unit and 36 in the paediatric medical unit.

3.3 Research Method and Design

A qualitative, descriptive and phenomenological research method was used to explore the professional nurses' perceived experiences when providing care to patients living with HIV/AIDS (Creswell, 2009). Welman, Mitchel and Kruger (2006) described a study design as a plan according to which participants are obtained and information is collected from them. It also describes what is going to be done with the participants, with a view to reach conclusions about the problem statement.

3.3.1 Qualitative Research Design

The qualitative research method has few preconceived ideas and stresses the importance of people's interpretations of events and circumstances rather than the researcher's interpretation (Brink, 2006). In this study, the method attempted to assist the participants to give views of their own experiences regarding health care that they provided to HIV/AIDS patients in the Polokwane municipality of Limpopo province.

3.3.2 Descriptive Research Design

The descriptive research design is aimed at obtaining complete and accurate information about a phenomenon through observation, description and classification and also provides new information on the phenomenon (Brink, 2006). According to De Vos, Strydom, Fouche and Delport (2004), the descriptive research method is defined as a more intensive examination of the phenomena and their deeper meaning, thus leading to a thicker description. In this study, the descriptive research method was used to obtain accurate

and complete information as the professional nurses were given an opportunity to describe their first-hand experiences pertaining to the health care that they provided to HIV/AIDS patients.

3.3.3 Phenomenological Research Design

A phenomenological research design is aimed at examining human experiences through the descriptions of the meaning of the experiences and understanding the events within the concrete or natural context in which they happen (Barbie and Mouton, 2002). This study only concentrated on the perceived experiences of professional nurses who are directly taking care of the HIV/AIDS patients in the Polokwane municipality, Limpopo Province.

3.4 Study Design

In this study, phenomenology was used as a design strategy that attempted to understand people's experiences and understanding of a particular situation whereby the research was related to the existing theory. The researcher was concerned with the phenomenon as borne out by the participants' description of their experiences related to the caring of HIV/AIDS patients in the Polokwane municipality, Limpopo Province (Welman et al, 2006). Leedy (2010) describes a phenomenological study as a design that tries to answer the question and the researchers depends almost on lengthy interviews with the carefully selected participants who have direct experiences with the phenomenon being studied.

The professional nurses described their problems during semi-structured interviews. The approach also included bracketing whereby the researcher

set aside pre-conceived ideas and focused on every perspective of the professional nurses, and intuition was used whereby the researcher paid attention to the participants during the interview and asked probing questions (De Vos et al, 2004).

3.5 Population

Population refers to the entire group of persons or objects that is of interest to the researcher and that meets the criteria the researcher is interested in studying (Brink, 2006). In this study the target population included all the professional nurses who provided health care to patients living with HIV/AIDS in medical units of public hospitals of the Polokwane municipality in the Limpopo Province.

3.6 Sampling

Sampling refers to the process of selecting a portion of the population that then represents the entire population (Polit, Beck & Hungler, 2010). The study rarely determines the sample size in advance and has limited knowledge about the larger population the sample was taken from (Neuman, 2006). According to Welman et al. (2006), purposive sampling is regarded as the most important part of non-probability sampling as the researchers rely on their experiences, ingenuity and previous research findings to deliberately obtain units of analysis in such a way that the sample obtained may be regarded as being representative of the relevant population. In this study, purposive sampling was used to select eleven (11) professional nurses

allocated in medical units of Polokwane Hospital as participants. The sample size was determined by the point at which data saturation was reached.

3.7 Inclusion Criteria

The participants were selected according to the following inclusion criteria:

* ✦ Professional nurses providing health care to patients living with HIV/AIDS in a public hospital of Polokwane municipality, Limpopo Province.

* ✦ The professional nurses allocated in the medical units for a period of one year and above because they were directly in contact with these patients as they provide care on a daily basis.

3.8 Data Collection

A semi-structured interview was used to collect data from the professional nurses. A private room for the interview was prepared at the participants' work place to ensure privacy (Bowling, 2002). The researcher used an audiotape to capture the responses of participants and recorded field notes during the interview to document important facts that assisted in structuring of the probing questions and for preparation of written reports (Neuman, 2006).

The researcher started with demographic questions to help the participants to relax. The central question was: *"What are the problems that you experience while providing health care to patients living with HIV/AIDS?"* The central question was followed by probing questions as guided by the responses of the

professional nurses. Probing was done until saturation of data was reached. Bowling (2002) stated that probing helps to generate more data on the phenomenon being studied and to obtain clarity or a better picture of the participants on issues which were vague during note taking in the personal interview. It also enables the researcher to rationalize the facial expressions and gestures on comments of the participants.

The researcher secured appointment dates with the participants to promote the smooth running of the study and also identified a suitable room for the sessions. The researcher conducted semi-structured interviews that consisted of open-ended questions, including the central and probing questions that were aimed at obtaining the factual significance of the participants assigned to the events of their experiences (De Vos et al, 2004).

In the sessions agreed upon, the researcher interviewed eleven (11) professional nurses individually from Polokwane Hospital until data saturation was reached. Each interview session lasted 30-45 minutes per professional nurse.   The interview was conducted in English as the medium of communication among health professionals. Follow-up dates were adhered to as per initial arrangement for confirmation of the information provided. The researcher had two follow-up sessions with the professional nurses. The information collected was captured on the audiotape and field notes were written.

3.8.1 Interview Technique

The researcher collected the data guided by the following interview techniques as indicated by De Vos et al. (2004):

* The professional nurses dominated the interview sessions as they covered about 90% of the dialogue because they were telling a story and the researcher did a lot of listening and a lesser amount of talking.

* The professional nurses were asked clear and brief questions that were easily understandable as indicated in Appendix 1.

* The researcher asked one question at a time.

* Experience questions were asked before the opinion or sentiment questions.

* Leading questions were avoided, but questions were asked to clarify answers that were not understood.

* Professional nurses were given an opportunity to think out what they wanted to add or say before the next question.

* Good stories were not interrupted because the researcher had another good question to ask.

* The researcher followed-up on the professional nurses' responses for confirmation.

* The researcher monitored the effects of the interview on the professional nurses in order to know when to focus and when to defocus.

* The audiotape was kept on at all times to avoid unnecessary distraction when it is turned on and off during the session.

* Interviews were concluded with a general question, "Is there anything further that you feel is important?"

3.8.2   Communication Technique

In this study, the following communication techniques, according to De Vos et al. (2004), were utilized during the semi-structured interview:

3.8.2.1 Minimal Verbal Responses

Verbal responses correlated with occasional nodding, for example, "Mm-mm, yes, I see", to show the participants that the researcher was listening and followed the responses. This type of response encouraged the professional nurses to carry on talking and that the researcher could follow what they were talking about.

3.8.2.2 Clarification

This embraces the method used to get clarity on unclear statements. The researcher asked follow-up questions, "Could you tell me more about …" to get more clarity and a better understanding of the responses given.

3.8.2.3 Encouragement

The participants were encouraged to pursue a line of thought. In this study, the researcher encouraged the professional nurses to say more about the phenomenon, that is, to express their experiences fully.

3.8.2.4 Listening

The researcher is expected to have good listening skills. The professional nurses were given an opportunity to talk and describe their experiences without interference. The researcher also observed verbal and facial expressions.

3.8.2.5 Paraphrasing

Paraphrasing involves a verbal response in which the researcher will enhance meaning by stating the participants' words in another form with the same meaning. The researcher tried to obtain more meaning by asking the professional nurses the same questions in a different manner, using the same words given by the participants.

3.8.2.6 Probing

This is the technique used to persuade the participant to give more information about the issue under discussion. This helped the researcher to deepen the response to a question, to increase the richness of the data being obtained and to give cues to the professional nurses about the level of response that is desired.

3.8.2.6.1 Linking

The researcher linked the professional nurses' responses to the information desired to obtain what is already known about the phenomenon.

3.8.2.6.2 Challenging

The researcher explored more information from the professional nurses as a way to prove validity of the information given.

3.8.2.6.3 Acknowledging

The researcher showed a sign of attention to the professional nurses by intermittently repeating after them what they have said.

3.8.2.6.4 Direct Questioning

The researcher obtained more information by asking the professional nurses questions that were directly linked to the problem under discussion.

3.9 Data Analysis

The data analysis was done according to Tesch's open coding method cited by Creswell (2009):

✦ The researcher read through the transcripts and jotted down ideas of the whole interview.

✦ The researcher picked transcripts that were interesting and shorter out of the pile and went through them, while writing thoughts in the margin.

✦ A list of topics was made and information was clustered accordingly. These topics were arranged into columns as major topics, unique topics and leftovers.

- ✦ The most descriptive wording for the topics was suggested and turned into themes and sub-themes, aiming to group those topics that relate to each other.

3.10 Measures to Ensure Trustworthiness

Trustworthiness was ensured by using Guba's model as illustrated by De Vos, Strydom, Fouche, Poggenpoel and Schurink (2002), that is, credibility, dependability, transferability and confirmability.

3.10.1 Credibility

Credibility refers to the establishment of confidence in the truth of findings from the participants and the context in which the study was undertaken (De Vos et al, 2002). In this study, the researcher ensured credibility by having several contacts with the professional nurses. The prolonged engagement confirmed the responses given by the professional nurses whereby the researcher had an opportunity to dwell on the phenomenon over time until the study revealed itself and saturation point was reached. An audit trail was done whereby the supervisor and the co-supervisor listened to the recorded interviews. The researcher submitted raw data to an independent coder who is regarded as an expert in the field of qualitative research to do an independent examination of the data. This also served as an instrument for quality assurance. A literature control was conducted using previous studies to support the results.

3.10. Dependability 2

Dependability refers to the inquiry that provides its audience with evidence that if it is to be repeated with the same participants in the same context its findings will be similar (De Vos et al, 2002). The researcher adopted an inquiry audit that involved scrutiny of the data and relevant supporting documents by the independent coder as an approach that also had a bearing on data confirmability. The researcher asked the same questions during follow-up sessions to check if the professional nurses would give the same responses.

3.10. Transferability 3

According to De Vos et al. (2002), in transferability the burden of demonstrating the application of one set if findings to another context rests more with the investigator who would make the transfer than with the original investigator. In this study, the results may be replicated in another situation with a similar problem. The research design and methodology were described to the professional nurses and the researcher adhered to a purposive sampling method whereby the population only included the professional nurses who provided health care to patients with HIV/AIDS. A literature review was conducted followed by the literature control on completion of data collection (De Vos et al, 2002).

3.10. Confirmability
4

Confirmability guarantees that the findings, conclusions and recommendations are supported by the data and that there is an internal agreement between the investigator's interpretation and the actual evidence (Brink, 2006). To ensure confirmability in this study, the field notes and audiotape were kept safely for later submission to the independent coder for assessment and documentation of the dependability of the report. The researcher also had follow-up sessions with the professional nurses to confirm their responses.

Confirmability of the study does not focus on the characteristics of the researcher "if she is objective or unbiased", but focused more on the characteristics of the data, and whether it is confirmable or not. Both the supervisor and the co-supervisor had an opportunity to listen to the recorded interviews and also had hard copies of the same interview to confirm the process. This was done to persuade others that qualitative data are worthy of confidence (Polit et al, 2010).

3.1 Ethical Considerations
1

The following human ethical principles were maintained throughout this study:

3.11. Permission to Conduct the Study
1

Ethical clearance was obtained from Medunsa Research and Ethics Committee. Permission to conduct the study was obtained from the Limpopo

Province Department of Health and Social Development. The study was conducted in accordance with ethical stipulations of the Democratic Nursing Organization of South Africa (1998).

3.11. Informed Consent
2

The participants were informed that their participation was voluntarily and they could withdraw from the study at any time without any penalties (Breakwell, 2006). Informed consent was obtained from the professional nurses and therefore signed as evidence that they were not forced into participation. They were also shown and told of the instruments used to capture data so that they could give information without fear that the captured data could be tempered with.

3.11. Confidentiality and Anonymity
3

The information provided was only known to the researcher and the participant in order to protect the participant. All participants had the right and expected that the information provided be treated confidentially and, if published, would not be identifiable as theirs (Breakwell, 2006). The interview took place in a private room and participants were assured that the information gathered would not be discussed with unauthorized people, except the concerned professional nurses and the supervisor of the study.

Anonymity exists if the subject's identity cannot be linked, even by the researcher, with his or her individual responses (Neuman, 2006). Each

professional nurse was given a code number and the researcher kept a control list of their names with their corresponding code numbers in a locked-up facility to ensure anonymity. The code numbers were allocated next to their names and known only by the researcher and the supervisors.

3.11. Right to Protection from Harm 4

The right to protection from harm is based on the ethical principle of beneficence which stated that the researcher should not cause any form of harm to the participants. The researcher tried to bring about the greatest possible balance of benefits over harm (Breakwell, 2006). The researcher conducted the study bearing in mind the protection of the professional nurse's right to comfort, maintaining the right to confidentiality and protection from harm to their self-esteem.

3.1 Conclusion 2

In this chapter, the research methodology was discussed and applied according to the proposed qualitative, descriptive and contextual research designs. Professional nurses who provided care to HIV/AIDS patients were selected purposively as participants. Data were collected and captured using an audiotape in a one-to-one semi-structured interview and the information was then analyzed through Tesch's open coding method.

CHAPTER 4

RESEARCH FINDINGS

4.1 Introduction

This chapter discusses the results of the data collected during the semi-structured interviews held with professional nurses allocated in medical units of Polokwane Hospital.

The researcher is a professional nurse who previously worked in medical units of three (3) different hospitals and Emergency units of two (2) different hospitals within the same province. At the time she commenced with this study she has been working in Emergency unit whereby she has been able to receive most HIV/AIDS patients as the presented to the hospital. This is where she was able to identify a few challenges and developed an interest in acquiring more information through research, to find out what other professional nurses could have experienced regarding the same problem. She is currently working at a Primary Health Care setting where she is still exposed to the care of people living with HIV/AIDS at different health stages.

4.2 Demographic Data

How long have you been allocated in the medical ward?

Six professional nurses have been allocated in medical ward for ten (10) years and above and five (5) f them have been allocated for about six (6) and two (2) years.

Clinical speciality qualifications

Most of these professional nurses only have General Nursing Science qualification, one (1) have Peadiatric Nursing Science qualifications while the other one (1) holds both Peadiatric Nursing Science qualifications and Occupational Nursing Science and lastly, one (1) holds a Clinical Nursing Science qualification.

Participants' ages

The professional nurses are aged between the ages of 63 and 30 years.

4.3 Results and Discussion

Tech's open coding method was used during data analysis and five (5) themes and seventeen (17) sub-themes emerged (Table 4.1). The results are discussed based on experiences expressed by the professional nurses during the data collection session and also put into perspective with existing research conducted by different researchers on the same themes.

Table 4.1: Themes and sub-themes

Themes	Sub-Themes
1. Feeling of frustration and emotions	1.1 Feeling of helplessness
	1.2 Fear of patients and relatives
	1.3 Fear of occupational injuries

		1.4	Shortage of staff
		1.5	Prolonged stay at hospital
2.	**Delay of treatment**	2.1	Non-disclosure of HIV/AIDS status
		2.2	Time of presentation to hospital
		2.3	Readiness to be tested
		2.4	Lack of confidentiality
3.	**Knowledge of HIV/AIDS**	3.1	Professional nurses' lack of knowledge of HIV/AIDS
		3.2	Family's lack of knowledge of HIV/AIDS
4.	**Social support system**	4.1	Lack of management support
		4.2	Lack of staff counseling
		4.3	Lack of appreciation
		4.4	Lack of family support
5.	**Presenting conditions**	5.1	Poor prognosis
		5.2	Patients' behaviour: confusion and signs of mental disturbance

4.3.1 Theme 1: Feeling of Frustration and Emotions

The issue of HIV/AIDS can be so demanding to even cause some frustration and emotional feelings to the professional nurses as they continuously provide care to the infected patients. Professional nurses gradually develop feelings of helplessness, fear of occupational injuries, fear of patients' relatives and the workplace inconveniences imposed by staff shortages. All these feelings pose as major problems that could lead to altered patient care. Tshweneyagae (2007) argued that the advent of HIV/AIDS has changed the nursing profession and has made services provided by the nurses to be complex.

This is because HIV/AIDS patients require more specialized care and longer treatment, which can be a burden to the nurses; especially in view of the multitudinous array of problems they face (Table 4.1).

The study conducted by Rujumba, Mbasaalaki-Mwaka and Ndeezi (2010) revealed that health care workers are more comfortable with and are used to treating adults, and Mavhandu-Mudzusi, Netshandama and Davhana-Maselesele (2007) confirmed aspects of emotional stress and frustration as well as difficulties linked with the caring of very sick patients and a feeling of being unable to help. Orner (2006) reported that emotional exhaustion and fatigue are common in health professionals who often work under great pressure with a stigmatized disease, meeting death and misery on a daily basis, without sufficient compensation or encouragement.

4.3.1.1 Sub-Theme 1.1: Feeling of Helplessness

The professional nurses expressed a feeling of helplessness as patients present with different conditions and behaviours, they are mostly disorientated, furious and aggressive. This was expressed as follows by a professional nurse*: "Some of the patients are so disorientated, furious and aggressive when it comes to delivering of medications to them and others are totally refusing because of the disorientation, they are confused, but we just carry on with them as such."*

In support to this experience, studies conducted by WHO (2008) discovered that HIV/AIDS imposes a significant psychological burden on affected individuals. People with HIV often suffer from depression and anxiety as they

adjust to the impact of the diagnosis of being infected and face the difficulties of living with a chronic life-threatening illness, for instance, shortened life expectancy, complicated therapeutic regimens, stigmatization, and loss of social support, family or friends. Apart from the psychological impact, HIV infection has direct effects on the central nervous system, and causes neuropsychiatric complications, including HIV encephalopathy, depression, mania, cognitive disorders, and frank dementia, often in combination. Stojanovski, Stojanovic and Belgrade (2007) supported this view by reporting that there are periods of psychological confusion that come in moments of crisis, like learning about the diagnosis, introduction of therapy, HIV-related hospitalization and other stressful transitions.

Some professional nurses mentioned that some of these patients are neighbours or just people they know and it affects the staff, but they have to continue providing care irrespective of the present situation. They also mentioned that these patients are often in denial of their status and think that it is the end of their lives, but the professional nurses have to carry on providing care. These experiences were articulated aptly: *"Most of them have got denial; they do not accept themselves and find that they do not have confidence. They also think it is the end of their lives and sometimes find that they are even aggressive to us even before you know that they are like that and you find that they already have an attitude because they think everybody knows their status."*

In corroboration of the above, Delobelle et al. (2009) and Smit (2005) also described that the nurses in their studies expressed feelings of emotional and

psychological distress, reporting that they are overworked and demoralized because of seeing patients with an incurable disease deteriorate over a long period of time. Professional nurses are expected to give quality care to patients, regardless of their illness and demanding nature of the care. Even though professional nurses felt rejected and manifested an emotional frame of mind, they still showed compassion and empathy for HIV-infected patients.

4.3.1.2 Sub-Theme 1.2: Fear of Patients and Relatives

Many professional nurses revealed their fear of patients and their relatives because they were threatened and accused of not providing proper care to their patients. They also indicated that this situation got worse as some of them were even followed and injured by these patients' relatives. One professional nurse expressed her experience as: "*Now they will plot you, they will be saying that sister, that nurse is so so, we will get her and nurse so and so we will get her. And it does happen, it does, people are being stabbed in town, wherever for nothing.*"

In support of these accounts, Smit (2004) and Harrowing and Mill (2009) reported that the family and public did not care anymore. The professional nurses' experiences were that the families of the HIV-infected patients think that they did not do their best for the patient, and this led to them facing abuse. The professional nurses were blamed for everything that goes wrong at the hospital, even the poor quality of service delivered under the circumstances beyond their control. One professional nurse quoted a scene as follows: "*I know of a colleague who was attacked at a taxi rank by the family of a patient because they said she wasn't giving him proper care.*"

Some of the patients were said to be aggressive and they were even considered a danger to other patients. The professional nurses also became afraid as the situation might worsen if they admitted more than one patient with a similar presentation in that same unit. The concern was expressed as follows: *"Most patients are aggressive, they hit other patients. Imagine what will happen if we admit more than one patient being aggressive".*

A study conducted by Freeman, Nkomo, Kafaar and Kelly (2010) revealed that deterioration of health in patients with stages 3 and 4 HIV/AIDS is highly likely to cause severe psychological distress and an increase in depression when the person first heard about the condition. After the initial diagnosis of HIV/AIDS, most people suffer severe shock and either retreat into depression-like states or engage in 'wild' behaviours (Freeman et al, 2010).

4.3.1.3 Sub-Theme 1.3: Fear of Occupational Injuries

The professional nurses expressed the fear of occupational injuries from needle pricks. One of these professional nurses mentioned that: *"Sometimes we are afraid, more especially if you are pricked by a needle."* There are procedures that are followed once an individual has sustained an occupational injury, but the circumstances are still unbearable to the victims.

These findings are reinforced by a previous qualitative research study in the Vhembe District of the Limpopo Province which demonstrated that the participants experienced negative emotions due to the perceived risks of contracting HIV infection as a result of accidental or intentional exposure to blood or body fluids of infected patients (De Villiers and Ndou, 2008).

Gaidhane, Syed Zahiruddin, Khatib, Shrivastav and Johrapurkar (2009) and Chan, Wakeman, Flanigan, Cu-Uvin, Kojic and Kantor (2008 [a]) revealed that while occupational exposure is high, most of the nurses believe that the fear of HIV has not influenced their career choice, but has contributed to a decrease in quality of the patient care due to fear of HIV.

Similar results were also presented in the study conducted in Bandar Abbas, south of Iran by Aghamolaei, Tavafian, Hasani and Zare (2009) and also one by the International Council of Nurses (2003), whereby the participants revealed that their main reason was the fear of being infected while caring. In addition, nearly half of the healthcare providers stated that even thinking about caring of HIV-infected patients made them worried (International Council of Nurses, 2003).

4.3.1.4 Sub-Theme 1.4: Shortage of Staff

Five of the professional nurses indicated that as the hospital experiences shortage of staff, some of the services were then compromised. The experiences were expressed as follows: *"We have no time to do post counselling in the department as we are short staffed. This also makes it difficult and impossible for patients to get appropriate and quality care especially over the weekend whereby there is only one professional nurse on duty and cannot be able to adequately offer them care. These patients' care is demanding and they need to be cleaned up regularly."*

WHO (2004) indicated that health care workers have been overwhelmed by the impact of HIV/AIDS in the public health services, with the majority of

resources such as professional nurses, in many facilities to treat people presenting with opportunistic infections or dying from AIDS-related illnesses. This has resulted in overcrowding of under-resourced hospitals where professional nurses work under challenging circumstances that might compromise patient care and increase the risk of infection. Staff morale is often low, due to the poor working conditions and the distress of being unable to treat people effectively and that led to a number of complaints about the health system. The working conditions are made worse by lack of specialized training and staff shortage. Benatar (2004) also discovered that there was a shortage of qualified health workers in hospitals, with low wages and heavy workloads.

4.3.1.5 Sub-Theme 1.5: Prolonged Stay at Hospital

The professional nurses expressed incidents whereby most patients were admitted with HIV/AIDS and this made it difficult for other patients with acute conditions to be accommodated. Prolonged periods of admission also added to the workload and these conditions are made worse by the presenting condition which necessitated constant observation of HIV-infected patients. These experiences were expressed by two professional nurses as follows: "*It depends on an individual, but they do stay for long,*" and *"They can stay for 2 weeks and more."*

Joubert (2009) and Tamiru and Haidar (2010) agreed that diseases like HIV/AIDS also increase the length of time that a person is likely to spend in hospital per visit. HIV-positive patients generally stay in hospital four times longer than an HIV-negative patient admitted for the same condition.

Professional nurses' views on patients' stay at hospital were described differently and were expressed as follows:

"Most of the patients are kept in hospital for longer period of 1-2 months and their prognosis is usually very poor."

"It depends on an individual, but they do stay for long and this could be 2 weeks and more."

"Some patients can stay for about 72 hours and some more than a month. Not all patients are taken home by their families and some do not have families. If that happens they are taken to step-down facility in Mankweng where they are being nursed there until such time when the Almighty says come".

In support of these findings, Mashau and Davhana-Maselesele (2009) also revealed that some hospitals were reported to have eventually decreased the patient's average stay from 14 days to just 3.5 days, and started referring them to the home-based organizations.

4.3.2 Theme 2: Delay of Treatment

This theme describes the standard and quality of knowledge acquired on HIV/AIDS by both the patient, family and the staff providing health care to these patients. Delayed commencement of treatment is the main cause to increased mortality due to the HIV/AIDS pandemic. This is caused by a few factors that could mostly have been avoided, but because of different believes and fears, patients still decided to stay without treatment. Patients found it difficult to disclose their HIV status, they refused to be tested while it was still

early and they reported to the hospital for medical help when the disease had progressed to a stage that made it difficult to be treated. This fact is supported by Dominicé Dao, Ferreira, Vallier, Roulin, Hirschel and Calmy (2009) who deduced that stigma and fear of diagnosis exposure and discrimination were the predominant issues that were widely reported and identified as leading factors to negative consequences of delay in getting treatment and hiding of drugs.

Another study conducted by Holzemer, Makoae, Stewart, Phetlhu, Dlamini, Greef, Kohi, Chirwa, Cuca and Naidoo (2008) and Mbonu van den Borne and De Vries (2009) explained that failure to disclose one's status delays initiation of care; treatment; and support, all of which people living with HIV/AIDS need as the disease progresses. This, in turn, contributes to delayed or no initiation of anti-retroviral therapy (ART) when opportunistic infections have already begun to set in.

4.3.2.1 Sub-Theme 2.1: Non-Disclosure of HIV/AIDS Status

Professional nurses explained that patients do not disclose their HIV/AIDS status and they go from one institution to another for medical care. They pretend to be unaware of their HIV/AIDS status every time they visit the hospital and later during their care they disclose and find that they have wasted a lot of time and delayed their treatment. Such non-disclosure of their HIV/AIDS status leads to misdiagnosis by the medical doctor, who then just treat the sign and symptoms until tests are done again and at that time the

patient may confess knowledge of his/her HIV status for some time, but did not want to disclose it. Some patients said the opposite, especially if the test was positive, of what their results were during Prevention of Mother-to-Child Transmission (PMTCT) sessions. One participant said: "*Their PMTCT was positive, but some would say that they were HIV negative and when you do the retest they come out positive*". There are few cases, however, where mothers would declare their HIV/AIDS status right away.

Njozing , Edin, Sebastián and Hurtig (2011) presented evidence that participants support the idea of routine HIV status disclosure since life-saving ARTs are now provided free of charge to all eligible persons in the country. Applying this approach would ultimately be beneficial both to the patients and those at risk since it would reduce HIV transmission, and increase patients' access to HIV services. By contrast, Klitzman, Marhefka, Mellins and Wiener (2008) observed that some parents try to protect their children by attributing the need for medical care to other, more benign, or less stigmatized conditions.

The professional nurses in this study also raised experiences that patients go from one hospital to another, not disclosing their HIV status to anyone so that they cannot be identified by anyone and that they may not be associated with the disease. Such an experience was expressed as follows:

"Other patients do not want to divulge their status, they go from one hospital to another, meaning they go from Hospital X get the medication as such, but not divulging that they are having this hiding, go to Hospital Y same story, go to

Hospital Z same story, I can say go from one hospital to another with the same story, and maybe when he is there at the last hospital is then that he can say 'no I am an RVD patient and I am taking ARV's' and the rest you name them as such. But prior to that one we suffered a lot; we tried to find out what is wrong with you and when you say to him let's do HIV tests they refuse ('I don't want'). What are we supposed to do?"

In support of this study, Coetzee, Kagee and Vermeulen (2011) and Kagee and Delport (2010) revealed that patients visit clinics far away from home in order not to be identified by a member of the community as being infected with HIV. SANAC (2012) also indicated that it would be an improvement if patients could be tracked down in future so that they are monitored.

4.3.2.2 Sub-Theme 2.2: Time of Presentation to Hospital

Most patients were reported by the professional nurses who participated, to be in denial of their status and by the time they come to the hospital it is often very late and they have already developed complications and the professional nurses have to start all over again. This experience was expressed as follows: *"Others agree and others still say no, but thereafter, after denying, after 2-6 months they come for readmission being worse and now you must start from 'A-Z' which is a delay of the patient's condition as such."*

Mascolini (2004) conducted a study in Chicago whereby one participant relayed the case of a man who worked as an HIV care manager in another city. He had known his HIV status for five years, but avoided treatment despite daily counselling others on the benefits of therapy. Eventually he

returned to Chicago with seizures and rapidly deteriorated and died with progressive multifocal leukoencephalopathy in eight weeks. Why? "Denial," was suggested, "is a powerful motivator." Zulu and Lehmann (2004) observed that sometimes if patients find that they are positive, they run away and come back when they are very ill.

All professional nurses confirmed that such problems like denial of one's HIV status delays the commencement of treatment and improvement of the condition therefore leading to prolonged stay at hospital. Some of the patients have defaulted treatment because they believed that they could be treated traditionally and they reported for medical care when their condition had taken a turn for the worse. One participant said: "*These patients are defaulters and they still believe in their tradition that they can be healed and on the other hand they come to hospital being very sick*".

According to Ehlers (2005), many people in Africa visit traditional healers prior or concurrently with formal health care services. Nurses form bridges between traditional and western health care systems because they are familiar with both these traditions (Oramasionwu, Hunter, Skinner, Ryan, Lawson, Brown, Makos and Frei, 2009). In separate studies conducted in Kwa-Zulu Natal by Mhlongo (2010) and by van Dyk (2007), most participants admitted that when living with HIV they were using Zulu medicines from traditional healers. Some mentioned that they were scared of ARVs, although the counselling that they received in the clinics after testing positive included literacy sessions on ARVs, still most preferred traditional remedies in the form of 'Imbiza' (herbal medicine) to ART.

4.3.2.3 Sub-Theme 2.3: Readiness to be Tested

In interviews conducted in this study, professional nurses mentioned that they had a policy that every patient admitted should be tested, but some patients still refused to be tested. Patients did not readily respond to the HIV counselling and testing by the professional nurses that mostly deal with counseling to such patients and this contributed to the delays in commencement of treatment. These experiences were expressed as follows:

"Even if the people from Hope Clinic come they still refuse to an extent that our medical practitioners discharge them and maybe after 2-3 months the very same patient comes back again being worse; delirious and confused you name them and then the same medical practitioners have to start afresh. How do you then counsel a disorientated individual?"

Pallangyo and Mayers (2009) presented evidence that there is a patient-related stress that was described by the participants where patients refused to get tested or were tested late in the illness after being persuaded by the nurses. This frustrated the nurses as the patients were often severely ill by the time of diagnosis, and they linked the delay to poor response to medication and poor adherence.

Participants in the study conducted by Meiberg, Bos, Onya and Schaalma (2008) expressed fear of knowing the positive status as the main barrier to go for voluntary counselling and testing (VCT). All claimed to be too scared to have an HIV-test because of the risks they might have taken in the past. Many expressed that it was better to be unaware of your HIV status, so that you just can go on with your life and do not have to face the fact that you will

die young. Many participants mentioned that life is easier when you ignore the disease. Participants also frequently pointed out that they would only go for VCT when they feel very sick. As long as there is no direct and serious physical cause, there is no reason to go for VCT (Meiberg et al, 2008).

4.3.2.4 Sub-Theme 2.4: Lack of Confidentiality

Professional nurses mentioned that they have an ethical code that guides their practice, such as maintaining confidentiality. One participant expressed her experiences as follows: *"I feel that they don't trust our confidentiality because they think if I know their status, when I meet them outside I will still attach what I have nursed them with, I will still associate them with what I see outside the hospital environment."* A study by Shabani (2011) also found that if the patient does not trust or believe the nurse, then the effectiveness of the treatment and the professionalism of nursing could also be jeopardized.

Studies conducted by Pool, Nyanzi and Whitworth (2001), Toivo (2005) and Chandra, Deeothivarma and Manjula (2003) revealed that lack of confidentiality concerning HIV-test results among health workers have a negative impact and has also been found to negatively affect the general population's consideration of availing themselves of HIV-testing. Patients have fear of violation of confidentiality about HIV-test results among health workers, which makes one vulnerable to stigmatization and serves as a barrier to HIV testing acceptance.

4.3.3 Theme 3: Knowledge of HIV/AIDS

This theme discusses the issues that are still lacking and that may need more attention regarding HIV/AIDS. Both the family members and the professional nurses need to have more information and knowledge so that they can cope with the circumstances.

4.3.3.1 Sub-Theme 3.1: Professional Nurses' Lack of Knowledge of HIV/AIDS

All professional nurses felt the need to have adequate knowledge on HIV/AIDS and treatment so that they know exactly what to do when patients present to them. They expressed the importance of being able to differentiate between the normal and the abnormal presenting conditions and to act appropriately. This would also help the professional nurses in advocating for the patients in cases where no progress is noted and they feel that there should be a change or alteration of treatment. This scenario could only be possible if the necessary knowledge has been acquired.

Some professional nurses expressed their experiences as follows:

"In the medical ward there are a lot of HIV/AIDS patients. I think most of us need training as not all of us have the knowledge on what to do because we have the knowledge about VCT, but not the treatment. We need training on how to take care of the treatment not only for the professional nurses, but also

for the enrolled nurses because they are also involved in taking care of the patients."

"Mmm … This is because we have to know, like if you have given treatment to the patient and you don't know what will happen, e.g. the side effects. You won't be able to see if the patient is reacting because you will not have the necessary knowledge. Sometimes the doctors also prescribe the wrong treatment for the patients, but if you have the knowledge you will be able to advocate for the patient e.g. 'doctor I think here you made a mistake can we fix it?' and if you don't have the knowledge you will just have to give that treatment. This is what I think it is important."

Shabani (2011) and Delobelle et al. (2009) conducted a study in this regard and revealed that the lack of knowledge which the nurses possessed with regards to HIV/AIDS. Nurses with a general lack of knowledge about HIV/AIDS may impede the building of a successful nurse-patient relationship. Participants reported a higher workload because of HIV/AIDS, lack of training that impacted negatively on their work and stigma and shared confidentiality affected them emotionally. Mhlongo (2010) also reported that health care providers need ongoing training on HIV/AIDS-related care to prepare them to face daily challenges in the management of HIV-infected individuals.

4.3.3.2 Sub-Theme 3.2: Family's Lack of Knowledge of HIV/AIDS

The professional nurses were concerned that family members were mostly unaware of their members' HIV/AIDS status and it presented a problem to professional nurses since they have to maintain the professional secrecy.

They are ethically bound not to divulge the patient's status to anyone unless the patients themselves asked them to do so or gave consent. These situations put the professional nurses in a dilemma and at the same time leave the family members clueless - and that includes the wives of patients.

This experience was expressed as follows: *"Some relatives would just come to hospital with the patient not knowing what is happening with this patient and find that only the patient knows that he is HIV-positive and the relative do not know and don't have light of the diagnosis. Even the wives sometimes do not know the diagnosis or status of the patient and when they come, you as the nurse cannot divulge the status to the relatives mmm …"*

The study by Hall (2007) found out that secrecy surrounding the disease reduced the nurses' efficiency, confronted them with ethical issues and hindered them in curbing the further spreading of HIV/AIDS. De Villiers and Ndou's (2008) study reported that participants mentioned that the ethical requirement of keeping the HIV status of patients confidential increases their risk of contracting HIV infection.

A study to explore the knowledge and practices related to HIV/AIDS by rural South Africans by Mabunda (2004) was conducted in an HIV outpatient clinic in the Limpopo Province. However, participants indicated that they lacked basic knowledge of HIV/AIDS and depended on support from families, but the families were not always aware of their relative's status. Mbonu et al. (2009) revealed that many Sub Saharan Africans are reluctant to disclose their HIV

status even when they have already gone for VCT. Moreover, those who disclosed it were selective about whom they divulged it to.

One professional nurse raised a concern that patients should feel free to talk and not keep their HIV status a secret. They will somehow be dependent on their family members who may be clueless of their conditions. Such feelings of fear were expressed as follows: *"My general feeling is that people should not hide their status especially to their relatives".* The same results were obtained by Stein, Lewin and Fairall (2006) who pointed out that the importance of achieving patient disclosure of the HIV status to partners, family and friends is a vexed one. Patients often fear disclosure to sexual partners and family members upon whom they may depend for emotional and financial support.

Another professional nurse was concerned about the information and knowledge acquired by the patients on HIV/AIDS. In their experience, the patients had no knowledge, primarily because they were mostly uneducated. This made it difficult for them to understand the disease progression and the importance of taking medication to curb the process. The experiences then expressed as follows: "*Most of the patients are from the rural areas and find that they are not educated; they do not know anything about HIV/AIDS. They do not know why they have to take the medication and find that they think they are ok even though they physically do not look like it."*

These sentiments are supported by previous studies conducted by Malta, Petersen, Clair, Freitas and Bastos (2005) and Tshililo and Davhana-

Maselesele (2009) that discovered a lack of knowledge that causes people to have false conceptions about the disease. Some of the family members who participated in the studies indicated that they associated HIV/AIDS with witchcraft. The misconception was with the person caring for the patient and also with the extended members of the family. They believed that if people have AIDS, they have been bewitched (Tshililo and Davhana-Maselesele, 2009).

4.3.4 Theme 4: Social Support System

For patients to be provided with quality care, the professional nurse deserves some element of support from different stakeholders. These involve support from the patient's immediate families who are expected to at least appreciate the professional nurses' efforts in providing quality care to their loved ones (Richter et al, 2009). The hospitals management is also expected to give emotional and psychological support to the professional nurses as they provide unconditional care to the patients (Pongruengphant and Tyson, 2004). This notion was echoed by Orner (2006), namely, that working with HIV/AIDS care places considerable emotional demands on caregivers. Moreover, health care workers are often thrown in the deep end without receiving adequate, on-going training and supervision.

4.3.4.1 Sub-Theme 4.1: Lack of Management Support

In a very stressful environment, health care workers may hide their emotions and cope in the work environment. Some people may not acknowledge that feeling of grief or frustration experienced by nurses who face frequent deaths

of their patients - some of whom might be relatives and colleagues. Thus, nurses who provide care to people with HIV/AIDS would not be able to cope with emotional trauma of HIV/AIDS if they are not appreciated and supported. Moreover, emotionally charged staff create a stressful atmosphere which is easily felt by patients, relatives and colleagues around them (Jackson, 2002). Participants in this study raised the concern that they lacked support from management in relation to the care they provide to patients living with HIV/AIDS.

One participant said: *"I am not happy with the support from the management as they do not respond when called for help, but only comes when there are problems that involved the nurses. They don't care."*

Another participant mentioned: "*Most of the time when the management come it will be to complain, and never for support. Sometimes when they are called they will say: 'It is not our responsibility, solve in your unit,' but they are sometimes helpful."*

Delobelle et al. (2009) also arrived at such a conclusion when hospital nurses expressed frustration over the lack of support in offering HIV/AIDS services and asked for allocation of permanent staff to ensure continuity. Campbell et al. (2010) reiterated that nurses are experiencing increased workloads. Overworked nurses who lack emotional support often fall back on tasks rather than patient-oriented care.

The study by Pongruengphant and Tyson (2004) is in agreement with the one of Makie (2009) that registered nurses in medical units experienced high level

of stress from a lack of adequate support or opportunities to participate in making decision directly affecting their patients. The lay caregivers also expressed the need for all kinds of support, of which the most important were visits and technical support from the health care workers. Participants also indicated that the support was not provided on a regular basis. These included visits, prayers, food and money. The support that the professional nurses received was thus not very reliable and sustainable (Dippenaar, Chiula and Selaledi, 2011).

4.3.4.2 Sub-Theme 4.2: Lack of Staff Counselling

In this study, the participants described their willingness to provide care to these patients, but are concerned about their support system. They emphasized the importance and the need for staff counselling so that they develop better coping skills toward the situations they are faced with. The concerns were expressed as follows by different participants:

"The problem is that we counsel patients, but nurses do not get counselled. It is hard because the nurses do not have support."

"It is so painful, to see a child dying there. Actually we are affected emotionally and psychologically. Sometimes we feel that we need counselling also."

Similar results were reported in the study conducted by Minnaar (2005), whereby concerns were raised by other participants that nurses needed counseling, not only when they have contracted the disease, but in order for

them to cope with the demands of the high number of patients who no longer recover from the illness, but die as the result of HIV/AIDS. Another study by Dippenaar et al (2011) emphasized that caregivers required assistance to meet their psychological needs as they experienced anxiety, worries and despair.

4.3.4.3 Sub-Theme 4.3: Lack of Appreciation

The professional nurses also found themselves in a dilemma because the relatives would bring a patient to hospital to be cared for, but the same relatives came back to blame these professional nurses for the patients' poor or delayed progress. One professional nurse said: *"I feel very bad if families do not appreciate because nurses are there to save life and not to promote death."*

In support of these findings, Smit (2004) and Harrowing and Mill (2009) reported that the participants' experiences were that the families thought that nurses did not do their best for the patient and that they abused the patients. Thus, the professional nurses are blamed for everything that goes wrong at the hospital and the poor quality of services delivered under circumstances beyond their control.

4.3.4.4 Sub-Theme 4.4: Lack of Family Support

The professional nurses were not sure of the level of support that these patients received from their family members when they were at home. Most patients do not really feel free to talk about situations in their home environment, but their presentation on admission can suggest the type of a

household they come from. These experiences were described by some of the professional nurses as follows: *"It is difficult to nurse the patient because you have to know the patient's background, level of education and lifestyle. It is a challenge because you do not know the type of support they get from home. Patients do not really open up and do not live what they say. This makes the nurses feel bad because most patients come back worse and they have to start from the beginning. Some patients do not say whether they have food or not at home and when they get home they do not have anything to eat while they must take the treatment."*

The study by Tshililo and Davhana-Maselesele (2009) sought to understand the environment that patients living with HIV/AIDS are exposed to by investigating the experiences of family members caring for patients with HIV/AIDS at home. Patients were discharged from the hospital and there was almost no contact with them until they were readmitted in a deteriorated state of health. The health workers were not aware of the context of the care by family members that the patients were exposed to in order to render appropriate care to their sick patients (Tshililo and Davhana-Maselesele, 2009).

Rujumba et al. (2010) discovered some challenges concerning the care of children with HIV and some of them were lack of support by the caregivers and the situation makes them look up to the professional nurses to meet all their needs. Caretakers of the children found it difficult to visit the health care facilities due to lack of money for transport and lack of consistency. Some of

the caretakers thought it was a waste of money since the children would die soon.

This study reflected the negative impact on the services rendered by professional nurses and its relationship to HIV/AIDS. Participants indicated that they seldom got support from the family members regarding the care of their own relatives. Moreover, family members were afraid of their relatives who would be a patient at that time. There are those family members who understood and had knowledge on HIV/AIDS, but are reluctant to help. Some family members do not take their patients home upon discharge and this keep the hospital beds occupied at all times which made it difficult for other patients to be admitted.

One professional nurse expressed the concern as follows: *"This situation affects the ward because other patients with acute conditions cannot be admitted because the beds are occupied. There is nothing we could do but always encourage the families to take the patient home and advise them that the patient can still be taken care of by the home-based carers."*

The study conducted by Melesse and Jemal (2010) reinforced this study in that the HIV epidemic will result in more and more people having health problems which will increase the burden and pressure on hospitals. One of the most obvious consequences of HIV/AIDS patients are the increased occupancy of hospital beds, suggesting that only 81.1 % of the beds are for all other afflictions in the hospital. It appears that there is a lot of concern that patients with HIV/AIDS are competing with the non-HIV infected patients in

resource-limited areas. Therefore, home-based care with a higher level of family member or community involvement and greater use of existing community resources might be a response to such limitations of curative hospital-based care and treatment needs of many HIV/AIDS patients (Melesse and Jemal, 2010).

4.3.5 Theme 5: Patients' Presenting Conditions

This theme presents the patients' conditions on admission and the chances of survival due to the intensity of the presenting diagnosis. This will depend on the damage that the disease has already caused and the rate at which the disease has progressed. When these patients are admitted, they present differently. Most patients present with some degree of confusion and mental disturbances that seem to be disturbing and difficult for the nurses to provide adequate and quality care to them. Some patients' conditions may change in the process of care as the side effects of treatment set in.

4.3.5.1 Sub-Theme 5.1: Poor Prognosis

Because of late diagnosis, patients are at a higher risk for AIDS diagnosis when they are found to be HIV-positive, which may require immediate hospital admission. The presence of an opportunistic infection is predictive of a higher mortality rate as well as an extended hospitals stay (Oramasionwu et al, 2009).

In this study, the patients' poor prognosis was also part of the participants' experiences. One professional nurse expressed a feeling of depression because these patients come too late to the hospital and most of them did not

survive: "*They come to hospital being very sick, coming from the peripheral hospitals and the prognosis is poor because they have already complicated. It has also been mentioned that some patients start with their traditional medication and come to hospital when it is already too late to recover*".

Dageid, Sedumedi and Duckert (2005) and Mashele (2012) corroborated that patients still go out seeking traditional explanations and treatments for their symptoms. Health workers noted that it was often difficult to motivate these patients to take an HIV test or to seek medical attention at an early stage of the disease, before their symptoms were pronounced. The following sentiments were expressed:

"When most patients come to the hospital they are already in the terminal stage or Stage IV of the disease progression whereby there is little chance of survival and recovery."

"Most of them the prognosis is very good and it is a problem when they come when they are already at Stage 4 whereby the prognosis is very bad."

Studies by Berhe, Melkamu and Amare (2012) and Nakanjako, Kyabayinze, Mayanja-Kizza, Katabira and Kamya (2007) revealed that most of the patients with neurologic manifestations of HIV/AIDS had advanced disease at presentation which was evidence that almost all were in Stage IV, many had low CD4-positive counts and most had opportunistic central nervous system infections as the leading aetiologies. The majority of patients were diagnosed to have HIV infection at admission and only a few patients were on ART and cotrimoxazole prophylaxis.

A study conducted by IRIN Humanitarian News and Analysis Service (2011) at Princess Marina Hospital in Botswana was reported by Bodilenyane and Motshegwa (2012) whereby it was revealed that people who sought treatment do so when they were already in the terminal stage of illness, a situation which forced the hospital to re-admit them.

Jameson (2008) also supported this study with the observation that most patients with AIDS present at a late stage to hospital because of issues of denial, failure to have VCT, and fear of stigma. At this late stage, the patients with AIDS are generally weak and have a large number of symptoms which predispose hem to an early death prior to initiating treatment with ARVs. The medical perception that the patients were terminally ill often results in a lack of further investigation or treatment (Jameson, 2008).

Abaynew, Deribew and Deribe (2011) bolstered this study by revealing that HIV-positive individuals who have symptoms/sickness at HIV diagnosis were significantly associated with late presentation to HIV/AIDS care, which is consistent. This could be partly explained by the fact that people living with HIV/AIDS presented late in the course of their disease or, more likely, had been diagnosed at advanced stages of disease progression (Abaynew et al, 2011).

4.3.5.2 Sub-Theme 5.2: Patients' Behaviour: Confusion and Signs of Mental Disturbance

The professional nurses who participated in this study indicated that the presenting conditions of most patients became unbearable to the extent that

they ended up cuffing the patients to their bed because they could not cope with their conditions. Their confusion was so disturbing that patients did not follow the orders or instructions from the professional nurses, and they displayed these through their actions. Some patients came to hospital in a good state of mind, well-orientated, but later changed when they started the ARVs due to the side effects. These experiences were expressed their experiences as follows:

"Not all of them are like aggressive, the only patient I can remember came and was fine, but after starting the medication he started having the side effects. Mentally he was very confused, talking to himself and it was said that it was one of the side effects of the medication. The patient was referred back to Hope clinic where they changed the medication and he improved after that."

In support of this study, Freeman and Thom (2006), Gallego, Barreiro and Lopéz-Ibor (2011) and Wong (2010) reported that HIV-infected patients who received ART infrequently suffered acute organic complications; the chronicity of the disease placed them at greater risk of psychiatric comorbidity than the general population. They had mania or hypomania, which might have been the result of a bipolar disorder, substance or alcohol, progression to AIDS, or side effects to medication, for example, zidovudine, ganciclovir, acyclovir, interferon, efavirenz, steroids and meperidine (Freeman and Thom, 2006).

A professional nurse also indicated that patients did present to hospital with some degree of mental disturbance especially when they had not been taking treatment at home. The treatment was meant to improve and control their

mental and emotional health and if patients defaulted they then showed signs of confusion and disorientation. This experience was expressed as follows: *"Yes, most of the patients, especially when they have defaulted, when they do not take the medication as prescribed, they become confused, disorientated sometimes."*

The sentiments and experiences expressed by professional nurses in the present study are in agreement with reports presented by Chan, Stoové and Reidpath (2008) and Beard, Feeley and Rosen (2009) that the patient worsened neurologically, becoming incontinent and acutely agitated, requiring medication with antipsychotics. These participants also mentioned that the patients presented with varying conditions, in a different state of mind like being confused and disorientated, most especially after they had defaulted their treatment.

Woodring, Cancelli, Ponteretto and Keitel (2005) described HIV/AIDS as a devastating disease that inflicts physical injury and mental anguish. It is therefore expected that people living with HIV/AIDS will suffer significant psychosocial consequences that tend to be chronic. Great contributors to the psychosocial challenges that people living with HIV/AIDS face are its association with fatality, its unpredictable progress toward terminal illness, and the lack of a cure (Woodring et al, 2005).

The study conducted by Freeman et al. (2010) showed no significant associations between CD4-positive counts and the presence of a mental disorder. However, a very strong association was found between depression

and disease stage. While in Stages 1 and 2, mental disorder differences were minimal, at Stage 3 respondents had identifiable psychiatric diagnoses and at Stage 4 respondents were diagnosed with mental disorder.

4.4 Guidelines to Support Professional Nurses

Based on the results discussed in this chapter, guidelines were developed to support professional nurses providing care to HIV/AIDS patients. Guidelines can help clinical facilitators reduce inappropriate variations in education practice; provide a focus for continuing nursing education and promote the efficient use of healthcare education resources (Muller, 2002). In-service education refers to the education of personnel that is directly related to their work (Muller, 2002).

This study explored professional nurses' experiences, their level of knowledge, and attitudes as they provided health care to people living with HIV/AIDS. The content of in-service education guidelines will include training and knowledge, and attitudes sections.

4.4.1 Support for Professional Nurses

Interventions to support and assist the professional nurses are proposed, so that they improve their stress management skills, the quality of care rendered to people living with HIV/AIDS and make the workplace safer for both health care providers and patients. The United Nations General Assembly Special Session on HIV/AIDS (2007) reported that the HIV/AIDS and Sexually Transmitted Infection (STI) National Strategic Plan for South Africa is a major threat to the full implementation of its interventions to provide treatment, care

and support because of unavailability of sufficient quantities of skilled personnel. Therefore, South Africa has already found innovative ways to mobilize local communities to participate in the provision of services and the strategies have been successful in promoting access to services.

4.4.1.1 In-Service Training Guidelines

Mo's (2006) study stated that one of the independent functions of a nurse is education. In order to fight the spreading of HIV/AIDS in South Africa, registered nurses have to acquire adequate knowledge and appropriate attitudes to provide patients and sub-categories of nursing personnel with effective education. For the purpose of this study, in-service education guidelines related to the prevention of all the problems experienced in the care of HIV/AIDS patients. Each facilitator using these in-service training guidelines needs to design his or her own in-service programme which is highly relevant to the development of nursing skills and nursing knowledge.

This study proposes that it would also be of an advantage for the professional nurse to receive adequate information, skills and training with regard to HIV/AIDS issues so that they are able to render quality care to the patients and at the same time develop a sense of job satisfaction. It is important for professional nurses to enjoy what they are doing on daily basis and the following strategies could serve as a guide:

★ Schedule regular in-service training for the staff in the medical wards.

✸ Plan to use a staff rotation system to encourage staff members to attend the HIV courses provided by the nursing services.

✸ Encourage staff to plan to use precautionary measures at all times when performing any procedure that involves body fluids of patients.

✸ Encourage staff to seek further information and new developments on HIV for self-empowerment.

International Labour Organization (ILO) and World Health Organization (2005) guidelines indicate that education and training should be designed to meet the needs and situations of the different groups being educated or trained. Employers should consult the relevant authorities for further information on training and collaborate with workers and their representatives, and professional associations, in the development of education programmes and training materials. To the extent possible, larger hospitals, particularly teaching hospitals, and other specialized health services should cooperate in developing knowledge-exchange mechanisms designed to provide education, training and information to smaller health services, including occupational health services, and to community services and home caregivers. They should seek up-to-date scientific knowledge from national, and international, academic and research institutions, including professional associations (ILO and WHO, 2005).

4.4.1.2 Encouragement of Management Support

De Cock and Grubb (2006) highlighted the guidelines stipulated by WHO and amongst them is the call for vigorous efforts to tackle health system challenges. These include inadequacies in human resources, laboratory and other infrastructure, systems to procure and supply drugs and other commodities, and overall administrative and management capacity. This will be made possible by engaging in long-term programmes for encouragement.

WHO (2007) suggested guidelines for a supportive supervision whereby the plan should include measures to ensure that all health workers receive supportive supervision which, in turn, requires well-trained and well-prepared supervisors. The plan should address the resources required to provide regular supervision and to do so on site whenever possible. Supportive supervision is one way of providing quality assurance.

4.5 Conclusion

These guidelines are mainly aimed at assisting the professional nurses to cope well with the care and management of patients with HIV/AIDS. Regular in-service training will provide the processional nurses with the necessary, recent and new developments on care and management of people living with HIV/AIDS. The professional nurses need regular encouragement and support from the hospital management so that they cope and feel fulfilled.

CHAPTER 5

CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

5.1 Introduction

In this chapter the results of the data analysis will be summarised in order to draw conclusions so that in-service education guidelines are implemented in reducing the problem experienced by professional nurses as they provide health care to patients living with HIV/AIDS. Limitations and recommendations of the study will also be discussed.

5.2 Conclusions

This study has explored the problems experienced by professional nurses regarding the health care provided to patients living with HIV/AIDS in the public hospitals of Polokwane municipality. These professional nurses have been allocated in the medical units for a reasonable period of time and this made them more experienced and they still do their best in providing the care, irrespective of the problems they are faced with. They experienced problems related to the poor support they get from the families. The management was found to be lacking in staff counselling and support services so that they are unable to cope with the prevailing circumstances.

Another experience is the non-disclosure of the HIV-positive status by patients, either to the nursing staff or their families and this causes a negative

impact on the initiation of treatment and poor prognosis at the time of admission. Professional nurses also saw the need for extended knowledge, especially regarding treatment so that they are able to identify the normal and abnormal presenting conditions of the patients and, at the same time, be able to advocate these patients.

The patients' presenting conditions to the hospitals, the length of stay and prognosis are the most crucial circumstances that the professional nurses are faced with. These patients present with some psychological and mental challenges, their stay in hospital is prolonged, making it difficult for admission of other patients with acute conditions. Most patients are brought to hospital when their condition is difficult to treat and there are no chances of recuperation.

The professional nurses feel obliged to render quality care to the patients, irrespective of their circumstances, but are also concerned about the lack of support they receive from the management and family members of their patients. Professional nurses face threats by family members for the patients' failed conditions and are expected to take all the blame.

5.3 Limitations

This study was conducted in one tertiary hospital (Polokwane Hospital) in the Capricorn District, Polokwane Municipality in Limpopo Province. Hence, the findings of this study cannot be generalized to other hospitals in the province and other provinces in the country. The limitation was partly addressed by the

fact that most hospitals within the province refer their patients to this hospital

for specialized management and care.

5.4 Recommendations

This involves a few standards that could be utilized in order to achieve the best results in the provision of health care to the people living with HIV/AIDS and the awareness of the pandemic. If these recommendations are carefully and correctly followed there will be better nursing practices and involvement of the patients, family members and the entire community. Recommendations are arranged according to the themes that emerged in Chapter 4.

5.4.1 Theme 1: Feeling of Frustration and Emotions

It is recommended that people who live with HIV/AIDS be encouraged to seek, access and commence treatment at early stages of diagnosis (Valdiserri et al, 2008). This will help to maintain their stable mental state and, therefore, they will not show any signs of aggression and disorientation upon admission to the hospital which leaves the professional nurses with feelings of frustration and emotions. Once the treatment is started and adhered to the patient's length of stay at hospital will be reduced and a good health status maintained (Valdiserri et al, 2008).

Richter et al (2009) emphasised that family members need to understand the impact of HIV/AIDS on the patients and therefore understand the need for these patients to be supported and still be accepted as part of the family. They need to recognize the dangers of rejecting and discriminating against infected individuals as these elements make it difficult and impossible for the patients to disclose their status and therefore they will not access health services and treatment. Family members should also be encouraged to be

part of these patients' treatment and be a source of encouragement, so as to make adherence easy and prevent them from defaulting their care and treatment. These patients should be encouraged to live positively with their status and also accept all the efforts of care provided by the professional nurses when admitted to hospital (Richter et al, 2009).

The available policies regarding the precautionary measures should be followed as this will then reduce the risks and fears of being infected. Safety equipment should be available at all times to avoid excuses by care providers. Regular demonstration and supervision by the infection control personnel should be done in order to detect the needs and achievements. This will also assist in the planning and arrangement of in-service training.

The number of the available professional nurses in hospitals makes it difficult for the people living with HIV/AIDS to receive adequate care. These shortages of staff make it challenging for patients to get post-counselling services, thus making it difficult for them to cope with their health status. The result thereof is that the available professional nurses also cannot manage to satisfy the patients' needs. Professional nurse who have left this profession for other ventures should be encouraged to return and make a difference in the patients' lives. Another input would be to encourage other professional nurses to rotate in the medical wards so that they are equally exposed to these patients' care requirements.

Despite clear policy directives encouraging routine HIV testing among U.S. health services, substantial evidence exists that HIV testing is underutilized

throughout the health administration system. "Among the documented barriers to HIV testing in the health system is "lack of provider prioritization of HIV testing and the time needed for pre- and post-test counselling" (Valdiserri, Rodriguez and Holodniy, 2008). It is essential for professional nurses to provide patients with reasonable time of pre- and post-test counselling so that patients are encouraged and provided with ways to accept their current health status and also have knowledge on further coping mechanisms.

For voluntary HIV testing, pre- and post-test counselling should be done to enable test results to be communicated to the person tested or, in the case of minors, to parents or guardians. The main aim is to reassure and encourage the 85-90% of the population who are HIV-negative to take definitive steps not to become infected, and those who are HIV-positive to receive the necessary support in counselling and care to cope with their status, prolong their lives and not to infect others (Government of Samoa, 2011).

5.4.2 Theme 2: Delay of Treatment

Patients and family members need to be educated regarding HIV/AIDS so that they know exactly when to seeking medical help. People should get tested regularly in order to know their health status and also when their status changes to be positive. In this way, there will be few patients who ignore their HIV-positive status and also disregard the chances and advantages of getting early treatment to avoid secondary complications.

Disclosure of an HIV-positive status will also be of help to the patients and to the professional nurses, and other health care professionals because they will

be able to know what they are dealing with and provide the patients with the necessary guidance. This will assist the patients to accept themselves and therefore deal with the status in a more effective way. These patients should also be encouraged to disclose their HIV-positive status to the immediate family members so that they are able to take care of them and take necessary steps when the condition changes.

5.4.3 Theme 3: Knowledge of HIV/AIDS

There are a few practices that could be undertaken to assist the professional nurses to acquire the required knowledge on HIV/AIDS issues. These are arranged as follows:

5.4.3.1 Nursing Practice

As the experience in caring for HIV/AIDS patients influence the level of the knowledge and coping skills of professional nurses and attitudes towards these patients, encouraging the professional nurses to participate in nursing patients with HIV/AIDS will advance the level of their knowledge and therefore improve the quality of these patients' care in public hospitals.

It is necessary for professional nurses together with other categories of nurse to be involved in the health care of people living with HIV/AIDS to have the necessary knowledge and information. The practices should be guided by policies and procedures that have to be followed and reviewed when due so that they are in line with the changing phases and the new trends of the epidemic.

Professional nurses should be taught and encouraged to increase their knowledge on HIV/AIDS and also have skills and capabilities on encouraging people living with HIV/AIDS to freely disclose their status to the healthcare team members for better and achievable outcomes of care and these patients also need to learn and know more on self-care. They should encourage these patients to live optimistically with their HIV status and be treated same in the same ways as any other patient with a chronic disease.

5.4.3.2 Nursing Education

The guidelines designed in this study should be used as standards for in-service education and evaluation of nursing practitioners. Professional nurses need in-service education and training on the new developments in epidemiology, disease presentation, diagnosis, prognosis, treatment and management of HIV/AIDS so that they can become better skilled in providing optimal care to patients. Professional nurses should acquire adequate knowledge and education regarding the treatment of HIV/AIDS, especially ARVs. This will enhance their understanding of the purpose of various treatment regimens, the effects and the contraindications, and how to cope with the normal and abnormal presentations of patients in the clinical setting.

A study conducted by Lehmann (2008) in order to improve primary health care (PHC) service delivery and coverage made three recommendations, namely, the current slow production of nurses has to be substantially accelerated to catch up with the growing demands and attrition, skills development and the re-orientation of educational curricula towards PHC have to remain a priority, and the training of mid-level and community-based cadres requires urgent acceleration and standardization.

5.4.4 Theme 4: Social Support System

The professional nurses lack support from both the hospital management and patients' families. It is accordingly recommended that hospital management arrange and provide sustainable counselling programmes for professional nurses in order to encourage them to provide adequate and proper care for

patients. The care provided by the professional nurses could be strengthened if they are also psychologically bolstered. The health managers should also be physically present to boost the morale of professional nurses and attend to those problems and challenges that are beyond their capabilities.

The knowledge that family members will acquire would make them understand and appreciate the noble intentions and services provided by professional nurses to people living with HIV/AIDS. They will realize the need and importance of taking their sick relatives to the hospital without any fears and doubts of the level of care they would receive. It is also recommended that they utilize the knowledge productively so that they understand exactly what is happening in their relatives' lives and be able to offer the necessary support to the professional nurses as they provide care to PLWHA.

5.4.5   Theme 5: Patients' Presenting Conditions

The study by Richter, Bayern, Klippex and Heidare (2010) expressed that families are the primary sources of behavioural patterns, and interventions involving the entire family may positively influence risk reduction and health-seeking behaviours and may even help to overcome disparities in access to treatment and health care observed between men and women.

There is an urgent need for family members to receive the necessary education and knowledge regarding HIV/AIDS so that they know exactly what is expected of them when one of their members is infected and how they are affected. They must be able to identify when the patient needs further management and care by professional nurses or needs to be taken to hospital

for professional care. They also need to become familiar with the concepts of self-protection as they provide care and prevention of complications and self-infection.

The family members must also receive frequent counselling because it may not be easy for them to cope with the situations they are faced with, especially upon disclosure of their members' health status. Counselling could improve their understanding of coping mechanisms that could benefit the patients as they might then feel accepted and free to talk about their conditions. Counselling should help the family members to talk honestly and openly to the infected individuals about matters concerning their conditions. Family members should also seek the necessary information about HIV/AIDS for personal development and empowerment, and to enable them to encourage patients to seek medical help promptly.

The knowledge acquired by family members could also help patients understand all the health changes and challenges they encounter, as their health status might fluctuate, showing some deterioration that would need urgent and proper attention. Through proper and adequate counselling, people living with HIV/AIDS will be able to know the actions and side effects of the prescribed medication and notice when these changes takes place. They will be aware of the dangers of defaulting the treatment as this will have a pronounced impact on their mental state.

5.4.6 Education and Counselling for Relatives

The first strategic direction proposed by De Cock and Grubb (2006) recognizes that wider access to HIV testing and counselling is essential. Data from recent surveys in heavily affected countries show that fewer than 10% of HIV-infected persons know whether they are infected. There has been a move towards offering HIV testing more routinely in health care settings, as well as a re-evaluation of the intensity of pre-test counselling (De Cock and Grubb, 2006).

The need to support families is also important because the responses by families have come with costs, sometimes also to their integrity and functionality (Richter, Sherrc, Adato, Belsey, Chandan, Desmond, Scott, Haour-Knipeh, Hosegood, Kimou, Madhavan, Mathambo and Wakhweya, 2009). However, Abebe and Aase (2007) emphasized the need for social protection, including stronger mechanisms of social justice and social welfare in highly affected communities. Given the primary role families are playing in responding to the epidemic, strengthening the capacity of families through systematic, public sector initiatives has been identified globally as one of the most important strategies.

5.4.7 How to Reach Out to Patients' Relatives and Community

The awareness of the HIV Counselling and Testing (HCT) campaign and its related aspects should be provided to community members to emphasize the importance of being tested so that their health status is known and attended to before the condition complicates. The campaign should involve all health care stake holders as they play an equally important role in these patients' health. This platform would also make it possible for the health care providers to talk

about the challenges they experience as they provide care to infected individuals.

The study conducted by Van Rensburg (2004) suggested the education campaigns that had to focus on increasing public knowledge and self-protective behaviour regarding HIV/AIDS have had a varied impact. In the context of the present study, it would be helpful as it will not only give them all the necessary information, but at the same time highlight the need for support and care to their infected and affected individuals.

Community awareness campaigns to reduce stigmatization are necessary in order to promote acceptance of those affected by HIV/AIDS. Activities aimed at reducing the stigma and the resulting isolation must also include the facilitation of access to health and social services by people living with HIV/AIDS and their caregivers. There is also a dire need for social and spiritual supports as coping mechanisms for people living with HIV/AIDS in order to promote expression of emotional and psychological distress that can ease the burden of the disease.

A door-to-door campaign can likewise be of great importance for reaching out those community members who are unable or reluctant to attend the organized campaigns. In most cases, these campaigns are effective as they are able to locate the people at risk of compromised health conditions and rescue those who need urgent and hospital care. The campaign will also help in detecting the environment - the family's functional state these patients live in. This will facilitate in determining if these patients will be able to be taken

care of at home or if they need special care like being placed at home-care facilities. Home visiting programmes in particular, seek to improve outcomes for children by targeting parenting knowledge, beliefs and practices, and by providing essential social support and practical assistance (Richter et al, 2009).

5.4.8 Further Research

There is a need for further research in this field. Similar studies can be conducted throughout the country to either confirm or reject the findings of this study to ascertain the level of the problem. This study should be repeated at all levels of health care workers in order to consolidate views of their experiences and also to determine their challenges. This, again, will help the researchers to check if the experiences are equivalent in all categories and enable them to come up with recommendations that will assist them overcome such challenges and obstacles that make it difficult to render their services.

The same study can still be conducted at other hospitals so that these results could be compared and more definite conclusions reached. This study was conducted at a tertiary institution and can further be conducted at the provincial peripheral (secondary) hospitals to experience how the professional nurses cope with the care of people living with HIV/AIDS.

An attempt can also be made to research the challenges experienced by management as they are always expected to offer support to the professional nurses when they encounter stumbling blocks within the services they provide. They are expected to unconditionally support these nurses and, at the same

time, could be having their own challenges that need to be considered and understood by every staff member. This is because most of the professional nurses who participated in the study did not appreciate the support they received from the hospital management, except that they were mostly supported by the unit managers.

Many challenges are faced by family members of PLWHA after the disclosure of HIV status. There is therefore a need to assess their level of understanding, knowledge, information acquired and ability to accept the infected individual. They are in a way affected by the change of status, but how do they then cope with the present situation?

Further research could be conducted on the availability of home-care settings in the communities in order to check if there are enough facilities and resources to provide for these patients. This will also help to determine if the community- or home-based care workers have the necessary knowledge and skills to provide care adequately. The productivity of the home-based care workers will reduce the risks of HIV/AIDS patients complicating and deteriorating.

5.5 Achievement of the Set Objectives

Chapter 1 of the project outlined the objectives of the study and the researcher managed to achieve the set goals. The first objective was to determine the problems experienced by professional nurses who provided health care to PLWHA in public hospitals of Polokwane municipality, Limpopo Province. This objective was achieved as the professional nurses expressed their

experiences during the process of care to their patients. Different views and experiences were expressed as areas of concerns and there were both positive and negative feelings about their experiences, but all these never obstructed or prevented them from rendering care to their patients. The second objective was to develop guidelines to support professional nurses in rendering patient care. These were outlined in Chapter 4, section 4.3.1.1.

5.6 Conclusion

This chapter has presented the conclusions, study limitations and recommendations that have been put forward in relation to the significance of the study for improving quality health care to PLWHA. The chapter also covered suggestions for further research opportunities in the field.

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APPENDIX 1

MEDUNSA RESEARCH AND ETHICS COMMITTEE
CLEARANCE LETTER

UNIVERSITY OF LIMPOPO
Medunsa Campus

MEDUNSA RESEARCH & ETHICS COMMITTEE

CLEARANCE CERTIFICATE

MEETING: 09/2011

PROJECT NUMBER: MREC/HS/195/2011: PG

PROJECT:

Title: Problems experienced by professional nurses providing care
for HIV/AIDS positive patients in public hospitals of Polokwane
municipality, Limpopo province

Researcher: VL Mametja
Supervisor: Dr ME Lekhuleni
Co-supervisor: Dr JC Kgole
Department: Nursing Sciences
School: Health Sciences
Degree: Masters of Curationis

DECISION OF THE COMMITTEE:

MREC approved the project.

DATE: 15 November 2011

PROF GA OGUNBANJO
CHAIRPERSON MREC

Note:
i)   Should any departure be contemplated from the research procedure as
approved, the researcher(s) must re-submit the protocol to the committee.
ii)   The budget for the research will be considered separately from the protocol.
PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES.

Finding Solutions for Africa

APPENDIX 2

CONSENT FORM

UNIVERSITY OF LIMPOPO (Medunsa Campus) ENGLISH CONSENT FORM

Statement concerning participation in a Clinical Trial/Research Project*.

Name of Project

PROBLEMS EXPERIENCED BY PROFESSIONAL NURSES CARING FOR HIV/AIDS PATIENT IN THE PUBLIC HOSPITALS OF POLOKWANE MUNICIPALITY, LIMPOPO PROVINCE.

I have read the information on the proposed study and was provided the opportunity to ask questions and given adequate time to rethink the issue. The aim and objectives of the study are sufficiently clear to me. I have not been pressurized to participate in any way.

I know that sound recordings will be taken of me. I am aware that this material may be used in scientific publications which will be electronically available throughout the world. I consent to this provided that my name / and hospital number is not revealed.

I understand that participation in this Project is completely voluntary and that I may withdraw from it at any time and without supplying reasons. This will have no influence on the regular treatment that holds for my condition neither will it influence the care that I receive from my regular doctor.

I know that this Project has been approved by the Medunsa Campus Research and Ethics (MREC), University of Limpopo (Medunsa Campus) / Dr George Mukhari Hospital. I am fully aware that the results of this results of this Project will be used for scientific purposes and may be published. I agree to this, provided my privacy is guaranteed.

I hereby give consent to participate in this Project.

GN Gongazhe ....   Gongazhe ....
Name of volunteer   Signature of volunteer.

Polokwane Hosp   17/02/2012 ....
Place.   Date.   Witness

Statement by the Researcher

I provided verbal and/or written* information regarding this Project
I agree to answer any future questions concerning the Project as best as I am able.
I will adhere to the approved protocol.

N. Mamethi ....   Mamethi ....   2012/02/17 ....
Name of Researcher   Signature   Date   Place

APPENDIX 3

PERMISSION TO CONDUCT THE STUDY

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH

Enquiries: Selamolela Donald

Ref:4/2/2

Mametja VL

University of Limpopo

Durban

4000

Greetings,

Re: Permission to conduct the study titled: The problems experienced by professional nurses caring for HIV/AIDS patients in public hospitals of Polokwane Municipality, Limpopo Province.

1. The above matter refers.

2. Permission to conduct the above mentioned study is hereby granted.

3. Kindly be-informed that:-

   - Further arrangement should be made with the targeted institutions.

   - In the course of your study there should be no action that disrupts the services.

   - After completion of the study, a copy should be submitted to the Department to serve as a resource.

   - The researcher should be prepared to assist in the interpretation and implementation of the study recommendation where possible.

Your cooperation will be highly appreciated.

_____
Head of Department

2011/12/29
Date

The heartland of Southern Africa – *development is about people*

APPENDIX 4

INDEPENDENT CODER'S REPORT

CODING OF THEMES AND SUBTHEMES
MAMETJA VL
STUDENT NUMBER: 200204157

THEME 1: Feeling of frustration and emotions

Subtheme 1.1: Feeling of helplessness

- 10# They also think it is the end of their <u>lives</u>…

Subtheme 1.2: Fear of patients and relatives

01# The quotation is not clear particularly the last three sentences. Let the quotation reads as follows:
now they will plot you, they will be saying that sister, that nurse is so we will get her and nurse so and so we will get her. And it does happen, it does, people are stabbed in town, wherever for nothing

1.3 Fear of occupational injuries

01# "Sometimes we are afraid more especially if you can be pricked by a needle"

- The other explanation does not relate to the subtheme

THEME 2: Delay of treatment

SUB-THEME 21: Non-disclosure of HIV/AIDS status

01# *Others…meaning they go from Pietersburg hospital to get the medication…hiding it, then they go to Seshego hospital and is the same story then they go to Mankweng Hospital … when he is in Pretoria it is then that he can say…*

02# *The problem…knew the status all along…*

*Subtheme 2.3: D*elete the sentence: Do you have a policy…

SUBTHEME 2.4: Lack of trust and confidence

06# Both quotations relate to confidentiality. I recommend that you substitute lack of trust and confidence with lack of confidentiality

Theme 4: Social support system

4.1: Lack of family support

- Delete the non- appreciation of service
- Transfer 01# to emotional threats
- Add another sub-theme of lack of appreciation. Then 02# will fit into the subtheme. Note the spelling of <u>save</u> life …
- 05# Does not belong to the theme and sub –theme.

4.2 Management support

08# Delete: those ones I have never come across. Start the quotation with *The unit manager gives us*

support and I don't know if others get support from the hospital managers

5.2 Poor prognosis

- I suggest that you should have another theme that relates to the prognosis of patients e.g. condition of the patients

03# transfer this subtheme to subtheme 1.1 as it relates to depression

5.3   Please add another theme that relates to patient's behaviour because the subthemes relate to the patients' behaviour and not to work overload

APPENDIX 5

EXAMPLE OF A CONDUCTED INTERVIEW

PARTICIPANT 10

Date: 2012-02-06

R: **Good morning sister.**

P: Good morning to you too.

R: **What are your basic nursing qualifications?**

P: I did General Nursing, midwifery and psychiatry and community. Then I also did diploma of child nursing science.

R: **How long have you been allocated in a paeds medical ward?**

P: I think is now 10 years.

R: **Has it all been in paeds medical ward or did you work in other units?**

P: I worked in adult medical wards before I came here but it was just for 3 months.

R: **What are the problems that you experience while providing care to patients with HIV/AIDS?**

P: Most of them have got denial; they do not accept themselves and find that they do not have confidence. They also think it is the end of their lives and sometimes find that they are even aggressive to us even before you know that they are like that and you find that they already have an attitude because they think everybody knows their status. When you approach them the way they respond, you will see that there is a problem and when you find out you will see that maybe this person thought that I knew the status.

R: **While you did not?**

P: Mmm … while we did not. I think that's what I have experienced. And some of them like the ones that are already on treatment, you find that they still have that believe that they have been bewitched and they don't believe that it is the virus and they just think that it is witchcraft. Then you find that some of them default like now we have one who defaulted.

R: **What is the impact of HIV/AIDS on professional nurses? How do you feel while providing care to these patients?**

P: Eish ... is so painful, to see a child dying there. Actually we are affected emotionally and psychologically. Sometimes we feel that we need counselling also.

R: **Do you often get something like that?**

P: No … and most of the time when we interview them, most of them are brought by their grannies and that's why we find that it really painful and it affects us because when we interview the granny, will tell you that the mother is late and the father is late so I am the only one. Then you ask yourself what will happen to this child if the granny also passes away.

R: **Do the grannies come knowing what they are dealing with, and knowing how to handle the patient?**

P: They don't know.

R: **So you start from the beginning?**

P: Mmm … it's only a few but most of them don't know and find that they even touch everything like blood bear handed so they don't have any idea. It is really bad because some of them are our relatives, our neighbours so it's really difficult like myself I am coming from the nearby township and find that most of them are my neighbours, I know them and when I am at home they think maybe I will tell others about their condition.

R: **So they don't trust you?**

P: Mmm … they lose trust and so we try by all means to tell them is a confidential issue.

R: **Do they understand after explaining that, do they open up and talk to you?**

P: Ja some, isn't it that people are not the same. I was doing VCT and I even said I wasn't going to do it because I stay with them, I know them and find that they don't trust me. But like now we have got a counsellor at least it is much better.

R: **Is the counsellor here on daily basis?**

P: Mmm … everyday.

R: **How long do your patients mostly stay in hospital?**

P: It depends whether it is a newly diagnosed and it depends on the condition because some of them who are already diagnosed and find that they come here critically ill, they spent close to maybe a month in hospital. But if they are maybe newly diagnosed and the condition is not bad then they don't spent a long time.

R: **Ok! Do you often have patient coming from the neighbouring countries like Zimbabwe and Mozambique?**

P: Ja…, we do.

R: **Like when they come, do they have visitors?**

P: No they don't have visitors most of the time unless if she stays with the husband. Some they have but you find that it is only the husband.

R: **Do you often get cases whereby they have been discharged but there is no one coming to fetch them?**

P: We have that and I even took one to my house, she didn't have a place to stay and she stayed for a few months and then got herself a place to stay.

R: **How was the condition when she left?**

P: The child was ok it is just that she had delayed milestones. She was not bad.

R: **Do you have safety routines in the hospital that guides you on how to handle these patients, e.g. precautionary measures?**

P: Hmm … we know that we must treat every patient as if he is HIV positive. We wear gloves when we insert drips, doing blood glucose**.**

R: **Do you always have them available or are there times where you find yourselves without any?**

P: Mmm… there are times when there is nothing, like now we only have the sterile gloves and the disposables are not there. And if there is nothing what to you do? Hmm… we just trust

God for protection, what will we do... laugh…

R: **Do you still continue providing care?**

P: Mmm … and during an emergency sometimes you find that you are not even wearing gloves and after that you ask yourself 'why didn't I wear the gloves' and you had to help the patient.

R: **Do you get the hospital management coming down to the ward for support?**

P: Eish… most of the time when the management come it will be to complain, for support no.

R: **How then do you handle your challenges, how do they get discussed?**

P: Mmm… we've got a book which we give the mother lodger during discharge to record everything in there, the complements and the complains, then they also write their numbers and I am one of the members for the Batho Pele committee and we do follow-up and even the unit manager will do a follow-up by phoning that person and try to find out what is the problem. We try to reassure her and if the problem can be solved then they solve it and we also have a suggestion box and we encourage them to write including the visitors and sometimes we even encourage them during morning prayers to talk, be open enough and talk to the unit manager.

R: **How do you then handle the challenges that nurses come across while providing care? Isn't it that the managers are not always here to give support…**

P: Mmm …

R: **How do you then sort them out?**

P: Sometimes we phone them, like maybe during the night and the weekend, there is one on call. Sometimes when we call them they will say "it is not our responsibility solve in your unit" but sometimes they help us**.**

R: **Ok!**

P: Like we used to have a problem with the father lodgers and some of them when we tell them they could not stay they got very angry and we didn't have a policy to cover us but now we are alright there is that policy and they understand.

R: **Is your service often appreciated by patients, parents and relatives?**

P: Mmm… most of them appreciate.

R: **How do they show it?**

P: They will just say thanks and even when we read in the book and find that they have written: "thank you for everything you did for my child".

R: **How is the patients' prognosis in most cases?**

P: Eish… most of them come being critically ill and about 90% who are already being diagnosed and who are already on treatment are doing well. The problem is those who didn't test or who defaulted. Most of them are doing well because if the child is sick they bring the child to the hospital.

R: **Is there anything that you would like to add on the information that you have given?**

P: I think it is enough. I have covered almost all.

R: **If that is the case I thank you very much, hope next time we will get the same response and participation.**

P: Thanks.