

**THE IMPACT OF HIV/AIDS ON HEALTH CARE PROVISION: PERCEPTIONS
OF NURSES CURRENTLY WORKING IN ONE REGIONAL HOSPITAL IN
NAMIBIA**

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KEYWORDS

Burnout

Perceptions

HealthCare Provision

Workload

Stress

Low morale

Absenteeism

Risk

Contracting HIV/AIDS

Health workforce

Human resource for health



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ACRONYMS

ARV FGD	-	Antiretroviral
HIV/AIDS	-	Focus Group Discussion
HR	-	Acquired Immunodeficiency Virus
HRH	-	Human Resources
HARM	-	Human Resources for Health
HW	-	Human Resource Management
MOHSS	-	Health Workers
PMTCT	-	Ministry of Health and Social Services
TB	-	Prevention from Mother to Child
UK	-	Tuberculosis
UNAIDS	-	United Kingdom
USAID	-	United Nations Against AIDS
UWC	-	United States Agency for International Development
WHO	-	University of the Western Cape
	-	World Health Organization

ABSTRACT

Title: Impact of HIV/AIDS on Health Care Provision: Perceptions of nurses currently working in one Regional Hospital

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Studies on the impact of HIV/AIDS on health workers conducted in the health sector in different countries in Southern Africa have shown that health workers are affected and infected by HIV/AIDS. This has affected the provision of care rendered by nurses negatively. The high workload emanating from increased numbers of patients contributed to the situation. As a result, a number of nurses suffer from stress related illnesses caused by many factors such as fear of contracting the HIV virus. Low staff morale has also been observed among nurses. Despite these serious negative effects of HIV/AIDS on health workers, many countries have not conducted studies to enable them to have a picture of the situation.

It was therefore decided to conduct a qualitative, exploratory descriptive study among nurses in one regional hospital in Namibia. Semi-structured interviews and focus group discussion guides were used to elicit information regarding the nurses' perceptions of the impact of HIV/AIDS on health care provision. The interviews were audio-recorded, transcribed and analyzed, using thematic content analysis.

The interviews shed light on the nurses' perceptions of the impact of HIV/AIDS upon health care provision. Issues discussed are constraints in the health service; low

morale, risk and fear of contracting HIV/AIDS from patients, lack of knowledge of managing and supporting HIV/AIDS patients on the part of the nurses as well as lack of opportunities for the latter to discuss problems with their supervisors.

Findings from this study revealed that the main challenges facing the health care provision are the increasing number of HIV/AIDS patients and a shortage of staff. In addition, the study has indicated that nurses are stressed and burnt out, which seems to result from fear of contracting HIV/AIDS from patients and the lack of knowledge on managing HIV/AIDS patients. The findings also revealed that nurses appear to have demoralised because of increased workload and lack of support from their supervisors. Consequently, some are contemplating tendering their resignation. Stigma also seemed to affect nurses at the workplace and at home. This resulted from comments made by colleagues and family members.



Results of this study indicate that there is a need for another exploratory study on a wider scale of nurses' perceptions. Furthermore, the results accentuate the need for the health sector in Namibia to find suitable strategies to retain experienced nurses in the health care system.

November 2004

DECLARATION

I declare that this mini-thesis is my own work and that all sources used or quoted have been indicated and acknowledged by means of complete references; and that this work has not been submitted before for any other degree at any other university.

Monika Pendukeni

November 2004

Signed :



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CHAPTER 1

1.1 Introduction

This chapter introduces the orientation to the study in which research problems, purpose of the study, research methodology, ethical consideration and limitations of the study are described. The outline of the study is also given.

1.2 FORMULATION OF THE PROBLEM

1.2.1 Problem Background

Namibia is situated in Southern Africa. The country covers 824 268 square kilometres, with a total population of approximately 1.8 million people (Census, 2002). Namibia's population growth rate is 2.9% with a life expectancy of 48 years for males and 50 years for females (*ibid*). Maternal mortality rate is 271/ 100 000 and 62/100 000 for children under five years (*ibid*). The highest cause of mortality is speculated as being HIV/AIDS (USAID-Namibia, 2004) with the most affected age group being 15-49. The most affected group is the most economically active group in the country encompassing many workforces, including nurses. It has been confirmed that over 50% of these deaths are also caused by AIDS (*ibid*).

Namibia is considered to be one of the top five countries affected by AIDS in the world (USAID, 2002). According to the HIV Sentinel survey of 2002, the HIV/AIDS prevalence rate in the 13 regions of Namibia among pregnant women aged 15-49 years varied between 9% and 43 % (MOHSS, 2002). The overall estimated crude prevalence rate stands at 22% for sexually active adults (15-49 age group) (*ibid*).

Due to HIV/AIDS, high morbidity has translated into increased hospitalisation of patients and mortality rates. This in turn has negative effects on human resources for health (HRH), particularly nurses who make up the majority of the frontline health care workforce. In addition, AIDS related hospitalisations now account for over 75% of all hospitalisations in the public sector hospitals (*ibid*). This imposes a huge burden on health workers who have to provide care in such settings. Consequently, HIV/AIDS may also have a negative effect on the quality of care provided in this difficult situation due to the increase in workload of the frontline staff such as nurses.

The Ministry of Health and Social Services (MOHSS), which is responsible for the organisation and delivery of health care in Namibia, sets out policies and plans and arranges the financing of the nation's public health care services. The Ministry also runs the majority of services within the public sector, which has a total workforce of 10, 000 (MOHSS, 2003). The majority (91%) of these staff are nurses who can be divided into three categories: registered nurses, enrolled nurses and assistant nurses (*ibid*).

The attrition rate among registered nurses and enrolled nurses has increased in recent years (MOHSS, 2003). Reasons for this attrition have included resignations for unspecified personal reasons and high death rates of nurses. As the result, the Namibian health service has suffered a loss of skilled and experienced nurses to the detriment of patients seeking health care in public hospitals (MOHSS, 2003). The nurses who remain in the service have felt the impact of high workloads and to some extent stress (Haoses, 2001), which may also be a factor behind the high number of resignations. Needless to say, together these factors may have negative effects on the health care given to the public in hospitals in the country.

Despite the fact that high hospitalization rates could have a potential negative effect on nurses, no study has been conducted in Namibia to gauge from the nurse's perspectives the impact of HIV/AIDS on themselves and on the provision of the of health care they provide. It is against this background that this study was designed to investigate the perceptions and views of nurses regarding the impact of HIV/AIDS on the provision of health care in their workplace setting.

1.2.2 Problem Statement

Health workers in Sub-Saharan Africa, especially in Southern Africa are affected and infected by HIV/AIDS (Tawfik and Kinoti, 2002). Nurses who make up the majority of the health workforce and health care providers in Africa are more affected than other health workers; and this has several negative impacts such as less productivity and inadequate health care provided to patients in hospitals (*ibid*).

The extent of the problem in terms of numbers of nurses infected in Namibia is not known. Many may suffer in silence without revealing their HIV/AIDS status. However, infected nurses continue to render health care to patients without any organised support from their employer. Such support could assist them to minimise suffering, which eventually would enable them to render quality care to patients. In most affected countries such as Namibia, a great deal of work in providing patient care is needed to seriously scale up the country's health programming capacity and clear the blockages and bottle necks in the health care system (UNAIDS, 2004). This may include addressing the issue of shortage of staff in order for the health ministry to deliver the needed quality health care to the public. Lack of nurses in Namibian hospitals is further undermined because the Ministry has rolled out the Anti-Retroviral-Viral Treatment Programmes and Prevention from Mother to Child Transmission Programmes, which have drawn health care staff from an already drained

workforce pool. This has resulted in a crisis arising from a shortage of staff where the numbers of nurses have decreased to a point where remaining nurses are unable to provide complete medical care to patients. It can be assumed that nursing care given by nurses might be of poor quality because the workloads may increase and the health facilities may experience a severe shortage of staff. This inspired the researcher to embark upon this study.

1.2.3 Purpose of the study

The purpose of the study is to gain insight into how HIV/AIDS is affecting nurses in order to inform support strategies.

1.3 AIM AND OBJECTIVES OF THE STUDY

1.3.1 Aim

The aim of the study is to study the nurses' perceptions, views and suggestions on the impact of HIV/AIDS on the provision of health care in terms of: increased workload, stress, low morale and fear of contracting HIV/AIDS in two Medical Wards and TB Ward in one regional hospital in Namibia.

1.3.2 Objectives

1. To collect and analyse the information provided by nurses with regard to their perceptions and views on the impact of HIV/AIDS on health care provision.
2. To explore nurses' perceptions, regarding the situation and their suggestions about possible ways of improvement.
3. To make recommendations based on the study findings.

1.4 ORGANISATION OF THE REPORT

CHAPTER 1

The first chapter introduces the study, i.e. the formulation of the problem, purpose and significance of the study as well as objectives.

CHAPTER 2

This chapter focuses on the review of the relevant literature. The literature review will draw upon issues on the impact of HIV/AIDS on health workers and health care provisions in the public sector.

CHAPTER 3

This chapter explains the research methodology namely; the study design, the sample study, procedures for data collection and data analysis, limitations of the study as well as ethical considerations.

CHAPTER 4

This chapter presents the study results

CHAPTER 5

This chapter discusses the results of the study

CHAPTER 6

Conclusion and recommendations are made in this chapter.



CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

This review focuses on previous studies conducted to determine the magnitude of the impact of HIV/AIDS in the health care service, the impact of HIV/AIDS on health care workers and perceptions of health care workers in the public health sectors.

The review reveals that previous studies on the impact of HIV/AIDS in the health sector were mostly conducted in other Southern African countries. Most findings show that health workers are negatively affected by the epidemic. This was demonstrated in their complaints about increased workloads and the shortage of staff, both hindering the delivery of service to the expected standards. Very few studies informed the researcher of the situation in Namibia. Only one Namibian HIV/AIDS related study was identified. This indicates that little attention has been given to the impact of HIV/AIDS in the health care provision in Namibia. However, the available literature still provided general insight into the impact of HIV/AIDS and the health care provision and lessons can be drawn from the experiences of other countries.

2.2 Global HIV/AIDS situation

The HIV/AIDS epidemic has become a global problem. The 4th global report of the UNAIDS clearly points out that it remains extremely dynamic, growing and changing character as the virus exploits new opportunities for transmission (UNAIDS, 2004). This report further states that there is no room for complacency anywhere (*ibid.*). The main concern is that the epidemic has affected virtually all countries in the world (*ibid.*).

An estimated 7.4 million people (range: 5.0-10.5 million) in Asia, are living with HIV/AIDS (*ibid*). Around half a million (range: 330 000-740 000) are believed to have died of AIDS in 2003 and about twice as many 1.1million (range: 610 000-2.2 million) are thought to have become newly infected with HIV by the end of 2003 (*ibid*). In Eastern and Central Asia HIV epidemics are underway with about 1.3 million people (ranging from 860 000-1.9 million) living with HIV at the end of 2003, compared with about 160 000 in 1995 (*ibid*). In the same region during 2003, 360 000 people (range: 160 000 – 900 000) were estimated to have become newly infected, while 49 000 (range: 32 000 – 71 000) died of AIDS. In Eastern Europe, Estonia, Latvia, the Russian Federation and Ukraine are the worst- affected countries, but HIV continues to spread in Belarus, Kazakhan and Moldova (*ibid*).

2.3 HIV/AIDS in Sub-Saharan Africa

The HIV/AIDS epidemic has its greatest impact in Sub-Saharan Africa, where about 30 million of the world's 42 million people living with HIV/AIDS reside (World Bank, 2003). In 2003 alone, an estimated 3 million people (range: 2.6 – 3.7 million) in the region became newly infected, while 2.2 million (range: 2.0 – 2.5 million) died of AIDS (UNAIDS, 2004). Among young people 15 – 24 years of age, 6.9% of women (range: 6.3 – 8.3%) and 2.1% of men (range: 1.9 – 2.5%) were living with HIV/AIDS by the end of 2003 (*ibid*). Many countries in Africa experience generalized epidemics (*ibid*). In other words, HIV is spreading throughout the general population, rather than being confined to populations at higher risk, such as sex workers their clients and drug users (*ibid*).

2.4 HIV/AIDS in the Southern Africa

The UNAIDS 4th global report (2004) states that the HIV epidemic has grown rapidly in Southern Africa. Data extracted from selected antenatal clinics in urban areas in 2002 shows an HIV prevalence of over 25%, following a rapid increase from just 5% in 1990s (*ibid*). In Swaziland, the average prevalence among pregnant women was 39% in 2002 from 34% in 2000 and only 4% in 1992 (*ibid*). In Botswana, the weighted antenatal clinic prevalence was 36% in 2001, 35% in 2002 and 37% in 2003 (*ibid*). Overall in Southern Africa, prevalence among pregnant women was 25% in 2001 and 26.5% in 2002 (*ibid*). These findings show that prevalence of HIV/AIDS in the adult population (15-49 years) in Southern Africa is increasing (*ibid*).

2.5 HIV/AIDS in Namibia

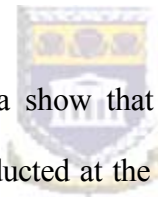
In Namibia, the estimated number of adults and children living with HIV is 210, 000 (range: 180, 000 – 250, 000) (UNAIDS, 2004). It is also estimated that the number of adults (15-49 age groups) living with HIV is 200, 000 to 230, 000 while the prevalence rate in this group ranges from 18.2 – 24.7 % (*ibid*). The number of women infected is estimated to be between 110, 000 and 130, 000 (*ibid*). The statistics show that Namibia is one of the countries that are worst affected by the epidemic in the Southern Africa.

2.6 The Impact of HIV/AIDS on Human Resources (HR) in Southern Africa

2.6.1 Morbidity, mortality, attrition

Many studies in different countries in Southern Africa reveal devastating results of HIV/AIDS on human resources in different sectors. Zambia for instance lost 1,300

teachers during the first ten months of 1998, equivalent to two thirds of the numbers of the new trained every year (Kinoti, and Tawfik, 2001). The impact of HIV/AIDS on HR is very serious and indeed urges action, in the Southern Africa, because it has negatively affected different service deliveries (*ibid*). Since those who are affected and/or infected are part of the skilled workforce, a crisis exists in human resources in all organisations whether public or private, that impinges on service delivery in these sectors. This has been emphasised by the World Bank's handbook for Local Government Responses, forecasting that areas in which HIV/AIDS is endemic will experience a negative impact on society, local economic development and service delivery (for example health services, community service) by reducing productivity due to increased absenteeism, high workloads and loss of skills (World Bank, 2003).



Reports from neighbouring Botswana show that the negative impact of HIV/AIDS on human resources is real. A study conducted at the University of Botswana by Chilisa *et al* (2001) generated the following findings:

- 14 out of 643 staff employed by the University of Botswana between 1990 and 2000 had died (Chilisa, Benne and Hyde 2001).
- 33 deaths out of 640 junior support staff were recorded at the same period together with 46 out of 483 among the industrial support staff (*ibid*). Ostensibly, the staff mortality rate at the University of Botswana is increasing.

The same study shows that the number of staff taking leave had increased from 150 in 1995 to 450 in 1999. Similarly, the total number of days of leave taken increased from 1,200

in 1995 to 5,000 in 1999. Leave is taken for a variety of reasons such as own illness, funeral of relative and friends and looking after a sick family member or relatives (Chilisa *et al.*, 2001). Out of 1,348 staff members who took leave between 1995 and 1999, 327 (24%) took compassionate leave and 668 members of staff took sick leave between 1995 and 2000 (*ibid*). This affects the productivity of staff members and therefore, may affect the service provision of the university. At the same university a Dean in one faculty reported that there have been delays in setting, marking and submitting examinations due to illnesses of some staff members (*ibid*). Students also complained of some courses not being taught because staff members were sick (*ibid*).

In another study conducted in a cement factory in Zambia (Whiteside and Sunter 2000), a fifteen fold increase in absenteeism was recorded for funerals between 1992 and 1995. Consequently, the employer had curtailed employees' funeral attendance to those of a spouse, parent or child. A study by Harvard and Haslegrave (2000) compared HIV/AIDS related deaths in Barclays' Bank of Zambia and USA companies and discovered that the Zambian bank's death rate was 10 times higher than that in the US companies.

Some evidence of the HIV impact on Human Resource can be traced in the insurance sector. SAfAIDS (1995), for example, find that in Zimbabwe one- third of group claims and almost 50% of individual payouts were due to suspected or known AIDS deaths. The Metropolitan Life Insurance Company in South Africa found in their projection that between 1995 and 2010 a lump sums at death will raise several folds (Jackson, 2002). Obviously, HIV/AIDS has a negative effect on different sectors and this may also be the case in the health sector in Namibia, although no study has yet been conducted in Namibia in this regard.

2.7 Impact of HIV/AIDS on Human Resources for Health (HRH) in Southern Africa

2.7.1 Workloads

AIDS affects the health sector by increasing ill health and death among service providers at all levels, and also by increasing demand on service provision as people become sick. Hence, it puts a heavier workload on health staff (Jackson, 2002). A study conducted by Shisana *et al.*, (2002) on the impact of HIV/AIDS on the Health Sector in South Africa revealed that 94.6 % of health facilities indicated an increase in patients seeking HIV/AIDS related care. In the same study 73% of the health workers said that they experienced an increased workload of 75% in 2002 compared to the previous year, (*ibid*). In the same study however, using the hospital attendance data it was demonstrated that the actual number of patients seen had not actually increased. The seemingly contradicting evidence is explained partly as subjective perceptions of nurses and partly because AIDS patients require more attention (*ibid*).

In Namibia, the situation seems to be worse. In 2000-2001, for instance, AIDS-related deaths accounted for about 50 % of deaths among individuals aged 15-49 (USAID-Namibia, 2002). AIDS-related hospitalisations accounted for over 75% of all hospitalisations in the public sector hospitals (*ibid*). Evidently the workloads ought to have increased. HIV/AIDS patients outnumbered the non-HIV patients, which resulted in higher demand of care needed by the HIV/AIDS patients.

2.7.2 Morbidity and Mortality among health workers

In many countries, the health personnel have high rates of HIV infection, leading to increased absenteeism and high staff turnover when they die (Jackson, 2002). For example, according to the Ministry of Health in Mozambique, deaths among health staff nearly tripled from 1995-1999 and occurred at increasingly young ages (Deveew, 2001). In one study, conducted in Zambia, the prevalence rates among midwives and nurses in Lusaka in 1991-92 were 39% and 44% respectively. While in two southern Zambian hospitals, the mortality of female nurses rose 13-fold between 1980 and 1991 (*ibid.*). In Malawi, the deaths rates of health care workers were 3% in 1997, a six-fold increase of the levels before the epidemic (*ibid.*). Medical professionals with their long training are difficult to replace.

It can also be expected that the nursing students experience rising morbidity and mortality rates which will make replacement difficult. Derveew (2001) reports that in Mozambique, in the Tete Province nearly 20% of student nurses in the training school died of HIV/AIDS during 2000, and 8.6% of students in the Zambesi Province. In conclusion, there is a huge decrease of nurses in the nursing profession resulting from HIV/AIDS and this threatens to create a serious crisis in delivering of health care services in the health sectors in the Southern Africa.

2.7.3 Stress and burnout

Apart from staff deaths and absenteeism, stress and burnout resulting from stressful work condition affects nurses and other health workers negatively and to some extent hinders their performance (MOHSS, 2003).

Occupational burnout is conceptualized as a particular type of stress occurring principally in professional contexts where work demands, especially those of an interpersonal nature, lead to chronic emotional exhaustion, depersonalization and reduced sense of personal accomplishment (Cordes & Dougherty, 1993). The consequence of burnout includes staff turnover, absenteeism and reduced productivity, facets of burnout that have serious repercussion for organisations, services and individuals (Gueritault-Chalvin *et al.* 2000). Gueritault-Chalvin *et al.* (2000) claim that burnout is a serious problem in the area of AIDS care. AIDS care providers experience stressful anxieties rooted in occupational exposure to HIV (*ibid.*).

Stress that leads to frustration may result from many factors such as nurse hiding their true emotions, lack of knowledge and skills in dealing with patients, work demand, lack of competence and fear. Nurses are often expected to hide their emotions even if they are upset, angry or frustrated (Jackson, 2002). This may cause more stress and therefore frustration. AIDS work may be particularly stressful because it means repeatedly facing the ill health, witnessing suffering and young people dying (*ibid.*). It is also clearly stated that another source of frustration may be lack of professional knowledge and experience, competence that may lead to psychological stress and burn out (*ibid.*). This could also

cause the risk of nurses becoming desensitized; becoming insensitive and cold towards their patients and clients (ibid). Miller and Bor, 1991; Kleiber *et al.*, 1992 reported that burn out symptoms such as emotional exhaustion, reduced personal accomplishment, loss of positive attitude towards client and intention to shun away from patients threatens to undermine the effort towards the effective health care.

In a study comparing 100 oncology nurses and 103 hospital AIDS nurses in the United Kingdom (UK), Miller (1995) found high levels of stress and burnout factors in both populations. Other studies show that stress and anxiety is experienced even faster in AIDS carers among oncology nurses (*ibid*).

Many of these studies identify that both contagion and the link with sexuality as sources of stress, while Dunkel & Hartfield (1986) and Drieger & Cox (1991), describe fear of infection as a significant stress factors among AIDS care nurses. Miller & Bor (1991) point out that burnout results in symptoms such as emotional exhaustion, reduced personal accomplishment, loss of positive attitude toward patients and the intention to leave the health service.

One example can be seen in the study conducted by Haoses *et. al.* (2001), where 90% of nurses working in one main referral hospital in Namibia said that they were not prepared to deal with HIV/AIDS patients thus stressed. As a result, they looked for every opportunity to stay away from work (*ibid*). That means poor service and low quality of health care to patients. Almost all (98%) of the nurses stated that they could not cope with the caring for HIV/AIDS patients and therefore felt stressed and frustrated as a result (*ibid*).

Their reactions emanated from the fear of contracting HIV/AIDS from patients and from their lack of knowledge on how to manage HIV/AIDS cases (*ibid*). Health personnel obviously face occupational risks from handling un-sterile injecting equipment and through accidental exposure to blood or serum (Kinoti and Tawfik, 2001). Additional risks of HIV/AIDS encountered by health personnel may occur by non-adherence to proper protocols and from a lack of sterilised equipment, surgical power tools and supplies (*ibid*). However, various reports clearly indicate that there is a low risk of contracting HIV/AIDS from occupational injuries. Due to the stigma attached to the disease (SAfAIDS, 2003; Jackson, 2002), nurses are afraid of contracting HIV/AIDS through work.

Vachon, (1987), reported that staff support may ameliorate stress and burn out in nurses. Professional relationship in the work place is also documented as stress-reducing mechanisms (Hartey 1999). Recognition and reward from supervisors are pointed out to act as buffers to stressor (*ibid*). Other writers such as Ross and Seeger (1988) and Bennet *et al.* (1993) indicated that a sense of achievement can offset burnout among nurses.

2.7.4 Stigma

In many cases employees fear stigmatization by colleagues (SAfAIDS 2003). It is further documented that employers and fellow employees discriminate against workers suspected or confirmed as being HIV positive (*ibid*). Some reasons for this behaviour include:

- Ignorance about facts around HIV transmission and progression of the disease

- Fear by employers or superiors, of medical aid, funeral and other care cost
- Fear by employers or superiors, of reduction in productivity and profits
- Fear of stigmatization of the organization in the advent that clients get to know workers are HIV positive (*ibid*).

Jackson (2002) demonstrated that virtually in all countries, examples exist of discrimination if not outright violence against people with HIV or AIDS. Discrimination and stigma may come from any level of society, from family and community members through to top leaders (*ibid*). Due to discrimination and stigma faced by people with HIV or AIDS, health workers who are infected by HIV may be hesitant to disclose their status. According to Fesko (2004), studies that examined HIV disclosure in the workplace show that the majority of individuals did not tell their employers or co-workers that they were infected. He further explained that the reasons may be fear of discrimination, harassment and anxiety about losing health benefits. Fesko (2004) also mentions concern about the possibility of losing opportunities for advancement such as promotions as the individual's future may be viewed as tentative. Disclosure of HIV status can be a double-edged sword because on the other hand it can create opportunities for medical and social support such as free antiretroviral drugs and moral support, but on the other it can also lead to extra stress as a result of stigmatization, discrimination and disruption of personal relationship (*ibid*). It should be emphasized that the achievement of HIV prevention, as well as the care of people with HIV/AIDS, is crucially dependent on reducing stigma, increasing expenses and enabling people to protect themselves and to cope with infection (Jackson, 2002).

2.7.5 Risk and fear of contracting HIV/AIDS

HIV/AIDS has become a major cause of morbidity and mortality in the world (Wasulumbi and Okonsky, 2004) and when people become sick they look for treatment at hospitals. As a result, nurses become frontline providers of care for HIV/AIDS patients and are in the direct contact with HIV patients (*ibid*) and may develop fear of contracting HIV from patients.

With respect to the effect of knowledge of the disease on attitude towards HIV/AIDS patients, the literature indicates mixed results. Some studies have found that despite higher levels of knowledge on how HIV/AIDS is transmitted, significantly negative attitude and fear prevail because of the stigma attached to HIV/AIDS (McCam and Sharkey 1998, Uwake 2000). On the other hand, other surveys on the same issue reveal that higher knowledge levels on how HIV/AIDS is transmitted are associated with positive attitude towards patients with HIV/AIDS (Wasulumbi and Okonsky, 2004). These equivocal findings imply that the effect of knowledge of the disease on attitude is perhaps confounded by other setting-specific factors, and thus it remains to be seen in the Namibian case.

2.7.6 Workload

Recent research also reports that health workers have become overloaded with work (MOHSS, 2003), as a result of the increased number of HIV/AIDS patients. They could no longer provide adequate care to patients in public hospitals because of several factors such as the workload, staff absenteeism, staff attrition resulting from resignations and

HIV/AIDS related deaths (*ibid*). Malawi's health service saw a threefold increase in staff deaths between 1992 and 2000 (Rau, 2004).

At one large hospital in South Africa 30 % of available nursing posts and 20 % of clinic nursing posts were vacant between 1991 and 2001 (*ibid*). It demonstrates that the available staff are few in number and overloaded by work. Rau (2004) concluded that the ability for the health workers to deliver adequate and appropriate services for all clients is affected by staff losses to HIV/AIDS. He also claims that the epidemic has increased demands on health services in terms of technical skills needed by staff and sufficient number of required staff.

It is clear that at a time when the efficient and staffing levels of the health work force is compromised by HIV, the demand for their services continues to rise, especially from people living with HIV/AIDS (*ibid*). Kober and Van Damme (2004) reported that hospital care for AIDS patients is not the only factor leading to facilities being overburdened; the antiretroviral treatment projects visits are also very labour intensive. Pre-test and post-test counselling, appointments with a medical doctor for every patient requiring antiretroviral treatment, and regular individual follow-up appointments with nurses involve a high number of qualified staff working to the limits of their capacity (*ibid*). Rau (2004) states that it is not only HIV/AIDS that is adding to the case load of health care providers, but the complexity of the disease demands additional skills. The workload is more highlighted in Southern African countries. In Mozambique the ratio of medical doctors per population is 1/30 000 and in Malawi is 1/100 000 (Kober and Van Damme 2004).

In 1998, WHO estimated that the number of doctors in Swaziland was 15 per 100 000 (*ibid*). This is clearly demonstrating that health workers are overworked to their limits.

2.8 Previous studies

In spite of the high prevalence rate of HIV/AIDS among the young adult population (15-49), only few countries such as South Africa that are severely affected have done a thorough assessment to determine the impact of the epidemic on human resources in the health sector (Kinoti and Tawfik, 2001). Such data is critical for health service improvement. Evidence in some countries suggests that the health sector may lose one fifth of their employees succumbing to HIV/AIDS over the next few years (Kinoti and Tawfik, 2001). Despite this fact, a lot is still to be done to create a better understanding on how the health workers are affected by HIV/AIDS and what impact it has on service delivery and health care provision in the health sector (World Bank, 2003). This has inspired the researcher to undertake this study.



CHAPTER 3: STUDY METHODOLOGY

3.1 INTRODUCTION

This chapter presents the research methodology used in this study. It focuses on study design, sampling, study population, data collection and data analysis, validity of the designed instruments, ethical considerations and limitations of the study. However, before the methodology is explained, it is necessary to explain the reason why the methodology in question was chosen.

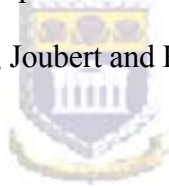
3.2 Choice of methodology for this study

The challenge faced in this research process was to gain an understanding of what nurses perceive to be the impact of HIV/AIDS on the health care provision. Consequently, the direct interaction with nurses would be the most feasible solution. Such interaction could only be done effectively using qualitative methodology. To gain a better understanding of nurses' perceptions of the impact of HIV/AIDS on the health care provision, qualitative research methods allow the researcher to inter-act with participants. Through this interaction the investigator will develop an understanding of the nurse's social world and its meaning to them. Researchers such as Schultz (1962) emphasise the importance of developing these interpretative understandings of the social world. The following quotation that represents both a critique of the application of a natural science approach to social life and a statement about the importance of a focus on individual meaning:

“The world of nature as explored by the natural scientist does not ‘mean’ anything to molecules, atoms and electrons. But the observational field of the social scientist-social reality has a specific meaning and relevance structure for being living, acting and thinking within it ... The thought

objects constructed by the social scientist, in order to grasp this social reality, have to be founded upon the thought objects constructed by the common-sense thinking of men, living their daily lives within the social world ” (Schultz, 1962 p.59).

Looking at the nature of this study, it can clearly be seen that it was not possible to use quantitative methods with structured questionnaires which may have not capture all information needed to answer these important research questions. As a result, the researcher chose qualitative research that could allow the semi-structured and focus group discussion guides to be used, without restricting participants to responses and allowed for probing as well. Furthermore, semi-structured interviews enable the researcher to obtain a great deal of useful information and produce a most useful individual opinion and or group’s perceptions (Katzenellebogen, Joubert and Karim, 1997).



3.3 Study Design:

An exploratory descriptive study design was used, since little is known about how nurses perceive the impact of HIV/AIDS. This was found suitable in describing the current situation and magnitude of the problem, knowledge that will hopefully contribute to the development of strategies on how to address the problems faced by nurses in this regard. It could also be used to create hypothesis for further research.

3.4 Study population and Sample

Study population refers to an entire group or aggregate of people or elements having one or more characteristics (Katzenellebogen, Joubert and Karim, 1997). In this study, the study population includes experienced nurses who work in the wards that admit HIV/AIDS patients.

The study sample comprised interviews with 10 experienced nurses and two group discussions, six different nurses in each group. Five nurses were drawn from a general ward and the other five were drawn from a TB ward. For the focus group discussions all twelve nurses were drawn from the medical wards.

Although nurses are affected and infected by HIV/AIDS along with the general public, little has been done to hear the nurses' voices that would assist in addressing the problem. Significantly, nurses are overwhelmed by the workload as the numbers of HIV/AIDS patients increase. The sample included experienced nurses who met the criterion of working in wards that admit patients with HIV/AIDS most of who are in the advanced stages of full blown Aids.

3.5 Sampling design

Purposive sampling was used to select rich information cases. This included experienced nurses, who have valuable information, which could have not been obtained if random sampling was used. Purposive sampling is often used when the researcher tries to represent all important subgroups in a specific sector (Katzenellenbogen, Joubert and Abdool Karim 1997).

In this study ten nurses of all categories (five from each ward) who had worked for more than three months in Tuberculosis (TB) and one general ward were selected.

Thus the characteristics of the study sample participants were:

- Nurses who have experience in the nursing profession
- Working in medical wards and TB ward
- Willing to participate in the study

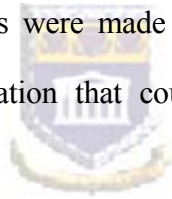
3.6 Data Collection Method

Data was collected between August and September 2004 in Namibia. A semi-structured interview guide was used to obtain personal detailed information and responses on perceptions from ten nurses of all three categories. Interviews allowed participants to talk about the topic expressing their own perceptions in their own terms (Katzenellenbogen *et al.*, 1997). Two Focus Group Discussions (FGD) consisting of six nurses each were also conducted to get multiple views, experiences, group opinions and norms formed on the topic by nurses (Vaughn, Schumn and Sinagub, 1996). FGDs create synergy and stimulate the group allowing more information to be collected (*ibid*). FGDs also provide an insight into the attitudes, perceptions and opinions of the studied group (Katzenellenbogen *et al.*, 1997).

3.6.1 Procedure

The researcher collected data as an independent observer within the hospital. This arrangement facilitated easy access and a good rapport with the participants under study. Before the data collection took place, permission from the regional office was obtained (See appendix).

The researcher met with the nurse-in-charge of the hospital prior to the actual data collection. The nurse-in-charge was given a copy of the protocol to acquaint herself with the criterion to be employed. The researcher was firstly introduced to all the nurses in the hospital the day before data collection was done. The group discussion and individual interviews were conducted after the purpose of the study was explained. All interviews were tape-recorded and transcriptions were made immediately after the interviews. The researcher kept diaries with information that could be used during the data analysis processes.



3.6.2 Instruments

3.6.2.1 Semi-structured interview

Bryman and Burgess (1999) state that qualitative interviewing is concerned with uncovering the interviewees' meanings. Interviews are conducted in order for the researcher to find out from people's issues what they cannot directly see, such as intentions, feelings and experiences. By interviewing individuals you can get access to information that one cannot observe (*ibid*). Robson (1993) declares that the major advantage of qualitative interviewing is that the respondent gets an opportunity for personal explanation and detailed responses.

Robson (*ibid*) also claims that interviews offer a possibility of modifying one's line of inquiry, following up interesting responses and investigating underlying motives in a way that postal and other self-administered questionnaires cannot. Non-verbal cues may give messages, which help in understanding the verbal response and possibly changing or even reversing its meaning (*ibid*).

A semi structured interview guide was designed to elicit responses from nurses with regard to their perceptions of the impact of HIV/AIDS on health care provision. The instrument consisted of the collection of demographic data of nurses such as age, qualification and years of experience. These were included to obtain a general picture of the participants' characteristics. The main content included open ended questions that were followed up by probing questions, which mainly dealt with the issues of the study interest such as low morale, risk and fear of contracting HIV/AIDS from patients, framework for discussing problems with supervisors and suggestions for improvement. Each interview took approximately one and half hours. All interviews took place on the hospital grounds in the wards.

3.6.2.2 Participants

The participants were nurses with more than two years of experience in the nursing profession and who worked in general and TB wards during the past six months. These participants were chosen purposefully. That is, they were relatively knowledgeable and experienced in nursing practice. According to Rice and Essays (1999), purposive sampling

is aimed to identify the cases that will provide a full and sophisticated understanding of all aspects of the phenomenon.

3.6.2.3 Focus group discussions

The focus group discussions were conducted to complement information given by individual interviews. The purpose was to elicit substantive information and to gain more in-depth understanding of perceptions, beliefs, attitudes and experiences on the topic from a multiple points of view within a very limited time (Vaughn, Schumm and Sinagub, 1996). This was done by giving the participants opportunity as a group, to discuss and share their personal experiences, opinions and perceptions on the impact of HIV/AIDS on the health care provision. The researcher was able to assess and to some extent to identify the group opinions (Pope & Mays, 1995).



The focus group discussions were conducted in the hospital in two different general wards. They were held in the evening in order to accommodate nurses who are working during the night shifts. Each focus group discussion consisted of six nurses in total from all three nursing categories and lasted between two and two and a half-hours.

3.7 Data recording procedure

The data collection phase was facilitated by a diary book. Various pieces of information were recorded in this diary viz. appointment for interviews, details including contact numbers of nurses to be interviewed. Information pertaining to transcriptions and analysis were also recorded in this book. If information was not clear, it was for example noted to

make it easier for a follow-up visit or confirmation the next day. Progress was recorded on transcriptions and pending issues.

While collecting data, observations made in the hospital were noted. These notes included personal thoughts, ideas and feelings, impressions and biases. This information was used to see how it would influence the data interpretation.

Semi-structured interviews and focus group interview guides facilitated the interview. The questions were designed based on relevant literature and personal experience. Each interview was audio taped and recorded for security purposes. The recordings were transcribed later by the researcher before data analysis. The next section explains the data analysis process.

3.8 Data Analysis

According to Patton, (1990) quality data analysis is the process of systematically organising the interview transcripts, field notes and other accumulated materials until they are understood in such a way that they address the research questions and present the result and create understanding to others. Marshall and Rossman (1995) describe it as the process of bringing order, structure and meaning to the mass of collected data.

The researcher went through different stages of analysis before the report was produced. At first the data was coded to form different categories and subcategories of the main themes from the raw data.

Thematic content analysis, which involves identifying, themes from the primary patterns in the data, was used to analyse data (Patton, 1990: 381). This was done with the help of Burnard's (1991) model of content analysis which is derived from different works. The purpose of qualitative analysis is to produce a systematic recording of the themes and issues discussed in the interview and to link the themes and interviews under an exhaustive category system (*ibid*). This prevents the data from deviating from the original form but allows categories to be generated and at the same time allows the researcher to make sense and meaning out of the data (*ibid*).

By adopting Burnard's model the researcher went through the following stages:

1. The audio taped interviews were listened to shortly after the interview was completed.
2. Notes were taken on emerging topics from the interview. Through this process the researcher became familiar with the data recorded.
3. Transcriptions were made through listening repeatedly to the audiotapes.
4. The transcribed tapes were browsed through and notes were taken on the emerging themes within the transcripts.
5. Themes identified were grouped together and main themes and sub themes were listed to see whether all aspects of the study were covered.

Phrases and sentences that had meaning to the researcher were grouped into units to form the basis of categories. Codes were then developed based on the list of the themes. Similar transcripts were cut out and collected together. The cut out pieces were first pasted on

flip charts into different sections and, later on, typed into a computer. Afterwards, the writing-up process started. During the process the researcher had also linked the emerged themes to relevant literature. After all sections were compiled, a list of themes of categories and subcategories were identified and data was discussed under the identified categories below:

1. Category: Constraints in the health service

- Subcategory: **Reasons for Increased workload**
- *Stress and burn outs*

2. Category: Low morale

- Subcategory: **Incentives**
- **Job satisfaction**
- **Feeling of Guilty**



3. Category: Risk and fear of contracting HIV/AIDS from patients

- Subcategory: **Medical procedures**
- **Fear of death and leaving the loved ones behind**
- **Fear of taking life long medications**
- **Stigmatisation**

4. Category: Lack of knowledge on management of HIV/AIDS patients

5. Category: Support system for solving problems

3.9 Validity and Rigor of Data

One of the consistent criticisms that has been raised against research emanating from qualitative enquiries is that they lack validity (Kvale, 1989). Qualitative research is said to rely too heavily on the interpersonal involvement of the researcher and on interpretative subjective judgement (*ibid*). Some authors such as Salner (1989) argue that a discussion of the validity of qualitative research must proceed within the context of the epistemological assumption researchers have made about their domain and their enquiry to it (Kvale, 1989). To increase validity in this study, which intends to understand feelings of nurses in regards to the impact of HIV/AIDS, the following was done; the researcher reflected and strove to set aside attitudes and preconceptions regarding the topic, which could influence any process of the study.



3.9.1 Triangulation

Gifford, (1996) emphasises that triangulation should be included in qualitative research to increase rigour. Triangulation means using a number of different approaches to get to the same question and the need to strengthen and increase rigour in qualitative research (*ibid*). As a result, different sources of data such as individual interviews and group discussion interviews to unpack the nurses' perception plus FGDs to generate data and understand the norms and meaning of HIV/AIDS formed by nurses were used. It was useful as a comparison during the data analysis.

3.9.2 Respondent Validation

Respondent validation is considered to be a fair process in reducing error in data analysis that in turn give value to data quality for qualitative research (May and Pope, 2002). For this particular study the investigator gave copies of data collected to the participants for comments and to confirm the information provided. Their comments were incorporated in the study findings.

The researcher kept a diary for taking notes during every stage of data collection. These notes were consulted when the data was analysed.

3.10 Ethical Statement

The investigator was aware of the challenges, obstacles and difficult nature of the study because HIV/AIDS touches the emotional and psychological aspects of all human spheres in society. The study had to consider ethical standards from the outset. Prior to data collection, the investigator requested the permission to conduct a research from the Permanent Secretary of the Ministry of Health and Social Services (MoHSS) in Namibia. The research proposal and data collection instruments were brought for approval before the Research Committee of the University of the Western Cape (UWC) and the Ministry of Health and Social Services. Participants in the study were informed of its purpose and scope. They were also informed that participation was voluntary and that they could withdraw at any time. The study did not record names of individuals on questionnaires. Instead codes were used to maintain confidentiality.

11. Limitations of the study

11.1 Timing of data collection

Data collection was limited to between August 2004 and September 2004 as the researcher had to collect data at a far region and had to continue with the office work in mid September 2004.

11.2. Small sample due to Lack of Funds

A single hospital may not truly reflect the perceptions and views of health workers (nurses) throughout the country, but lack of funds prevented the study from being conducted in all four referral hospitals as originally planned.

11.3 Language used during data collection

The interviews of participants, who could not speak English, were recorded in the language they were conversant with and later the researcher translated their responses into English which was time-consuming.

This chapter presents the research methodology. The type of research chosen was qualitative and semi structured interview and focus group discussion guides were used to collect data. The next chapter gives a detailed description, discussion and interpretation of the data.

CHAPTER 4: RESULTS

This chapter presents the study findings using content analysis. Interpretation of the findings will be done in the discussion section.

The interviews were conducted within a period of one and half month between August and September 2004. The participants were nurses working in Medical Wards and TB Ward, where many HIV positive patients were admitted. In this chapter, the participants are referred to as nurses and remain anonymous.

Ten nurses from all three nursing categories; registered nurses, enrolled nurses and assistant nurses were interviewed. Each interview lasted for one to one and half hour. Five nurses were drawn from the TB Ward while the other five were drawn from the Medical Wards. Two focus group discussions were also held in the same hospital and each consisted of six nurses from Medical Wards and different from those who were individually interviewed. The group discussions lasted for two to two and half hours.

The researcher used the semi structured interview guide and probing questions technique to collect data. Interviews were conducted within the hospital in the wards that were not particularly conducive because there were some disturbances from lodgers who were caring for their relatives. However, the nurses tried to focus on the interviews and refer these people to colleagues who were not interviewed at that time. Group discussions were conducted in a very conducive environment because the sisters in charge allocated their treatment rooms to be used for this purpose, away from the centre of the area of service.

4.1 PROFILE OF PARTICIPANTS IN THE STUDY

Table 1: Demographic Profile of Study Participants

The researcher had an in-depth interview with ten respondents and their profile is indicated below:

Characteristic variable	Number of participants
Age	
20-49 years	6
50-60 years	4
Sex	
Female	9
Male	1
Nursing category	
Registered nurses	3
Enrolled nurses	4
Assistant nurses	3
Years of experience	
1-10 years	2
11-20 years	4
>20 years	4

Table 2: Focus group discussions

The table below shows the demographic profile of the two group discussions' participants

Characteristic variable	Number of participants
Age	
20-49 years	8
50-60	4
Sex	
Female	10
Male	2
Nursing category	
Registered nurses	3
Enrolled nurses	4
Assistant nurses	4
Years of experience	
1-10 years	4
11-20 years	5
>20 years	3

The minimum age group of nurses interviewed and those who were in the focus group discussions is 20 years and the maximum age is 60 years.

As regards to gender, 19/22 of the participants were females which reflects the gender profile of nurses in the overall nursing population in Namibia and other African countries (Wasulumbi and Okonsky, 2004).

The number of active years of experience of the interviewees ranged from 11 to 20 years and above, which ensures that the population has extensive experience in nursing and can talk knowledgably about experiences before and after the onset of the HIV epidemic.

The results of the interviews are clustered around the following five themes:

- Constraints in the health service
- Low work morale
- Risk and fear of contracting HIV/AIDS from patients
- Lack of knowledge on HIV/AIDS patients' management
- Support system for solving work related problems

4. 2 Constraints in the health service

All ten nurses interviewed described increased workloads over the past three years. They attributed this to the growing number of patients seeking HIV/AIDS related health care and the shortage of health staff. This is said to have adverse effect on their work. The two focus group discussions gave similar responses. However, they revealed that, in addition to the increased work demand, caused by the increased workload, deaths of nurses who are not replaced have also increased. This can be inferred from the following quotation:

“The main constraint in the health service is the work that has increased since 1999 presumably due to increased need related to HIV/AIDS and the attrition of nurses who were not replaced, which also partly attributed to deaths from

HIV/AIDS and some of us who are old and have no knowledge about the new disease”.

One nurse who seemed to be extremely overwhelmed by a heavy workload specifically pointed out the years when the increased workload started:

“Work has increased especially from 1999 and became worse in 2002 till to date. I have no words to say, it is overwhelming. Sometimes one cannot even find time to go to the toilet”.

4. 2.1 Some reasons for the increased workloads in the hospital

A number of reasons were advanced by the nurses for the increased work they are expected to do.



Eight out of the ten nurses stated that, there is a staff shortage in the hospital but could not substantiate this observation. However, it is reported that in one intermediate hospital in Namibia with a total number of 1200 nursing staff, a total number of 4 366 sick leave days were reported within a period of seven months. At the same period 1,116 compassionate leave days were also recorded (MoHSS, 2003). The report further revealed that the Ministry has lost 234 staff (ibid). The main reasons for staff attrition were resignations (35.3 %) and death (26 %) respectively. Nurses accounted for about 17.1% of the staff attrition (MoHSS, 2003).

The two group discussions and the two remaining participants pointed mainly at the increased number of HIV/AIDS related illnesses as the reason for the increased

workloads. The workload could be compounded by the fact that HIV/AIDS patients need more care than other patients without HIV/AIDS. This was based on the researcher's own observation that most of the HIV/AIDS patients in this hospital are already in the advanced stage of full blown AIDS. As a result, the care of one patient might equate to the care of four non HIV patients. In this hospital only two nurses on duty care for over sixty patients, the majority of whom are HIV positive. The hospital was initially designed to admit fewer in – patients, with a capacity of only 120 beds. After the epidemic took its peak, no change was made with regards to plan for more beds and staff to cope with the change of the patient profile. The hospital bed occupancy rate is 135 with bed turn over of 73 – indicating over utilisation (MoHSS 2003). The number of nurses in this hospital is 107. Moreover, there are a total number of 61 vacant nurses' posts.

It appears that despite a very high levels of bed occupancy rate and bed turnover ratio, there is a high staff vacancy rate of (36%), which if not addressed will further overstretch the existing nurses and lead to further resignations and reduced productivity related to work stress.

The nurses explained the increased workload by describing the way the work is being carried out which points to a chaotic situation: *“Can you see there is no dressing room, because it is being used as another additional room for patients who are in critical conditions?” How are we expected to give proper care in these conditions? ”*

4.2. 2 Stress and burn outs

Nurses in this hospital describe themselves as overwhelmed and stressed by the amount of work that they are expected to do. As a result, they are highly **stressed** as they experience physical and emotional exhaustion caused by overwork and burnout. The following excerpts describe the situation:

“I am stressed all the time and angry with myself which spills over to my kids and husband, and this is due to my stressful work especially when I am thinking of HIV/AIDS it stresses me it is working on my nerves”

“There is a shortage of staff that cause workload, sometimes I am left alone in the Ward for the whole day and I am an enrolled nurse, I become very much stressed and scared that something might go wrong ”.

The other factor exacerbating nurses' stress emanates from the fact that they provide medical treatment to people they know, related to or close to them. One nurse told the following anecdote from her personal experience:

“My nephew (mental sick sometimes) who was staying with me went out one night when he came back the next day he told me this and I quote “Auntie, I am sure I am infected by the virus last night there at the club. I had money and one lady good looking was forcing herself on me, the owner of the club asked me to pay something small to get a quick room for service. I did that when I woke up in the morning I looked at the girl she had rashes all over her body I am sure she was sick that was AIDS.... I am sure I am having it from today” Now guess.... this nephew of mine died few days ago. I am stressed by nursing people I know and I have no mercy for those who looked for it”

The study revealed that patients are being blamed by some nurses for their increased workloads and stress to the extent that they (nurses) are unsympathetic towards HIV/AIDS patients. One of the nurses expressed it in this way;

“HIV/AIDS patients like coming to the hospital for minor illnesses and insist for admission, they are just too much.... I am angry with patients and I don’t feel sorry for them because they went and look for HIV/AIDS and as a consequence I have stress from this work and therefore suffer”.

4.3 Lack of knowledge in managing HIV/AIDS patients

Nurses interviewed feel that they do not know how to manage the HIV/AIDS patients well and this frustrates them:

“Some times I feel that I don’t know how to manage the HIV/AIDS patients and I get fed up ”



Frustration seems to stem from the fact that nurses lack knowledge in the management of HIV/AIDS patients. One nurse clearly expressed this phenomenon:

“I was not trained in the management of HIV/AIDS patients therefore I have no knowledge about it and it frustrates me so much, so people should not expect that much from me ”. “I am telling you it is frustrating if you don’t have necessary skills in your job and it makes you feel small...too.

Training in HIV/AIDS care seems to target nurses who deal with HIV/AIDS programmes only, excluding nurses who work in the wards and who are in direct contact with HIV/AIDS patients on a daily basis. One informant explained how supervisors select participants for these training programs:

“I think supervisors don't see the needs of everyone I mean all nurses to be trained on HIV/AIDS issues, but it is really needed because even if we are working at departments almost every patient seen need to be counselled before treatment, because we don't know their status. But most of the time supervisors choose their own people to go for these training programs and we are left out yet they still expect us to work with a smile on the face with no knowledge in these issues”

Following from the nurses' responses above, the researcher wanted to know whether nurses had any suggestions that could be implemented to solve their problems. Different suggestions were made as follows:

“The Ministry should look at the staff shortage issue and plan to increase the number of nurses needed to provide quality care to patients and create another category of health care specialty to deal with AIDS home basic care”

Other suggestions were made related to the training of health workers in different related HIV/AIDS cases. This could be deduced from the following excerpts:

“Staff that is dealing with logistics should be sent for training to update their knowledge on stock maintenances e.g. gloves, needle containers ”.

“Nurses from clinics should be trained on ARV so that patients get their medications from nearby clinics instead of travelling long distances to hospitals. ”

One group discussion strongly felt that nurses need more knowledge of managing HIV/AIDS patients. Thus suggesting that training of nurses should be considered valuable in the health care situation:

“Education should start from home; we nurses do not have the knowledge on how to deal with HIV positive patients and our supervisors do not know how to handle

us when we are frustrated, therefore we suggest that training of nurses in managing HIV/AIDS patients is crucial ”.

4.4 Low work morale

When nurses were asked whether their work morale is negatively affected by the workload, 9/10 nurses agreed. Some nurses felt that they are putting more efforts into their work but their supervisors are unwilling to recognise and appreciate the efforts. This demoralise nurses and prompts them to contemplate resignation. Some felt that due to increased workload they should be paid more. The following quotes describe the nurses’ low work morale:

“I don’t think my effort is being appreciated in this difficult situation”

One nurse expressed herself in this way:

“If I work overtime and I am not paid on time. I receive the overtime payment after eight months. I am of the opinion that our salaries should be revised because what we get does not worth our effort” I am looking for less risky job”

In the group however, participants agreed that, the low work morale results from the feeling that they do not have time to give adequate care to patients. This situation affects them morally than money motivated issue. Nurses also feel that they experience stress because of lack of support from their supervisors:

“When we make mistakes at work due to exhaustion and lack of concentration, we don’t get support from our supervisors”

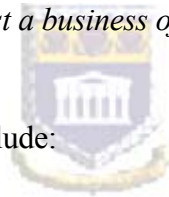
Nurses indicated that their stress is felt more when they are in the working environment:

“Sometimes you come to work in a good mood but when you reach the hospital and look at patients or hear that one of your colleagues is dead or sick then you become stressed and you take it out on other colleagues and patients”

4.4.1 Job satisfaction

Many nurses indicated that they do not get any job satisfaction from their work. The two group discussions came out with a similar result for example that most of the time they are exhausted due to the stressful working conditions and that patients die in hospital rather than being discharged. These quotes describe the nurses’ feelings:

“Previously I enjoyed every minute of my work and I was proud of it. Now I can’t treat a patient who will come back to thank me, they always die. We look at them dying every day, and that is more emotionally stressful and draining. Therefore, I want to resign and open up just a business of a different form”



Other expressions made by nurses include:

“You know conditions of patients do not change any more. Sometimes they come to the hospital and get worse in the hospital and die. This has affected me and made me not to enjoy my work. May be, because I saw too many thin dead bodies and it is hurting to see relatives crying everyday. It is too much draining. I want to leave nursing. Any opportunity I get I am gone”

4.4.2 Feeling Guilty

Nurses have developed feelings of guilt in their jobs when they cannot render proper care as needed by patients and the public. This was indirectly expressed. For example many nurses felt:

“Let me tell you the truth, we do not do any sterile dressing procedure in this ward any longer. And we don’t wash patients anymore. Their relatives do that.

We don't make their beds or even dust the rooms as it is supposed to be, and this pains me a lot. What will God think of me? I took a pledge to this profession"

One nurse clearly accepted the blame and put it this way:

"I know that I am to be blamed for the inadequate care as I told you and I also know that I am the guilty party, but truly speaking I am a human being and cannot work like a machine".

4.5 Risk and fear of contracting HIV from patients

When nurses were asked whether there is a risk of contracting HIV virus from patients, one focus group discussion and interviewed nurses agreed. They described three medical procedures, which, if not done carefully, would expose them to the risk of contracting HIV virus from patients. These are injecting patients, wound dressing and assisting in deliveries.

The other focus group also declared that there is a risk of catching HIV virus from patients. They have identified the cause as mainly resulting from lack of materials in the hospital.

"The main problem of supplies is containers for needles, which are sometimes full. And for two weeks, you may put needles in card boards and this causes many people to incidentally prick themselves with used needles. Sometime these containers go to other hospitals, where they should be emptied and it takes too long to get them back."

When asked whether they fear to get infected while performing their duties, both FGDs and individual nurses declared:

“We are scared, because if you contract HIV/AIDS there are no way you can get it out of your system?”

Nurses seem to have fear of the unknown because many patients who come

in contact with them are not HIV tested, thus patients do not know their HIV status:

“There is no cure for AIDS. ” “I am scared of contracting that damn thing. Because you don’t know their status... patients. Most of them are already infected and they don’t even know themselves”

Another phenomenon that was raised by interviewed nurses was fear of the risk of contracting HIV/AIDS from fellow colleagues who are HIV/AIDS positive or suspected to be HIV/AIDS positive. This came out clearly as it is described below:

“I am scared of getting HIV virus not only from patients but from colleagues as well. I know it cannot be contracted from sharing a cup of coffee, but surely, some colleagues have open wounds and some oozing rashes from the lips and all over the face. And imagine we have to share the telephone handles. Really it is serious because you cannot clean the telephone handle while your colleague is watching you as a result you just talk”

However, when asked what precautions they took to protect themselves some seem to take more precautions than others. Others seem to be calm and did not worry much about whether they will catch the virus while performing medical procedures. For example one nurse made fatalistic observation:

“What else can I do, I have accepted the situation as it is and I have given my life to God”

The two focus group discussions provided a similar response, agreeing that sometimes they feel embarrassed when they have to use protective materials;

“We know we have to protect ourselves but at the same time we are confused. Even if we know that we have to protect ourselves by using protective materials sometimes patients shout at us, therefore some times we just have to work just like that without embarrassing them”

Others, who take precautions in order to avoid being infected by patients, responded confidently:

“I use gloves and handle the needles carefully”

“I cover open wounds if I have some that may risk the chance of contracting HIV/AIDS from patients”

Other concerns described by the nurses are:

- Fear of untimely death leaving the loved ones behind.
- fear of becoming sick and taking medication as a life long treatment
- fear of being stigmatised,

4.5.1 Fear of untimely death and leaving the loved ones behind

The nurses bluntly explained how they fear to catch the virus and why. These are some of their concerns:

“I am scared of contracting HIV/AIDS from my job; I am the only person who is working in the family and they will suffer if I die. I also know that once I get it I will die and my folks will suffer and I will also be forgotten by the Ministry”

4.5.2 Fear of taking life long medications

Nurses who were previously pricked by infected needles seem to be more overwhelmed by the fear of catching the virus from patients. This could be seen from the following statements:

“I am very much scared because I once pricked myself with an infected needle. And since then I get even more scared to prick myself again. When I am thinking of dying or taking too many tablets for the rest of my life it is even worse”.

4.5.3 Fear of being stigmatized

Stigma seems to play a role in the work place, and has become a source of fear for catching the virus. This is demonstrated by the quote from one of the interviewees:

“Once you are exposed to an infected blood, the risk of contracting the virus is high. And if you get it in your system you will never get it out, with no cure yet. To make it worse, who will know that it is from your job? Everyone will laugh at you and the Ministry will not even feel sorry to give you drugs for free. ”

The pressure placed on nurses by their family members due to stigma also emerged. One nurse shared her experience:

“Do you want to hear it...? I don't know where to start but well... here it is....my husband who claims to love me in bad and good times just started one day as a joke... That he wouldn't have sexual contact with me if I continue to work in the wards. He insisted that I should be transferred to the kitchen. But I am not the only nurse in this ward and I am not a cooker for that matter. So can you see that this new disease is affecting us, as far as our bed rooms? ”

4.6 Support system for solving problems at the workplace

Generally there should be a support system to solve problems that may arise in work situations. From what was described by nurses interviewed, and what came out of the two focus group discussions, nurses have problems concerning their work. An attempt was made to find out whether there is a support system where these problems could be discussed. When asked, nurses seem to have different opinions:

“There is a support system in place but we are not open to discuss our problems”

Some nurses seem not to know whether there is a support system in place:

“I cannot say that there is a frame work because we normally don’t sit but sometimes we talk to other colleagues to help us”

In the focus group discussions nurses confirmed that there is a support system in place, but felt that, it is not supportive enough to solve their problems:

“We have meetings in the Ward every month to discuss our problems internally and these problems are taken to our superiors by our supervisors. But the only thing is, you really don’t see any solution until we become hostile then”

People seem to take work-related issues as personal which in most cases disturb their good working relationships:

“Problems are not solved in a good spirit people do take it personal on themselves and spent some months not talking to each other”

Some nurses are unhappy with the support system that is in place, and feel that, there is lack of transparency hence problems are left without any form of discussion in order to productively solve them:

“There is no open communication system with one another that is transparent, which is the only way to solve problems”.



CHAPTER 5: DISCUSSION

5.1 Overview

Nurses as members of a society are affected by whatever happens to the general population. Over half of the respondents (14/22) belong to the age group which is most affected by HIV/AIDS in Namibia. The HIV/AIDS prevalence for the 15-49 years, age group is 22%. Assuming that the same rate applies to the population of nurses, it could be discerned that, many nurses are also infected by the virus. This will have a negative impact on the health care provision, as it will increase the attrition rate which is already high.

5.2 Constraints of work in the health care service

The interviews indicate that the main challenge for the health care system is increased demand of health care services owing to growing number of HIV/AIDS patients. This is in line with findings of a study in South Africa by Shisana *et al.* (2002) which concluded that the increased demand for care by HIV/AIDS patients was draining the available health care resources. The increased demand generated by HIV/AIDS is seriously affecting the country's health system, which is also overstretched by other emerging and re-emerging diseases. The latter include upsurge in malaria, tuberculosis and non-communicable diseases related to the epidemiological and demographic transition. This is perhaps manifested in the health indicators of Namibia, relative to the resources that it commits to health care. The country spends about 342 international dollars per capita on health care (WHO 2004), a figure that is one of the highest in sub-Saharan Africa.

However, its performance as measured by indicators such as healthy life expectancy is comparable to those in the sub-Saharan region who spend by far less than that of Namibia.

Furthermore, staff losses that are ascribed to HIV/AIDS are said to compound the problem of scarcity of resources by affecting the supply of nurses. Consequently, there is an inadequate number of nurses available to provide good quality care in the hospitals; hence the quality is compromised.

Staff shortages result in poor quality care. The available nurses in the hospitals are failing to cope with increased workload, thus they are experiencing stress. This is because they have to care for HIV/AIDS infected people, with little knowledge about medical problems their clients face. This is also highlighted in the literature that, health workers have to cope with role expansion, bear new responsibilities in situations for which they are untrained (Tawfik and Kinoti, 2002).



5.3 Lack of knowledge and skills in managing HIV/AIDS patients

Shisana *et al.* (2000) noted that, nurses have inadequate knowledge in managing HIV/AIDS patients. Nurses overtly, expressed a need to acquire knowledge and skills in managing HIV/AIDS patients. This serves as a call to the health sector to take action by identifying new training needs of nurses pertaining to HIV/AIDS.

5.4 Low work morale

The study indicates that nurses have lost work morale and this has resulted in job dissatisfaction. The main sources of low work morale are said to be increased by workloads and lack of supportive supervision. Low work morale has resulted in feeling hopelessness and helplessness. As a consequence, many nurses are considering leaving the nursing profession. This implies that nursing as a profession is in peril in Namibia. If no mechanism is found to remedy the situation in terms of retaining the skilled and experienced nurses, the health system's objectives may be jeopardised in Namibia. Mechanisms such as supportive supervision of health workers are found to play an important role within the AIDS care relationship and to some extent can motivate nurses to stay in the nursing profession (Hayter, 1996).

5.5 Risk and fear of contracting HIV/AIDS in the work place

Participants have expressed an increased fear of contracting HIV/AIDS from their patients. It came out clearly that when performing their nursing jobs, nurses fear to contract HIV virus. Furthermore, they seem to be overwhelmed by the idea that they may contract the virus from patients. This is attributed to previous bad experiences of needle stick injuries and by the fact that, the nursing profession is risky, in terms of contracting any communicable disease including HIV/AIDS from patients. In addition, their fears are compounded by the reason that many patients in Namibia are infected with HIV virus and only a few know their HIV/AIDS status (Haoses, 2001). It appears that nurses are over-reacting by developing fear of contracting the disease in the work place, based on their bad experiences and perceptions. This undue fear may be related to the fact that the disease

is not curable and at least in the short-run access to anti-retroviral drugs that could prolong life and enhance the quality of life is limited.

The above finding on nurses' reactions is similar to findings of other studies. For example, Horstman and MarkKusick (1986) in their study on psychosocial reaction of physicians working with AIDS patients reported that the degree of depression, anxiety, overwork, stress and fear of contracting HIV/AIDS and death were experienced frequently.

Another critical issue that emerged from this study was that nurses are scared of succumbing to AIDS. This implies that the fear of death may drive nurses to shun their patients, thus compromising the quality of care that patients are entitled to.

It is demonstrated in the literature that health workers have benefited from information provided through workplace programs. This is proved to have increased their knowledge that attributed to positive attitudes towards the infected patients. In this study nurses indicated the will and eagerness to learn and acquire knowledge in managing HIV/AIDS patients. Therefore, the situation could be improved if the health sector would establish and strengthens workplace programmes that could support health workers. In line with the above, the 4th UNAIDS report on the global AIDS epidemic (2004) suggests that, targeting HIV-positive health workers for antiretroviral treatment and ensuring workers' occupational safety and health by providing adequate information and protective clothing

may help in protecting the health and safety of health personnel thus minimising the risk and fear of contracting HIV/AIDS from patients.

5.6 Stigma

Not unexpectedly, the respondents commented that latent stigma exists at the work place, in the community and among family members. Similar findings were indicated by Hayter (1999) and Tawfik and Kinoti (2002). Consequently, nurses may be discriminated against, because of their profession. The potential discrimination that the nurses are likely to face adds to the fear of contracting the disease and the resultant negative effects on the quality of care that they provide to their clients. Thus, reducing stigma through sustained and intensified information, education and communication campaigns become important to avoid the undue fear of contracting the disease that the nurses have developed.

5.7 Support system for solving work related problems

Another critical issue that emerged from the findings was that nurses experience stress and burn out due to increased workload and demand. Lack of knowledge of managing the HIV/AIDS patients is found to exacerbate their stress level. This could result in sickness and absenteeism which could have a negative effect on staff productivity. Gueritault-Chalvin et al., (2000) report that consequences of occupational burn out include reduced productivity, absenteeism and high staff turnover in organisations. This may have a tremendous negative effect on the health care provision in Namibia, because there is already a gap between bed occupancy rate and nurses ratio. This suggests for an urgent

call to design a strategy that may be used to rescue the anticipated crisis as a result of stress and burn out.

Furthermore, the results clearly show that, HIV/AIDS adversely affects the provision of health care through increased workload and creating stressful working conditions. To minimize this effect, it is essential to establish a support system at the workplace. However, as reported by the respondents, the system available lacks support. The health sector thus should consider developing support systems at the workplace in order to mitigate the negative effects on the health system that are likely to result from the psychosocial impact of the disease on nurses.



CHAPTER 6: CONCLUSION AND RECOMMENDATIONS

6.1 CONCLUSION

Based on the research findings, the following conclusions are drawn:

The Ministry of Health and Social Services in Namibia has certainly faced an enormous task of transforming the health care system since independence in 1990. During the post-independence period a number of successes have been achieved for example the decentralisation of the health care system to thirteen regions was implemented successfully. However, the gains made are being reversed by the HIV/AIDS epidemic and its impact on the health sector and the macro-economy at large.

In this study, the findings revealed that there is growing number of HIV/AIDS patients, shortage of staff resulting from resignation and HIV/AIDS related deaths with no replacements. This was found to adversely affect the level of quality of care provided to patients. It is also stated that nurse's experienced stigma therefore are discriminated against by family and community members. This led nurses to develop fear of contracting HIV/AIDS from patients which resulted in stress and burn out. Lack of knowledge on managing HIV/AIDS was also indicated as one of the challenges in rendering quality care to patients with HIV/AIDS.

It surfaced from the findings that there is no effective supportive and supervision for nurses to enable them to air their views and find productive solutions to the problems faced. This causes low work morale among nurses.

This study investigated the nurses' perceptions as well as their opinions on the impact of HIV/AIDS on the health care provision. However, it should be noted that individual's view of reality differ and may be part of past experiences and settings in which the phenomenon is explored.

6.2 RECOMMENDATIONS

Quality health care is an essential element to sustain quality life and should be researched thoroughly if Namibia needs to keep its nation healthy, especially in this era of HIV/AIDS. Based on the conclusion the following recommendations are made:

6.2.1 Intervention Recommendations

1. The Ministry of Health and Social Services should put a mechanism in place to monitor the health staff's absenteeism and movements in order to find strategies to address these challenges.
2. The Ministry of Health and Social Services should identify training programmes for nurses such as providing information on how HIV/AIDS is transmitted, HIV/AIDS counseling skills, Anti-retroviral treatment to manage HIV/AIDS patients thus minimise stress and fear in the work place.
3. There is a need to establish the support system such as monthly meetings where nurses could discuss freely with their supervisors on issues related to their work settings in order to improve the health care system of the country.

4. The ministry should further strengthen the health workers' workplace programmes by clearly indicating its objectives, the program benefits and make HIV/AIDS information available to all health personnel.

6.2.2 Recommendations for further research

In light of the results, various issues arose from the research and a number of considerations for future research are recommended:

1. The MoHSS should conduct a study to assess the reasons for staff attrition and absences from work. This would assist the Ministry to determine the magnitude of the problem and help the sector to devise strategies for staff retention thus increase health staff productivity hence quality care.
2. The MoHSS should develop a tool to investigate and monitor the shortage of staff versus the patients' workloads.
3. The MoHSS should study the current disease patterns to determine what causes the deteriorating disease profile of the country.

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APPENDICES

APPENDIX A: LETTER OF REQUEST FOR A PERMISSION TO CONDUCT A STUDY

P.O Box 99017
Tauben-Glen 2
July, 2004

To: Omusati Region Hospital
Manager Utapi
Hospital

Through: Dr K Shangula
The Permanent Secretary
MoHSS
Windhoek

Dear Dr Sir/Madam

Request to conduct a research on the Impact of HIV/AIDS on Health Care Provision in Omusati region, Utapi Hospital

I am currently registered with the University of the Western Cape undertaking my final year of the Master Degree in Public Health. One of the requirements to be awarded with the above-mentioned degree is to conduct a mini-thesis pertaining to public health issues.

Namibia is one of the Southern-African countries that are negatively affected by HIV/AIDS. This could have a negative effect on the Human Resource in the country including Human Resources for Health.

I therefore, chose to conduct a study in this regard. The study will be based on the perceptions of nurses on the impact of HIV/AIDS on the health care provision. The findings of this study will provide an insight on how the health care provision in Namibia is affected. This could be useful in strategic planning and management of the epidemic.

Based on the information above, I therefore apply for a permission to conduct this study in Utapi Hospital starting in early August, 2004.

Attached please find the research protocol of the proposed

I thank you

Ms. M Pendukeni

cc: Ms. M Zauana: Head of management Information and Research Subdivision

APPENDIX B: LETTER OF APPROVAL

GOVERNMENT REPUBLIC OF NAMIBIA

154903

*done 27/8/04
all the way*

MEMORANDUM

(5 lines)
2283383

Tel. No: Extension 19

From Ms ET Kashile
Nursing Manager
Outapi Hospital

My reference:
No.

To To all Heads of
department.
Outapi Hospital.

Your reference:
No.

Dated 27-08/04

RE: Authorization for conducting Research
in Outapi Hospital.

Kindly be informed that Ms Monica
Penderon would like to conduct
research in Outapi Hospital regarding
her Masters in Public Health during the
period of 30 August - 10 September 2004
as per attached letter + proposal.
She will interview nurses in groups
as well as individual.
Please give her your usual co-operation
Thank you very much.
ET Kashile

SEP. 29 2004 PHONE NO. : 065251020 OUTAPI DISTRICT HOSPITAL

APPENDIX C: FOCUS GROUP DISCUSSION GUIDE

ASSESSMENT OF THE IMPACT OF HIV/AIDS ON NURSES CURRENTLY WORKING IN ONE REGIONAL/DISTRICT HOSPITAL IN NAMIBIA

Question checklist 2. Guiding questions for the FGD with the nurses

Name of the institution:

Date:

Name of the facilitator:

Names of recorders:

FGD by cadre:

6 Nurses

General Working Conditions (Availability of Supplies, and commodities)

Career development

Job satisfaction,

Impact of HIV/AIDS on working conditions, e.g increased workload, working environment perception e.g more risky?

45 Minutes to 1 hour of discussion

Tape discussion but seek permission. if not provided write notes.



1. Welcome / introduction and purpose of the discussion.
2. In your opinion, has there been any change in the workload at this station over the past years?
3. Has the work increased or decreased?
4. How do you know about this change?
5. When (which years) have you noticed a marked increase in the workload?
6. What do you think are the reasons for this increase/decrease in the workload? Put them in order of importance.
7. How have you adjusted to this increased workload in you cadre at this station?
8. Has this increase in workload affected your attitude/morale towards your work?
9. What should be done by all health stakeholders (government, NGOs, health staff, the community etc) to deal with this problem?

10. Are HIV/AIDS counselling activities being implemented in your institution? How are they going on? What should be done to improve these?
11. Are VCT activities being implemented in your catchment area? How are they going on? What should be done to improve these?
12. Are PMTCT activities being implemented in your catchment area? How are they going on? What should be done to improve these?
13. Are uses of ARV activities being implemented in your institution? How are they going on? What should be done to improve these?
14. What are other activities / programs you are undertaking in response to the HIV/AIDS pandemic?
15. Are there other services that you think are essential to help alleviate the burden that is faced in trying to improve the care of HIV/AIDS patients?
16. Are there new cadres of health workers that you think are necessary to effectively deal with HIV/AIDS?
17. Have you noted an increment in the absence of health staff or you colleagues from duties?
18. What are the main reasons for the staff absence? List in order of priority.
19. Do always you have adequate supplies of protective materials at this institution?
20. What protective materials are usually in short supply and why?
21. What is your perception to the risk of getting infected by various diseases while on duty?
22. What are the main diseases that you feel you are most exposed to and why? List in order of importance.
23. Is there anything else that you would like to add concerning HIV/AIDS in this district?

THANK YOU VERY MUCH FOR YOUR PARTICIPATION !

APPENDIX D: SEMI-STRUCTURED INTERVIEW

<p style="text-align: center;">ASSESSMENT OF THE IMPACT OF HIV/AIDS ON NURSES CURRENTLY WORKING IN ONE REGIONAL/DISTRICT HOSPITAL</p> <p>Questionnaire 1. Work load relating to HIV/AIDS</p>
--

Name of Enumerator: _____ Name of supervisor: _____

Current date: / ___ / 04 _ Name of facility:
(dd / mm / yy)

Parent organization: _____ District: _____

My name is Monika Pendukeni, I am currently studying at the University of Western Cape undertaking Masters Degree in Public Health. One of the requirements to be awarded with this degree is to conduct a mini-thesis in your area of interest. I have chosen to conduct a research assessing the impact of HIV/AIDS among nurses in one regional or district. I would like to ask for some of your time to answer the questions below. All the information obtained will remain strictly confidential and your answers will never be identified. I would like to use results of this study also when planning for training of nurses. If you have no objection, I would like to start asking you the questions. *BEGIN THE INTER VIEW IF PERMISSION IS GRANTED.*



Current profession (cadre): _____

1. How old are you? [] []

3. Sex (M/F): ___

2. How long have you worked in the public hospital

- a) Less than one year
- c) 6 - 10 years
- e) 16 - 20 years

- b) 1 – 5 years
- d) 11 – 15 years
- f) > 20 years

3. In your opinion, what is the single most important constraint in health service delivery these days?

4. How do you compare workload during the early period of your employment and this time?

- a) the same
- c) decreasing

- b) increasing
- d) don't know

5. If the answer to #4 is b) (increasing), what do you think is the fundamental reason for the increase?

- a) Shortage of staff
- c) Increased number of patients
- e) Others (*specify*)

- b) HIV/AIDS
- d) Don't know

6. Has this increased of workload affected your morale towards your work? (a)

Yes b) No

7. If yes, in which way does the increased workload affected your moral

Please explain

.....

8. Have you been absent from working any time during the past four weeks? a)

Yes b) No

9. If yes, what was / were the reason (s); were these HIV/AIDS related?

Reason(s) <i>(tick those that apply; write the others)</i>	No. days absent	HIV/AIDS related? <i>(Yes / No)</i>
a) to look after a sick spouse or child		
b) to look after a sick relative		
c) went for funeral of a relative		
d) went for funeral of an accomplice		
e) was sick		
<i>Others:</i>		
f)		
g)		
h)		

HIV/AIDS prevention

10. Do you fear the risk of contracting HIV/Virus from patients who are diagnosed with HIV positive?

a) Yes b) No

11. If yes, why? Please explain

.....

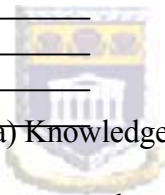
12. If no, why please explain
.....
.....

13. What do you do to minimize the risk of contracting HIV/AIDS from infected patient?
.....
.....
.....

14. Do you know about Universal Blood Precautions?

Yes b)

15. If yes, please tell me at least five elements of Universal Blood Precautions



Interviewer assessment: a) Knowledgeable b) lack adequate knowledge

16. If your work involved direct patient care or handling of biological specimens from patients, what measures would you take if you were pricked with a needle containing patient blood?

- a) clean the wound
- b) patient should seek pre-test counseling
- c) you (staff) should seek pre-test counseling
- d) patient should be tested for HIV
- e) you (staff) should be tested for HIV
- f) patient should seek post-test counseling
- g) you (staff) should seek post test-counseling
- h) where necessary you (staff) should start ARV therapy
- i) where necessary patient should start ARV therapy

Others (*specify*):

17. Are there national guidelines to follow in the circumstances described in Q10 above? a)

Yes b) No c) Don't know

HIV/AIDS initiatives

18. Please tell me all the HIV/AIDS initiatives taking place in your working place

- a) None
- b) VCT
- c) PMTCT
- d) Home Based Care
- e) Others (*specify*):

19. Please tell me all the HIV/AIDS related training you have attended (*tick [✓] the appropriate cells*)

Initiative	Type of		When trained	
	Pre-service	In-service	<2 years ago	2 or more years
a) VCT				
b) PMTCT				
c) Home Based Care				
d) Others:				
e)				
f)				
g)				

20. Have you ever been trained in HIV counseling?

- a) Yes []
- b) No []
- c) Don't know []

21. If yes, are you involved in HIV/AIDS counseling on regular basis? a)

- Yes []
- b) No []
- c) Don't know []

22. If not, why?

23. In your opinion, what do you think about the level of availability of supplies and commodities for management of patients?

- a) adequate
- b) inadequate
- c) more than necessary

24. Does this pose any challenge regarding your work?

- a) Yes []
- b) No []

25. Do you have ideas on what could be improved?

- a) Yes []
- b) No []

26. If yes explain

27. If yes what?

How? _____

28. Do you have a framework where your work related problems can be discussed and solved with your supervisors?

a) Yes b) No

29. If no, how your problem is normally solved:

30. What do you think could be done to solve this problem?

Thank you for your participation

