

Workplace Stress and Coping Strategies among Nurses in HIV/AIDS

Care: Geita District Hospital, Tanzania

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UNIVERSITY of the
WESTERN CAPE

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KEY WORDS

Nurses

HIV/AIDS

Workplace stressors

Coping

Occupational Stress

Coping strategies

Workplace support

HIV/AIDS Caregiving


Occupational Burnout

Nurses in AIDS care



DECLARATION

I hereby declare that this Mini-thesis 'Workplace stress and Coping Strategies among Nurses in HIV/AIDS care in Geita District Hospital, Tanzania' is my own work and has not been submitted, or part of it for any degree or examination in any other University. All sources used or quoted in this report have been indicated and acknowledged by means of complete reference.

Signature:

Constance Mubekapi

Supervisor:.....

Verona Mathews



DEDICATION

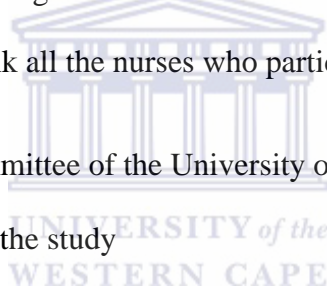
Firstly, I would like to thank God the almighty who guided me during this phase and made it possible for me achieve my goals through the faith and trust I put in him. I would like to dedicate this to my husband, Jasper and my children, Makanaka and Henry for their understanding, patience and allowing me to deprive them of quality family time. I will always treasure their love and support which got me through this period. Lastly, I would like to dedicate this to my mother and late father, Sihle and Aaron Toendepi who have always inspired me to do great.



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ABSTRACT

The unprecedented increase in HIV and AIDS cases has trickled down to the already impoverished health sector, thus impacting health workers in various ways. In a shrinking health workforce, HIV/AIDS has created an extra demand and workload, emotional burden and stress among health workers. The study aimed to explore and describe nurses' workplace stressors and coping strategies with regards to HIV/AIDS environment.

The exploratory- descriptive study was qualitative in nature. Geita District Hospital was selected as it is the only health facility in the district that provides in-patient care services related to HIV/AIDS. The study population consisted of all nurses who work with HIV and AIDS patients and the managers providing support to nurses. The researcher interviewed twelve nurses and two key informants. Face to face interviews were conducted and a semi-structured interview guide was utilised to collect data. Thematic content analysis was utilised and themes were derived from the concepts that emerged during the process. Validity and trustworthiness of the study was established through triangulation and member checking.

The findings of the study revealed that nurses in HIV/AIDS experience stress from the workplace. Nurses struggled with issues of death and dying, feared occupational exposure and found it difficult to cope with nursing shortage, increased workload and inadequate training. The nurses were generally disturbed by lack of organisational support and the unavailability of resources such as; basic medical supplies and protective equipment. Nurses seemed to be resorting more to positive reappraisal, planful problem solving and seeking social support strategies.

ABBREVIATIONS

ART	Antiretroviral therapy
AIDS	Acquired Immunodeficiency Syndrome
CPD	Continuous Professional Development
CTC	Care and Treatment Clinic
DMO	District Medical Officer
FHI	Family Health International
GHI	Global Health Initiatives
HIV	Human Immunodeficiency Virus
MoHSW	Ministry of Health and Social Welfare
NGO	Non-Governmental Organisation
PEP	Post exposure prophylaxis
PLWHA	People living with HIV/AIDS
SSA	Sub Saharan Africa
STIs	Sexual Transmitted Infections
TACAIDS	Tanzania Commission for HIV/AIDS
UNAIDS	Joint United Nations Programme on HIV/AIDS
VCT	Voluntary Counselling and Testing

WHO

World Health Organisation



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CHAPTER ONE

INTRODUCTION TO THE STUDY

1.1. Introduction

Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) has been noted as the most devastating disease humankind has ever faced. In spite of progress being made in combating HIV/AIDS epidemics in some regions/countries, statistics for the year 2008 revealed that around 33.4 million people were infected with HIV/AIDS (UNAIDS, 2009). Approximately 2.7 million people were newly infected with the virus and 2 million deaths were recorded by the end of 2008 (UNAIDS, 2010). HIV/AIDS has continued to manifest itself globally affecting all levels of human existence and development. Sub-Saharan Africa remains the most heavily affected region, with about 68% of all people living with HIV, a region with only 12% of the global population (Delobelle, Rawlinson, Ntuli, Malatsi, Decok, and Depoorter, 2009). Two thirds of the 33.4 million HIV infected population resides in Sub Saharan Africa (UNAIDS, 2009). In 2008, an estimated 1.9 million people were newly infected with HIV, bringing the total to 22 million (UNAIDS, 2009). Seventy-two percent of worldwide deaths occurred in Sub-Saharan Africa (UNAIDS, 2009).

Tanzania is one of the countries that have not been spared by the HIV pandemic in the Sub-Saharan Africa region. It is among the least developed counties situated in the Great Lakes region of East Africa and is composed of two distinctive states, Zanzibar and Tanzania mainland (WHO, 2005a). The estimated total population is more than 40 million, with an adult population of 46% (UNAIDS, 2008). The UNAIDS (2010) report, revealed that the

adult HIV/AIDS prevalence in 2009 was estimated at 5.6%. An estimated 1.2 million adults (aged 15 years and older) were living with HIV, with 730 000 women being infected (UNAIDS, 2010). More than 160 000 children (0 to 14 years) have been infected with HIV and 1.3 million AIDS orphans aged 0 to 17 years were recorded (UNAIDS, 2010). In addition, 86 000 deaths were attributed to AIDS. In 2003, the rollout of antiretroviral drugs was initiated in the public health sector. In 2008, nearly 136 000 people received antiretroviral treatment (ART) and an estimated 440 000 are in need of ART (UNAIDS, 2009). The WHO guidelines revealed that by 2010, only a third of Tanzanians in need of treatment were receiving it (UNAIDS, 2011a).

Beyond the significant human toll, HIV and AIDS have a wider impact on the economy and the society (ILO, 2006). The rapid spread of HIV disease progression and the unavailability of a cure create major challenges in the socio-economic development of persons, households and communities (ILO, 2006). HIV/AIDS has had far reaching implications worldwide. It is reversing the major socio-economic gains in areas such as health and education (ILO, 2006). In particular, health care services have not been spared by the pandemic; it has increased both their demand and complexity (Tawfik and Kinoti, 2003). As a result, HIV and AIDS have increased public health expenditure and the demand for preventive, rehabilitative and curative services (Tawfik and Kinoti, 2003). Effects such as an increased burden of disease, increased service needs associated with caring for the ill and an inadequate and diminishing capacity to respond to HIV/AIDS have been felt in the health care system in Tanzania (TACAIDS, 2008).

Tanzania had made tremendous advances in health care and health systems (ILO, 2006). However, the HIV/AIDS epidemic has reversed these gains, thus affecting the quality of care. HIV and AIDS have been ranked as one of the major burdens of disease. It is increasingly becoming the major underlying cause of hospital admission with AIDS-related hospitalisations taking up much of the public health expenditure (TACAIDS, 2008). Consequently, fifty percent of the national bed occupancy is attributed to AIDS-related illnesses, suggesting that nurses render HIV/AIDS care on a daily basis (TACAIDS, 2008). Akin to most developing countries, nurses in Tanzania are the initial contact for patients and provide as much as 80% of the health services in rural areas (Nkowane, Boualam, Haithami, Ahmed El Sayed and Mutambo, 2009).

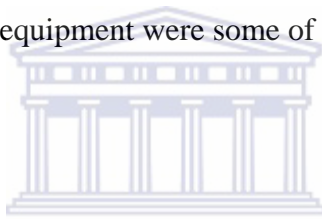


1.2. The Current State of Nurses in Tanzania

Tanzania is facing major challenges with regards to health care professionals. Statistics have shown that the country has a shortage of health professionals. The Health Statistics Abstract Report of 2006 indicated that about 65 000 health workers were employed in the health sector (MoHSW mainland Tanzania, MoHSW Zanzibar and WHO, 2007). In relation to nurses, Tanzania has a total of 4 841 professional nurses and 9 990 nurse midwives, corresponding to 1.3 nurses and 2.5 nurse midwives per 10 000 population; which translates to a ratio of 1:40 (MoHSW mainland Tanzania, MoHSW Zanzibar and WHO, 2007). Nonetheless, the country has failed to meet the World Health Organisation (WHO) minimum standard of 23 health workers per 10 000 population (Touch Foundation, 2009). In fact, Tanzania has a health worker deficit of approximately 84 000 (Touch Foundation, 2009). Studies have approximated that one nurse serves an entire medical ward of more than 50 patients, while international benchmarks set the proportion at 1:6 (Mjasiri, 2009). It is estimated that within

the next decade, this number would increase to 104 000 if the Tanzanian government does not explore larger systematic interventions (Touch Foundation, 2009).

Nurses, who are the front-runners of patient care, are fleeing Tanzania for overseas. It is estimated that nearly over 13 000 nurses and midwives depart yearly (Mjasiri, 2009). This current situation in the country has been attributed to opportunistic emigrations in search of greener pastures, where working conditions and remuneration are favourable (Mjasiri, 2009). At the same time, some of those who remain have been affected by HIV/AIDS, thus widening the human resource challenge (Mjasiri, 2009). The Chairperson of the Tanzania Nursing and Midwifery Council revealed that salary issues, staff shortages, service placement schemes and inadequate requisite equipment were some of the major concerns among the nurses (Mjasiri, 2009).

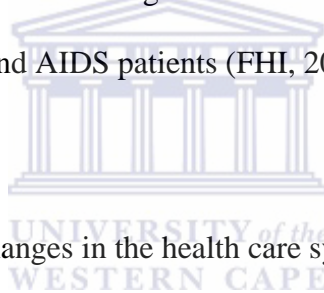


Quality healthcare services can be realised by adequate, well trained and staffed nurses, efficient uses of health care resources both human and material resources, patient satisfaction and an influence on individual health wellbeing. Small nurse-patients population ratios imply less workload and this in turn allows for better nursing care. Joint Learning Initiative (2004) recommends a minimum health worker density of 2.5 per 1000 population. On the other hand, the shortage of health care workers has a negative effect on the delivery-and-quality of health care services (Health Information and Research Section, 2008). Health workers face workload pressures due to staffing deficiencies. As a result, they encounter pressure prompted by ambiguity of changing responsibilities, conflicting workplace demands, insufficient time to complete tasks, challenges in dealing with dying patients as well as organizational pressures from non-involvement in planning and decision making (Health Information and Research Section, 2008). Consequentially, nurses experience low work

morale, impaired work performance, absenteeism, adverse interpersonal relations with clients, negative attitudes toward work, low job satisfaction, high job turnover, poor health and psychological well-being (Health Information and Research Section, 2008).

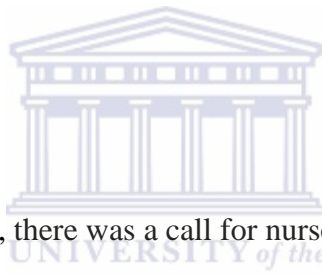
1.3. Nurses in HIV/AIDS Care

Nurses in Africa have been described as the linchpins for health care. They have long been acknowledged to engage in innovative activities that contribute to the much needed state of good health among patients and the community at large (WHO, 2009). They are expected to give quality nursing care to patients regardless of their illness (Smit, 2005). In essence, nurses have adopted both multiple traditional nursing roles and roles in new areas to successfully gratify the requirements of HIV and AIDS patients (FHI, 2008).



HIV and AIDS brought unique changes in the health care system and necessitated nurses to expand their roles and functions to suit people living with HIV/AIDS (PLWHA). These changes required nurses to perform their roles in a transformative manner. Nurses are expected to consult and actively engage with patients and communities in order to provide comprehensive HIV/AIDS health care services. The adoption of new responsibilities and priorities changed the nurses' perceptions of HIV/AIDS clinical practices (New York State Nurses Association, 2002). This included addressing the needs of HIV/AIDS patients with families at the central point. New duties and priorities also include HIV counselling and diagnosing, fulfilling the needs of HIV and AIDS patients and the management of opportunistic infections in HIV/AIDS patients (New York State Nurses Association, 2002).

However, nurses have expressed concerns on the adoption of new responsibilities. Miller (2000: 89 as cited by van Dyk, 2007) noted that prior to the emergence of HIV/AIDS; patient “counselling was almost unheard of as a cornerstone approach to public health management...” Nurses expressed comfort in traditional advice-giving, patient-provider role and found it difficult to adhere to counselling principles (Gerbert, Caspers, Moe, Clanon, Abercombie, and Herzig, 2004). They lacked training and support for emotional and technical issues surrounding AIDS patients (Dieleman, Biemba, Siching-Sichali, Sissolak, van der Kwaak, and van der Wilt, 2007). As a result, nurses expressed feelings of insecurity and frustration because they provided HIV counselling which they were not capable of performing since they lacked the appropriate counselling skills (Lehmann and Zulu, 2005 as cited by van Dyk, 2007).



As the AIDS epidemic intensified, there was a call for nurses to transcend their fears and provide effective compassionate care to individuals living with HIV/AIDS (Sherman, 2000). However, the complexity and chronic nature of HIV/AIDS presented many challenges for nurses caring for patients with the AIDS related disease. Certain organisational factors were found to be commonly associated with stress. These included high job demands, fear of contagion, poor interpersonal relationships/ organisational support, lack or shortage of essential resources including, nursing staff, excessive workload and dealing with dying and death (Moore, 2001; Dorz, Novara, Sica and Sanavio, 2003).

Nurses have been reported to care for chronically ill AIDS patients who need constant care, while at the same time providing nursing care to general patients and counselling patient's

relatives (Dieleman et al., 2007). As a result, nurses experience frustration, anger and inadequacy due to stringent workplace conditions, minimal supervision and lack of staff, inadequate training and lack of managerial support (Smit, 2005). van Dyk (2007) and Delobelle et al. (2009) noted that nurses often expressed frustration over the lack of support from their immediate managers. Working in an unsupported environment affects the quality of care and morale among nurses (Fournier, Mill, Kipp and Walusimbi, 2007). In the long run, nurses find working with persons living with HIV/AIDS to be both physically and mentally taxing (Sherman, 2000; Moore, 2001; Fournier et al., 2007; Mkhabela, Mavundla and Sukati, 2008).

While nurses have the potential to make critical changes in HIV/AIDS management by providing both physical care and emotional support for people living with HIV/AIDS (Nyamathi, Vasta, Khakha, McNeese-Smith, Leake and Fahey, 2008), they are often ill-prepared to deal with occupational exposure and how to respond effectively to the clinical and nursing aspects of HIV/AIDS care (Panter et al., 2000). As HIV/AIDS care becomes increasingly complex, nurses face a difficult task of maintaining cutting-edge skills and knowledge at a time of rapid change. The task of managing PLWHA is becoming increasingly difficult with widespread new HIV infections, evolving treatment regimens and complex management strategies (Liljestrand, 2004).

The absence of an HIV cure or vaccine has also pose challenges for nurses in AIDS care. HIV/AIDS is not a notifiable disease and many patients are either not aware of their HIV status or, if they are, they do not feel obligated to disclose their status (Hall, 2004).

Accordingly, as a result of the exacting and demanding nature of AIDS care, many nurses experience challenges that may escalate as a result of fear of HIV transmission from accidental injuries such as; blood splash, needle pricks and cut injuries. Consequently, the risk of HIV infection is a major concern among nurses who fear contracting the virus in the course of carrying out their professional duties (Hall, 2004; Fournier et al., 2007; Smit, 2005). This risk is further escalated by the low quality and the infrequent supply of protective measures such as gloves, masks and apron (Smit, 2005). This has increased nurses' apprehension while working with HIV/AIDS patients.

Nurses working with HIV/AIDS patients experience some degree of emotional stress. They are inclined to get an emotional attachment with patients to compensate for unfair treatment and the stigma patients face (van Dyk, 2007). Nurses confront stark suffering, grief, and death as few other people do. They often do not have time to grieve, this results in bereavement overload (van Dyk, 2007). Moreover, over-involvement or identification and boundary problems between staff and patients are important factors that contribute to workplace stress (van Dyk, 2007). The difficulty in discerning the fine line between involvement and over-involvement with patients often has serious consequences (van Dyk, 2007). Consequently, nurses experience occupational stress and burnout due to emotional challenge encountered while caring for AIDS patients (Sherman, 2000; Moore, 2001; Fournier et al., 2007; Mkhabela et al., 2008).

There is little control over many stressors that affect job satisfaction and a sense of well-being (Chang et al., 2006). An individual's perception or appraisal of a specific problem

determines the coping strategy. Coping strategies can either include an attempt to manage or alter the problem or to regulate an emotional response (Lazarus and Folkman 1984 as cited by Healy and McKay, 2000). Nurses experiencing workplace stressors have been found to utilise a variety of coping skills. The adoption of effective coping strategies is beneficial to nurses, as it decreases the risk of burnout. Kalichman, Gueritault-Chalvin and Demi (2000) found that nurses utilised wishful thinking, rational problem solving, social support and avoidance (directing attention away from the situation) to cope with workplace stressors. Individual coping strategies have been found to be efficient buffers of perceived stress, with internal and problem-focused coping showing protective effects against occupational stress (Gueritault-Chalvin, Kalichman, Demi and Peterson, 2000; McCausland and Pakenham, 2003; Lambert and Lambert, 2008).



Coping with workplace stress could be enhanced by both baseline and continuous education among the novice and experienced nurses (Corless and Nokes, 1996). Health worker education is one of the many critical factors that enhance the quality of care. An integrated approach is essential for the management of HIV/AIDS patients. The pace of new information necessitates a coordinated and effective approach in educating and training nurses in the aspect of HIV and AIDS care (Liljestrand, 2004). HIV/AIDS specific information has the potential to address the epidemic in the continuum of care and to increase the likelihood of consultations that have a salient role in the provision of HIV care. Rigorous interactive HIV training workshops can enhance knowledge, attitudes and willingness of nurses to provide care to infected persons (Nyamathi et al., 2008).

Despite the fact that high HIV and AIDS hospitalisation rates could have potentially negative effects on nurses, no study has been done in Tanzania to elicit nurses' workplace stressors and coping strategies.

1.4. Problem Statement

Nurses in Tanzania make up the majority of the health workforce and health care providers with prolonged and regular contact with HIV and AIDS patients. The debilitating nature of AIDS and its growth in the public health care system has created increased health care needs among people with the disease. Nursing AIDS patients entails extensive physical and emotional care. In the context of a high HIV prevalence and increased numbers of AIDS patients, nurses are often exposed to a variety of stressor related to HIV/ AIDS care. Work-related stress has been recognized to contribute towards increasing job frustration, rapid turnover, and high attrition rates among nurses (Lee, 2003). The complexities of working in an HIV environment under stringent conditions have led to fear of contagion, negative attitudes towards patients, fear of the unknown, fear of dying and high staff turnover, which exacerbate workloads. Workplace stress impacts not only on nurses' abilities to cope with job demands but also their health. Nurses' coping strategies with regard to HIV/AIDS care have not been fully explored and described in Tanzania. In fact, the increase in the number of HIV and AIDS patients necessitates tremendous support mechanisms to ensure that the health workforce can cope with the challenges posed. It is against this background that the study sought to explore nurses' experiences in HIV/AIDS care, and their coping strategies within the workplace context in Geita District Hospital in the Mwanza Region of Tanzania.

1.5. Purpose of Study

The purpose of the study is to describe the workplace stressors and coping strategies utilised by nurses in HIV/AIDS care, so as to assist hospital managers in developing workplace stress prevention and management plans applicable to their setting.

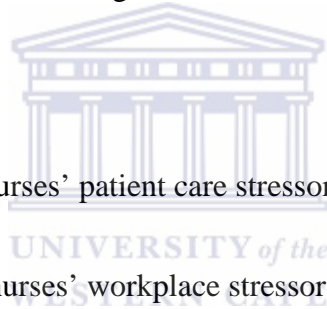
1.6. Aims and Objectives

1.6.1. Aim

The aim of the study is to explore and describe nurses' workplace stressors and coping strategies specifically in relation to working within an HIV/AIDS hospital environment.

1.6.2. Objectives

1. To explore and describe nurses' patient care stressors in HIV/AIDS care.
2. To explore and describe nurses' workplace stressors in HIV/AIDS care.
3. To identify and describe nurses' awareness and utilisation of support services available to health workers in HIV/AIDS care.
4. To describe the coping mechanisms utilised by nurses to deal with the stressors in HIV/AIDS care.



CHAPTER TWO

LITERATURE REVIEW

Introduction

This chapter outlines and discusses the global and the Sub Saharan regional trends in HIV/AIDS and its impacts on healthcare services. It continues with the concept of stress and its effect on nurses in the workplace concluding with the coping mechanisms utilized by nurses to overcome the challenges of HIV/AIDS care.

A search of online databases including MasterFILE Premier, Academic Premier, SocINDEX, Cumulative Index to Nursing and Allied Health (CINAHL), Health Source: Nursing/Academic Edition, JSTOR, MEDLINE, Sage Journals, ScienceDirect, SpringerLINK Journals and Wiley Online Library was conducted from the Electronic University of Western Cape Library. Due to scarcity of recent publications on HIV/ AIDS Workplace Stressors and Coping Strategies among nurses, the researcher reviewed published articles between 1990 and 2011. Search terms included workplace stressors, stress, coping, coping strategies, occupational burnout, occupational stress, AIDS care and HIV/AIDS nursing. Moreover, extensive internet searches were also carried out. Relevant articles were located through broader searches with the following key terms: nurses in AIDS care, HIV/AIDS caregiving, HIV/AIDS care challenges, nursing in Africa, organisational support, stigma, fear of contagion, lack of support, nursing workload and health care worker shortage. The internet search was limited to articles published from 2000 to 2011.

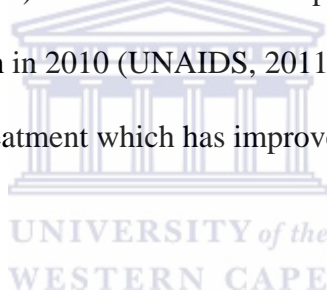
2.1. Global Overview of HIV/AIDS

According to the Global Health Council (2007) report, there is a global decline in HIV prevalence rates. It is estimated that by the end of 2010, 34 million people were already living with HIV (UNAIDS, 2011a). Approximately 2.7 million persons acquired HIV, down from the 3.1 million in 2007 (UNAIDS, 2011a). The annual AIDS related mortality reduced from 2.2 million in 2005 to an estimated 1.8 million in 2010 (UNAIDS, 2011a). Between 2001 and 2009, 33 countries recorded a decline in the HIV incidence of which twenty-two of them are in Sub-Saharan Africa (UNAIDS, 2011a). Countries with a great HIV burden have recorded decreases in numbers of young people acquiring HIV. The decline has been linked to changes in sexual behaviours, especially unprotected sex among other factors. Twenty countries in Sub Saharan Africa and the Caribbean have provided evidence for these changes. For instance, Burkina Faso, Botswana, Democratic Republic of the Congo, Ethiopia, Ghana, Kenya, Malawi, Nigeria, Namibia and Togo have noted an increase in the utilisation of prevention measures among young adults aged 15-24 years (UNAIDS, 2011a). In addition, a regression model applied to antenatal clinic data from 2000 to 2010 estimated the HIV prevalence trends and revealed a decline in HIV prevalence (UNAIDS, 2011a). The effects of antiretroviral therapy (ART) are evident in Sub-Saharan Africa. In 2010, there was a 30% decline in the number of AIDS-related deaths than in 2004 where ART began to be expanded (UNAIDS, 2011a).

The overall trend of HIV infections was reported different in the Middle East and North Africa region with an increase in HIV infections. According to the UNAIDS report, the number of people living with HIV increased from 43 000 in 2001 to 59 000 in 2010

(UNAIDS, 2011a). In the same period, the number of deaths due to AIDS-related diseases increased from 22 000 to 35 000.

Sub-Saharan Africa (SSA) continues to bear an uneven share of the HIV/AIDS global burden (UNAIDS, 2011a). In 2010, it was reported that about 68 % of the HIV infected population resided in SSA (UNAIDS, 2011a) which represents 12 % of the world population with about 839.6 million people (World Bank, 2012). In 2009, an estimated 1.8 million people were newly infected with HIV (UNAIDS, 2010). However, the incidence of HIV in this region is declining. There was a 16 % decline in the number of people with HIV infection in 2010 compared to 2001(UNAIDS, 2011a). The total number of people living with HIV in SSA is increasing; it reached 22.9 million in 2010 (UNAIDS, 2011a). This increase has been partly credited to the increase in HIV treatment which has improved the livelihood of PLWHA.



HIV/AIDS in Tanzania

In Tanzania, the HIV prevalence has been on the decline since 1998 (WHO, 2005b). This decline is attributed to decreased HIV transmission risk behaviours and increased coverage of biomedical interventions (Mujinja et al., 2009). For instance, the number of individuals testing for HIV increased from 15 % in both men and women in 2003 to 37 % for women and 27 % for men in 2008 (Mujinja et al., 2009). Similarly, the country saw an increase in the number of mothers accessing prevention of mother to child transmission of HIV (PMTCT) services. For instance, in 2008, the PMTCT data revealed a 61% increase over the last nine years (Mujinja et al., 2009). Sexual transmitted infection (STI) services were made available in both public and private facilities, thus increasing the effectiveness of STI

management. In addition, the procurement and distribution of male condoms increased from 50 million in 2003 to 150 million in 2006 (Mujinja et al., 2009).

2.2. Impact of HIV/AIDS on the Health Sector

The rapid spread of HIV/AIDS has had far reaching consequences globally and most especially for countries with high levels of HIV infection. As a result, health care provision and costs have been stretched to accommodate the HIV/AIDS pandemic. HIV/AIDS affects the health sector by increasing ill health, thereby escalating the demand for service provision (Jackson, 2002). Studies conducted in South Africa, Botswana, Zambia, Swaziland and Malawi revealed the effects of HIV/AIDS on healthcare workers. Some of the notable effects of the HIV epidemic on health workers included; absenteeism, productivity, increased tasks and workload, and increased emotional burden and stress levels (Shisana et al., 2002; Tawfik and Kinoti, 2003). Health care workers experienced work overload due to additional duties required to care for HIV /AIDS patients (Tawfik and Kinoti, 2006). These included voluntary counselling and testing and training family members about home based care. Shisana et al. (2002) found that 73 % of health workers experienced an increased workload. In Namibia, 75 % of hospitalisation cases in public hospitals are patients with AIDS related illness (USAID-Namibia, 2002) which obviously out numbers patients with non-AIDS related illness; thereby increasing the demand for HIV related services.

As the demand for HIV/AIDS care continues to exceed the available resources, health care workers are also faced with occupational risks. Globally, approximately 170 000 health care workers are exposed to HIV infection annually, resulting in 500 new infections (WHO, 2007). However, these occupational HIV incidences among health workers occur mostly in

low- and middle-income countries. Although 91 % of health workers in Senegal recognised the risk of infection at work, only 25 % took the necessary precautions and adhered to infection guidelines (Tawfik and Kinoti, 2006). In Tanzania, it was found that 42 % of the health workers had been accidentally exposed to potentially infective material within a period of five years (Muhondwa and Fimbo, 2006). The majority of accidents (67.5 %) were attributed to needle pricks and thus instilled fear of contracting HIV infection among nurses who are the frontline providers of AIDS care (Muhondwa and Fimbo, 2006).

The literature reviewed found that health workers are not only vulnerable to contracting HIV infection at the workplace but the high rates of HIV infection leads to increased attrition (Jackson, 2002). In Swaziland, 20 % of the deaths among health workers were due to AIDS related illnesses (Tawfik and Kinoti, 2006). Similarly, Mozambique noted a significant increase in health worker deaths (Tawfik and Kinoti, 2006). The authors concluded that countries with HIV prevalence of 15 % will have a projected mortality rate of between 1.6 % and 3.3 % among health workers.

As attrition levels increase, the remaining health workers bear the brunt. An increase in workloads and staff absenteeism affects nurses negatively. A review of records in Tanzania revealed that between 2003 and 2004, about 38 % of the health workers were absent from work either due to AIDS related illness or that of relatives (Muhondwa and Fimbo, 2006). Jackson (2002) revealed that AIDS care may be particularly stressful, because health care workers repeatedly face very ill patients, witness suffering and death, thus giving rise to anxieties rooted in occupational exposure to HIV. As a result, nurses may experience stress

and burnout. Stress and burnout have a negative impact on nurses and other health workers thus hindering their performance. Consequentially, the effects of burnout have serious repercussions for organisations, services and individuals (Gueritault-Chalvin et al., 2000).

2.3. Roles and Responsibilities of Nurses in HIV/AIDS Care

The healthcare landscape in SSA and in other resource- constrained regions has changed considerably over the past decade (Willard, 2004). The scale up of HIV/AIDS services has highlighted the health worker resource challenge and its consequences in delivery and sustainability of HIV/AIDS interventions (Zachariah et al., 2009). The scenario in SSA is worsened by high levels of HIV infections against the backdrop of health workers. Healthcare workers have witnessed various challenges such as work overload, absenteeism, and fear of infection, stress and burnout (Gueritault-Chalvin et al., 2000; Tawfik and Kinoti, 2006; van Dyk, 2007). To counteract the challenges imposed by HIV/AIDS, nurses are changing their roles in order to satisfy the needs of patients. The increase in treatment of chronic conditions for patients with HIV/AIDS has demanded that nurses extend their responsibilities beyond nursing care (Willard, 2004). HIV/AIDS management has necessitated a collaborative and communicative approach among health workers requiring a transformative tactic that offers a comprehensive and multidisciplinary approach to health care (Willard, 2004 2002).

In support to nurses expanded roles, WHO (2007 as cited by Zachariah et al., 2009) released recommendations and guidelines for task shifting in resource limited settings. In-service training, task-shifting and pre-service training have been noted as imperative elements indispensable in capacity development of health workers (WHO, 2006). Training enhances

and reinforces workforce knowledge as it provides opportunities for continued professional development (WHO, 2006). As nurses took on HIV/AIDS duties, they set new priorities and viewed nursing practices from a different standpoint (New York State Nurses Association, 2002). It is apparent that nurses have adopted new functions and responsibilities such as:

a. Nurses have adopted an advocate role. They are obligated to provide expertise and assist colleagues and the community in understanding risk behaviours associated with HIV transmission, the importance of counselling and testing with emphasis being placed on confidentiality and to meet the needs of persons with HIV/AIDS (New York State Nurses Association, 2002).

b. With every patient encounter, nurses should offer HIV education to patients, as well as the opportunity for voluntary HIV testing and counselling. Patients should be accorded an enabling environment that emphasise rapport and confidentiality (WHO, 2006).

In a shrinking health workforce, HIV/AIDS has created an extra demand on and increased the workload for health workers (Turan, Bukusi, Cohen, Sande and Miller, 2008). AIDS care is not the only factor leading to health worker overburden. Additional duties that come with the scale-up of HIV programmes increase the workload. This implies that nurses have to counsel patients on HIV and subsequently provide extra counselling to HIV-positive patients and their families (Delobelle et al., 2009; Turan et al., 2008). Rau (2004) noted HIV/AIDS related illnesses not only contribute to the workload of healthcare providers, but the complexity of the AIDS disease necessitates extra skills.

2.4. Stress

2.4.1. The Concept of Stress

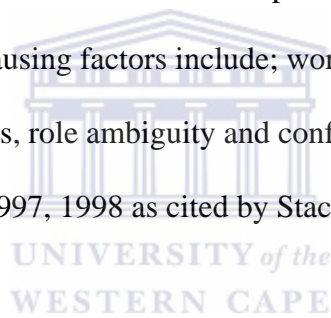
Selye (1956 as cited by Wheeler, 1997a: 710) defined stress as a “non-specific response of the body to any demand made upon it to adapt.” Viner (1999) noted that stress is a psychological and emotional imbalance of the body to excessive work-rate in the ever-changing society. Lazarus proclaims that the imbalance arising between environmental demands and the response capabilities of individuals produce stress (Lazarus, 1966 as cited by Lazarus, 1993a). Lazarus (1993a:4) mentioned four concepts that should always be considered when describing stress:

1. a causal external or internal agent, which Hooke called a load and others call stress or a stressor...;
2. an evaluation (by a mind or a physiological system) that distinguishes what is threatening or noxious from what is benign;
3. Coping processes used by the mind (or body) to deal with stressful demands;
4. A complex pattern of effects on mind and body often referred to as the stress reaction.

Lazarus (1966 as cited by Lazarus, 1993a: 5) expanded his theory by differentiating between three kinds of stress harm, threat and challenge. Harm denoted the mental damage an individual incurred. Threat was perceived as the expectation of harm that was imminent while challenge was viewed as a result of demands experienced by individuals, except that one feels self-assured to manage the demands through the adoption of coping strategies (Lazarus, 1966 as cited by Lazarus, 1993a). Environmental conditions bring about different psychological stress situations. As a result, individuals continually assess their environment in a bid to understand the perceived demands (Wheeler, 1997b). In essence, stress occurs when an individual cannot cope with the primary appraisal strategy.

2.4.2. Workplace Stress

Workplace stress has been defined as the “physical and emotional outcomes that develop in the presence of disparities caused by the demands of a job and the amount of control the individual exerts” (Lambert and Lambert, 2008:38). Workplace stress only develops when circumstances are perceived as surpassing one’s resources (Lazarus and Folkman, 1984). Workplace stress ensues “when the challenges and demands of work become excessive, the pressures of the workplace exceed the worker’s ability to handle them, and job satisfaction turns to frustration and exhaustion” (Lambert and Lambert, 2008: 38). Various factors that cause stress in organisational settings have been linked to precise situations that are characteristic of a work environment and to individual perceptions and responses (Stacciarini and Troccoli, 2004). The stress causing factors include; work dissatisfaction, work overload, interpersonal relationship conflicts, role ambiguity and conflict, resource shortages and pressure from clients (Wheeler, 1997, 1998 as cited by Stacciarini and Troccoli, 2004).



Nurses in different work settings experience different sources of stress. Workplace stress in clinical nurses has been associated with patient care, staffing levels, interpersonal relationships, administrative duties and workload (Sullivan, 1993; Tsai, 1993 as cited by Wang and Lee, 2002). In Australia, Healy and McKay (2000) found that the stress experienced by nurses has a direct relationship between work stresses, subjective perceptions of psychological distress and high incidences of stress-related burnout and emotional disorders. McNeely (1996) revealed that nurses in the United Kingdom experienced stress from work overload, staff shortage, failure to meet patients’ needs, very difficult or violent patients and poor or lack of support from senior staff. Psychiatric nurses have been shown to experience stressors associated with violent incidents, potential suicide, work overload of

observation staff, interpersonal conflicts, lack of support, and unclear goals and direction of the organisation (Sullivan, 1993, cited in Wang and Lee, 2002). Haematology and oncology nurses experienced stress through work load, while surgical nurses experienced stress through death and dying (Tyler and Ellison, 1994 as cited by Wang and Lee, 2002). The stress experienced by community health nurses includes inadequate time to complete work on time within scheduled hours, and work schedules not permitting adequate time to organise work (Walcott-McQuigg and Ervin, 1992, cited in Wang and Lee, 2002).

HIV/AIDS health care providers are particularly susceptible to workplace stress. Nursing of HIV/AIDS patients involves providing physical and psychological care and sharing the traumas of illness and death. The patients are not the only recipients of much needed services, but also the patient's family as nurses tend to form meaningful relationships with HIV/AIDS patients and their families (Shisana et al., 2003). van Dyk (2007) identified stressors inherent in caring for PLWHA: stigma and discrimination, nature of disease, grief and bereavement load, fear of contagion, lack of support, and professional and role issues. Collectively, these professional challenges can make AIDS care stressful. Nurses working with HIV/AIDS patients deal with stressors associated with anxiety about contagion (Chang et al., 2006) and intense staff-patient relationships (Smit, 2005). Similarly, Bennett, Ross and Sunderland (1996) and Gueritault-Chalvin et al. (2000) revealed that high levels of burnout were associated with HIV/AIDS care, implying that HIV/AIDS care involves significant levels of work-related stress.

The traditional goal of medicine and nursing care, to improve patients' lives and cure diseases, is not attainable in the context of HIV/AIDS (van Dyk, 2007). An HIV/AIDS impact assessment conducted in South Africa revealed that health workers were not able to do much to prevent the spread of HIV/AIDS, given that HIV/AIDS is incurable (Shisana et al., 2003). The unavailability of curative medicine has left many nurses feeling powerless and hopeless (Smit, 2005). Nurses express a sense of ineffectiveness and emotional stress, as sick patients are discharged without any health improvement (Delobelle et al., 2009).

Healthcare workers who are constantly exposed to terminally ill patients are highly likely to experience grief due to the absence of hope for a cure (Gueritault-Chalvin et al., 2000).

Redinbaugh, Schuerger, Weiss, Brufsky and Arnold (2001: 187) defined grief "as psychological distress related to loss." According to Sherman (2000) and Smit (2005), the greatest source of emotional stress is attributed to watching patients' condition deteriorate and finally die. van Dyk (2007) noted that even though nurses were accustomed to death of patients, the absence of grieving often resulted in bereavement overload, whereby death was seen as a personal failure contributing to emotional stress among nurses. Besides, nurses have reported inadequate training to manage the overwhelming grief of the end of life. Bennett, Ross and Kelaher (1993) noted that HIV/AIDS nurses experienced a sense of hopelessness, pessimism and a feeling of non-achievement due to high death rates among AIDS patients.

Stress in HIV/AIDS care has been linked to certain organisational issues (Lehmann and Zulu, 2005 as cited by van Dyk, 2007; Mazodze, Richards and Pennymon, 2004; Smitakestrin, 2004). Health workers often face feelings of frustration, anger, inadequacy and helplessness due to numerous organisational issues. Nurses have raised concerns over lack of practical and

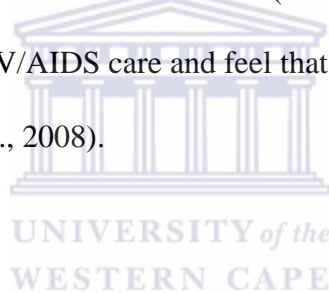
emotional support, lack of supervision and mentoring, and a heavy patient load and workload (van Dyk, 2007). Ninety-four percent of the health facilities participating in the study indicated that patients seeking HIV/AIDS care had increased (Shisana et al., 2002) Moreover, 73% of the health workers indicated an increase in workload. In South Africa, nurses expressed concerns over the deteriorating infrastructure, insufficient medical equipment, hospital understaffing and increasing numbers of patients in overcrowded wards (Shisana et al., 2002; Smit, 2005; Delobelle et al., 2009).

Lack of appropriate skills and role expansion are often mentioned as sources of occupational stress in AIDS care (Demmer, 2002; van Dyk, 2007). Nurses raised concerns about the lack of training and role expansion, with reports that some of the trained nurses were not willing to provide HIV/AIDS services (Delobelle et al., 2009). Gerbert et al. (2004) expressed that health workers were comfortable in their traditional roles of advice giving and patient-provider role. In Swaziland, nurses revealed feelings of discomfort in their counsellor role as sexual issues were not explored openly in their culture (Mkhabela et al., 2008). Similarly, nurses felt insecure and frustrated because they had to render HIV counselling they were unable to perform (Lehmann and Zulu, 2005 as cited by van Dyk, 2007).

While nursing HIV/AIDS patients maybe stressful, nurses acknowledge the importance of support. Both family and colleague support has been recognised as vital buffers to stress as it creates opportunities to discuss HIV issues (McCann, 1997). HIV/AIDS care volunteers expressed the need for organisational support which included emotional and educational support so as to foster communication and relief their personal burden (Held and Brann,

2007). Smit (2005) also expressed nurses' concerns over little or no support from hospital managers were lack of collegial support created an environment that was not favourable to work.

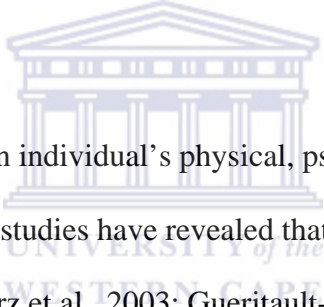
The issue of support has been partly attributed to HIV/AIDS stigma and discrimination. Stigma and discrimination are not only limited to patients, but also extend to nurses. They face secondary stigma due to their association with HIV infected patients. This challenge discourages nurses from working in HIV/AIDS services (Delobelle et al., 2009). Research has shown that secondary stigma has an impact on health care workers, thus contributing to emotional exhaustion, occupational stress and burnout (van Dyk, 2007). Nurses fear the stigmatisation associated with HIV/AIDS care and feel that they should be able to refuse to care for such patients (Turan et al., 2008).



While some nurses feared the stigma attached with AIDS, some expressed the fear of contagion despite the advances made regarding universal precautions (Sherman, 2000). Nurses are apprehensive about acquiring HIV in the workplace, and this is related to high levels of occupational stress (van Dyk, 2007). One study revealed that participants attributed the fear of HIV contagion to the awareness of physical risks of AIDS nursing. However, in another study, participants expressed concerns about HIV risks due to the low quality and an infrequent supply of protective measures such as gloves, masks and aprons (Smit, 2005). In Tanzania, needle stick injuries and cuts from sharp objects are the most feared hazardous in the health settings (Gumodoka, Favot, Berege, and Dolmans, 1997). Consequently, nurses have avoided and refused to care for patients (van Dyk, 2007).

2.5. Occupational Burnout

Occupational burnout is described as a particular type of stress which occurs in specialised settings where interpersonal work demands lead to chronic exhaustion, depersonalisation and reduction in the workers' sense of personal achievement (Cordes and Dougherty, 1993 as cited by Gueritault-Chalvin et al., 2000:149). It occurs mainly due to work demands or specification such as high expectations from either self or society (Khakha, 2006). The complexity and chronic nature of HIV/AIDS poses challenges such as; provision of extensive physical and emotional support for health care workers nursing patients with the disease. In the long run, nurses find working with PLWHA both physically and mentally taxing (Dorz et al., 2003) and over time, this can lead to occupational burnout.



Occupational burnout can affect an individual's physical, psychological, social and occupational functioning. Several studies have revealed that nurses experience occupational burnout (Fournier et al., 2007; Dorz et al., 2003; Gueritault-Chalvin et al., 2000; Mkhabela et al., 2008; Sherman, 2000). The authors identified the effects of occupational burnout. These included, diminished work morale, impaired work performance and reduced productivity, adverse interpersonal relations with both patients and colleagues and poor psychological well-being and health. Bennett et al. (1996) compared work stress among HIV/AIDS nurses and cancer providers and revealed greater symptoms of occupational stress and burnout were noted among nurses dealing with HIV/AIDS.

2.6. Nursing Studies on Workplace Stress in HIV/AIDS Care

International nursing studies on occupational stress

Sherman (2000) explored the physical, spiritual, emotional risks and stresses associated with AIDS care among 12 nurses in New York City utilising qualitative techniques. The results revealed that nurses assigned to AIDS care experience physical and emotional stress (Sherman, 2000). Nurses expressed fear of contagion, lack of confidence in skills to provide care for AIDS patients, and concern over the lack of resources and control over the environment (Sherman, 2000).

Kalichman et al. (2000) conducted a study among 499 members of the Association of Nurses in AIDS Care in the United States of America. The results revealed that nurses in HIV/AIDS care experience occupational stress. Quantitative analyses revealed that 64 % of the nurses cited patient care stressors as the primary stressor, these included stressors related to death and challenging patients (Kalichman et al., 2000). In addition, 36% of the nurses identified stressors from the workplace, these included stressors arising from the institution- 16 % and personnel- 20 % (Kalichman et al., 2000). A quantitative study identified the prevalence of stress among staff working in HIV palliative care of which nurses made up 14 % of the participants (Chandra, Jairam and Jacob, 2004). Nurses scored higher than any other staff on the Maslach's Burnout Inventory (MBI,) indicating a higher risk level of stress (Chandra et al., 2004).

Bellani, Furlani, Gnecc, Pezzotta, Trotti and Bellotti (1996) investigated whether there was a correlation between individual variables, burnout and job satisfaction among 196 Italian

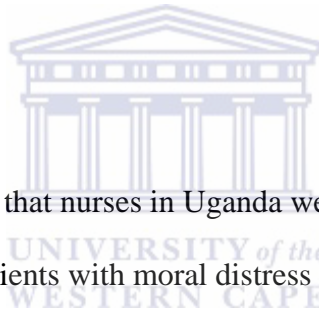
health workers of which 139 were nurses. The results revealed that there were no significant differences in burnout scores for sex, marital status, years in care-giving and years in AIDS units (Bellani et al., 1996). However, AIDS caregivers who perceived dissatisfaction with their work and professional role had significant higher burnout scores and were more frequently claiming risk allowance (Bellani et al., 1996). Moreover, health workers citing increased workload and anxiety due to HIV/AIDS patients experienced significantly higher levels of burnout (Bellani et al., 1996). The same was found in those who experienced fear of contagion as it was found to be a primary concern of health care workers in association with high burnout and low personal accomplishment. Furthermore, significant high scores were found in HIV/AIDS caregivers who felt discomfort in dealing with HIV/AIDS injecting drug users (Bellani et al., 1996). The findings suggest that feelings, attitudes and emotional reactions regarding PLWHA are significantly associated with burnout and personal accomplishment.



Dorz et al. (2003) studied psychological stress and coping strategies in staff working with AIDS and oncology patients. Self reported questionnaires were used to collect data among 528 participants (268 doctors and nurses working with AIDS patients and 260 doctors and nurses working in oncology). Nurses made 75.3 % of the workforce. Dorz et al. (2003) found contradictory results revealing a low degree of emotional exhaustion and depersonalisation. These findings are unusual since nurses are in constant contact with patients, as such they may feel the burden more than doctors. The researchers attributed this result to the likelihood of the degree of contact having a protective effect against burnout (Dorz, et al., 2003).

African Nursing Studies on Occupational Stress

van Dyk (2007) conducted a quantitative study among 250 caregivers. Healthcare workers (professional nurses, volunteer caregivers and doctors) made up 48.1% of the participants. The results revealed that nurses and volunteer care workers cared for HIV/AIDS patients on a regular basis (van Dyk, 2007). It was found that it was the intensity rather than chronicity of patients that contributed to occupational stress and feelings of burnout (van Dyk, 2007). The majority of caregivers reported symptoms of occupational stress and feelings of depersonalisation. They felt overworked and overburdened by HIV/AIDS care, struggled with bereavement, overload and feared occupational exposure (van Dyk, 2007). They felt unsupported by management and lacked training in HIV counselling thus battled with HIV care (van Dyk, 2007).



Harrowing and Mill (2010) found that nurses in Uganda were passionate about nursing and were committed to HIV/AIDS patients with moral distress attributed to lack of resources. The authors acknowledged the trauma imposed by systemic challenges on the nursing profession as well as the public's criticism of nurses' roles. However, participants were committed to their nursing duties and performed them in the best of their ability.

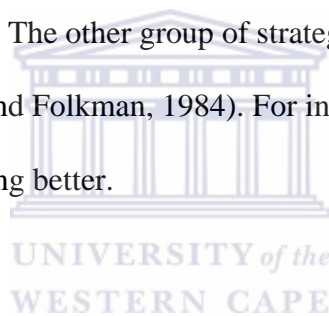
2.7. Coping

Lazarus and Folkman (1984: 141) defined coping as “constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person”. Coping is therefore an individual's ability to constantly process efforts to control demanding or overwhelming situations (Lazarus, 1993b). Research on occupational stress is mostly linked to coping strategies (van der Colff and

Rothmann, 2009). An individual experience on stress depends on one's ability to adopt and utilise coping strategies (Bhagat et al., 2001 as cited by van der Colff and Rothmann, 2009). According to Keil (2004:660) coping should include "elements of modification or alteration."

Coping strategies are conceptualized as endeavours to reduce or eliminate effects of stress on well-being (Lazarus, 1993b). In essence, an individual adopts appropriate coping strategies based on where the situational control lies and thus, one will alter or interpret a given circumstance so as to appear favourable (Lazarus, 1993b). Lazarus (1993b: 238) identified two types of coping strategies namely "problem-focused and emotion-focused." Problem-focused coping strategies employ strategies analogous to problem solving (Lazarus and Folkman, 1984). Individuals use problem-focused strategies to identify causative factors of a distressing situation and to devise means and ways of dealing with the issue (Lazarus, 1984). Therefore, an individual identifies, evaluates and acts upon the perceived stressor (Lazarus and Folkman, 1984). Problem-focused strategies that are self-directed include acquiring innovative skills and actions, soliciting alternative ways of fulfilment, or enacting novel behaviour standards (Lazarus and Folkman, 1984). Callahan (1993) revealed that in an organisation, problem-focused strategies either modify or eliminate the source of stress while individual strategies include seeking information by conversing with workmates, making action plans, bargaining and reaching a compromise. Stressors emanating from work are often met with problem-focused strategies since the circumstances are often appraised as changeable (Callahan, 1993). However, within a prolonged encounter, individuals may feel out of control and powerless, such that they adopt some form of emotion-focused coping (Lazarus and Folkman, 1984).

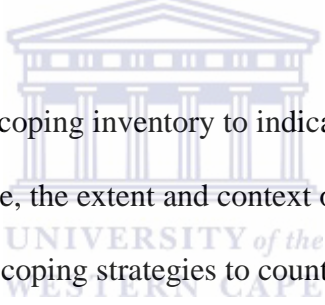
Emotion-focused coping focuses on internal emotional states and is also known as passive and emotive coping, which is the avoidance of a problem that can be used to maintain hope and optimism (Lazarus, 1993b; Lazarus and Folkman 1984, cited in McCausland and Pakenham, 2003). Emotion-focused coping helps to maintain an effective equilibrium by regulating feelings about the changes occurring (Callahan, 1993). According to Callahan (1993), coping recourses often influence an individual's coping strategy. Internal coping resources such as personality variables provide one with resources that can address adverse environmental events (Callahan, 1993). One group of emotion focused coping employ cognitive processes which are aimed at reducing psychological distress (Lazarus and Folkman, 1984). It utilises strategies such as distancing, wishful thinking, minimisation, selective attention and avoidance. The other group of strategies are intended at mounting psychological distress (Lazarus and Folkman, 1984). For instance, one might experience self-blame or punishment before feeling better.



Lazarus and Folkman (1984, cited in Lambert and Lambert, 2008) identified and described eight coping strategies utilised by individuals to cope with stress. These strategies are either emotion focused or problem focused:

1. Confrontive coping describes aggressive efforts to alter the situation (e.g., "stood my ground and fought for what I wanted"). It also suggests a degree of hostility (e.g., "I expressed anger to the person(s) who caused the problem") and risk-taking (e.g., "took a big chance or did something very risky").
2. Distancing describes efforts to detach oneself (e.g., "didn't let it get to me—refused to think about it too much,"). Another theme concerns creating a positive outlook (e.g., "made light of the situation; refused to get too serious about it," "looked for the silver lining—tried to look on the bright side of things").
3. Self-control describes efforts to regulate one's own feelings (e.g., "I tried to keep my feelings to myself,") and actions (e.g., "tried not to burn my bridges, but leave things open somewhat").
4. Seeking social support describes efforts to seek informational support (e.g., "talked to someone to find out more about the situation"), tangible support

- (e.g., "talked to someone who could do something concrete about the problem"), and emotional support (e.g., "accepted sympathy and understanding from someone").
5. Accepting responsibility acknowledges one's own role in the problem (e.g., "criticized or lectured myself") with a concomitant theme of trying to put things right (e.g., "I apologized or did something to make up").
 6. Escape-Avoidance describes wishful thinking (e.g., "wished that the situation would go away or somehow be over with") and behavioural efforts to escape or avoid (e.g., "tried to make myself feel better by eating, drinking, smoking, using drugs or medication, etc."). These items, which suggest escape and avoidance, contrast with the items on the distancing scale, which suggest detachment.
 7. Planful problem-solving describes deliberate problem-focused efforts to alter the situation (e.g., "I knew what had to be done, so I doubled my efforts to make things work") coupled with an analytic approach to solving the problem (e.g., "I made a plan of action and followed it").
 8. Positive reappraisal describes efforts to create positive meaning by focusing on personal growth (e.g., "changed or grew as a person in a good way). It also has a religious tone (e.g., "found new faith," "I prayed") (Folkman, Lazarus, Dunkel-Schetter, DeLongis, and Gruen, 1986: 995).



Kalichman et al. (2000) utilised a coping inventory to indicate the coping strategies utilised by nurses in AIDS care. The nature, the extent and context of problems were thought to detect the adoption of appropriate coping strategies to counteract personnel related stressors (Kalichman et al., 2000). Nurses utilised wishful thinking, planful problem solving and avoidance to cope with workplace stress, whereas stress originating from patient care was met with positive appraisal and acceptance (Kalichman et al., 2000). The authors indicated that personal stressors were managed through wishful thinking, avoidance and rational problem solving; institutional stressors such as; administration, managed care and workload were often managed using planful problem solving. Nurses dealt with the death stressor by adopting positive appraisal and acceptance strategies while stress related to patient notification was met through spirituality (Kalichman et al., 2000).

Dieleman et al. (2007) revealed that healthcare workers were ill equipped emotionally to cope with HIV/AIDS in the workplace. Organisational support to deal with HIV/AIDS was either chaotically in place or absent. The health workers confirmed that there were no official structures in place to help them cope better. Moreover, managerial support was perceived to be important, however, this was said to be minimal (Dieleman et al., 2007). Health workers utilised prayer and colleague support to deal HIV/AIDS-related problems.

Smit (2005) noted that nurses in HIV/AIDS care experience helplessness, emotional stress, fatigue, fear, anger and frustration. They attributed these experiences to the fact that HIV/AIDS care is taxing. The coping mechanisms employed were faith and a sense of self-fulfilment was associated with providing quality nursing care (Smit, 2005). Nurses indicated a moral obligation to nursing care in a non-judgemental and non-discriminatory manner (Smit, 2005).



Sherman (2000) found that nurses utilised both problem-focused and emotion focused coping strategies to alleviate the stress associated with AIDS care. Physical risk stressors were met with problem focused coping as nurses estimated the chances of infection as well as looking back at previous threatening situations (Sherman, 2000). Moreover, nurses employed problem focused coping by using universal precautionary measures to reduce their chances of occupational exposure to HIV infection. Emotion focused coping strategies we adopted by using a fatalistic attitude concerning HIV occupational exposure or believing that God was in control of their destiny (Sherman, 2000). Nurses enhanced their wellbeing and growth and found meaning in their roles as caregivers (Sherman, 2000).

Moore (2001) explored the roles, services and coping mechanisms of health professionals who worked daily with people with HIV/AIDS and revealed that health workers were afraid of the risk of infection, that they were overworked and that they became emotionally stressed and experienced feelings of helplessness. To survive the demands of AIDS care, health workers utilise various coping strategies such as; faith, prayers and sharing feelings with colleagues, family members and friends (Moore, 2001). Minnaar (2005) found that nurses overcame workplace stressors by utilising wishful thinking and rational problem-solving approaches, and that nurse managers played a supportive role for nurses infected with HIV without any formal policy on HIV/AIDS in the workplace.

2.8. Summary

It is without doubt that nurses in HIV/AIDS care face various work stressors. The impact of HIV and AIDS on nurses has forced them to adopt new nursing responsibilities. The literature review indicates that nurses in HIV/AIDS care feel overworked, lack resources and organisational support and fear contagion. Though nurses face workplace, emotional and occupational stressors, modalities of coping strategies are employed to provide HIV/AIDS care in health settings. The research studies used in the literature review utilised both quantitative and qualitative techniques and provided this study with important concepts and types of coping strategies to investigate.

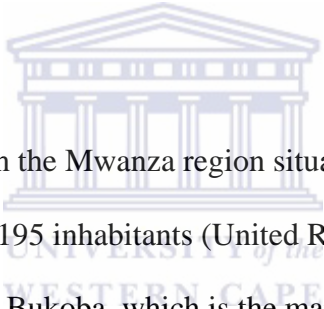
CHAPTER THREE

METHODOLOGY

3.1. Introduction

This chapter presents the methodology used to conduct the study. It sets out the aim and objectives of the study, the study design, the study setting and population. It then describes the sampling approach for the study population. Methods used to collect and analyse data, rigour and ethical considerations are also presented in this chapter.

3.2. Research Setting



Geita is one of the eight districts in the Mwanza region situated in the northwest of Tanzania and has a total population of 712, 195 inhabitants (United Republic of Tanzania, 2003). It is on the main road from Mwanza to Bukoba, which is the main port and entryway into Uganda and Rwanda. In the gold mining town of Geita, the burden of diseases is high, with communicable diseases still prevailing. Geita District Hospital provides health promotion, preventive health, care and treatment, rehabilitation services and services to the chronically ill. This includes catering for lifelong treatment like hypertension, diabetes, AIDS patients and other chronic conditions. The district is confronted with the double burden of disease, both communicable and non-communicable diseases. HIV/AIDS, tuberculosis and malaria are among the most dominating infectious diseases. The District Medical Officer (DMO) acknowledges the potential devastating impact of HIV/AIDS to both health care personnel and services. The estimated HIV prevalence in the district is eight percent, 2.1% above the national average and more than 50% of the bed occupancy is attributed to HIV-related

diseases (Personal communication with Dr L Mayi, District Medical Officer, Geita District Hospital, 1 September 2010). Geita District Hospital is the only health facility providing HIV/AIDS in-patient care services in the district and serves as a referral hospital to which most of the HIV/AIDS patients from other facilities in the district are referred for further treatment, care and rehabilitation. To expand access to HIV/AIDS prevention, care and treatment for the people of Geita, Geita District Hospital Care and Treatment Clinic (CTC) was inaugurated in August 2007 with the support from Catholic Aids Relief and the Ministry of Health. The centre offers two key services, the first service includes voluntary counselling and testing for both self referred clients and patients referred from other health facilities within the district. The second service includes issuing of antiretroviral therapy to patients who meet the Ministry of Health treatment guidelines. Since 2007, the CTC has had a cumulative enrolment of 7 285 persons living with HIV. Among these patients, 4 374 are taking antiretroviral therapy (Personal communication with Dr Ndalo, CTC Medical Officer, Geita District Hospital, 23 September 2012). Patients presenting with advanced HIV diseases and TB/HIV comorbidity are referred to the hospital for further management. The hospital has seen an increased utilisation of health services by HIV/AIDS patients. Currently, 50% of the hospital bed occupancy is attributed to HIV/AIDS. In fact, on a monthly basis, the hospital admits about 300 patients with AIDS related illnesses (Personal communication with Sr Ng'ombo, In Patient Nursing Services Manager, Geita District Hospital, 23 September 2012).

3.3. Research Design

The study utilised a qualitative research paradigm. Qualitative research permits “researchers to get at the inner experience of participants to determine how meanings are formed through and in culture to discover rather than test variables” (Corbin and Strauss, 2008:12).

Qualitative research yields information based on the premise that a social phenomenon is created and explained through the subjective experience of participants involved in communication (Mack, Woodson, MacQueen, Guest and Namey, 2005). In essence, it seeks to generate knowledge of social events and understand a given phenomenon by exploring meaning from individual perspective and how they interpret and interact with the world around them. Qualitative research methods effectively gather data/information about values, belief, opinions, behaviours and social constructs and contexts of particular populations (Mack et al., 2005). In essence, this method allows the researcher to elicit meaningful, salient issues and unanticipated by the researcher.

In this study, the researcher utilised a qualitative research design because of its usefulness in exploring people's views, beliefs, opinions and values. The research was conducted in a naturalistic enquiry utilising an exploratory-descriptive design as the researcher needed to understand and explain nurses' workplace and patient care stressors in HIV/AIDS care and the coping strategies they utilised to deal with stressors (Blanche, Durrheim and Painter, 2006). The description of the participants' experiences enabled the researcher to understand and explain the phenomenon in its natural setting. This allowed the researcher to be in personal contact with participants so as to produce descriptive data and present it in the participants' own words, views and attitudes towards the research topic.

3.4. Study Population and Sampling

The study population consisted of two groups: nurses and hospital departmental managers. The nursing population was made up of all nurses (registered nurses, enrolled and auxiliary

nurses), while the hospital departmental managers included all unit managers working in Geita District Hospital.

Purposive sampling was used to select the participants in the two study populations.

Purposive sampling gathers information relevant to the study by obtaining rich-based data from cases that have an in-depth understanding of all aspects of a certain phenomenon (Skinner, 2007). It therefore allowed the researcher to select study participants that are information rich, had valuable experiences and reflections on workplace stressors and coping mechanisms. Skinner (2007) notes that the sampling will be terminated when no new information is generated from the forthcoming successive interviews; thus redundancy is the primary criterion.

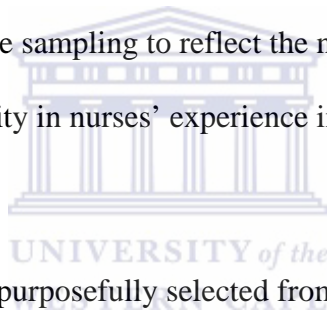


The study population consisted of 96 nurses (18 registered nurses, 22 enrolled nurses and 56 auxiliary nurses). The researcher approached the hospital matron and briefed her about the study and explained that nurses were to meet a set of criteria selected. This facilitated the selection of participants that would provide detailed and rich data relevant to the research problem. The hospital matron assisted the researcher in identifying participants until data saturation was reached by applying the following inclusion criterion:

- The nurses should have been able to converse in English
- The nurses should have worked in all four admitting medical units (female and male medical wards, tuberculosis ward and paediatric ward).

- The nurses should at least have undergone two HIV/AIDS-related training. The rationale being that these nurses would be in a better position to express their experiences in AIDS care against the HIV/AIDS teachings provided.
- The nurses should have been working at the hospital for at least three years. The rationale being nurses would have understood the Geita hospital context better thus they would be in a better position to articulate the issues experienced.
- The nurses should have been willing to participate in the study.

Twelve nurses were sampled from the study population and interviewed individually. The researcher obtained participants from different nursing categories (registered, auxiliary, and enrolled nurses) through purposive sampling to reflect the nursing care diversity within a given population, ensuring diversity in nurses' experience in HIV/AIDS care.



Key informants' interviews were purposefully selected from the hospital managers, who are involved in patient care and nurses' welfare. These included a number of medical doctors managing various departments (such as outpatient care, medical care, surgical care and the HIV/AIDS clinic) and nursing managers for various departments (in-patient care matron, outpatient care matron). This ensured that key informants provided vital information with regards to nurses' wellbeing from holistic approach within the work environment. Through this list, the researcher was able to choose the 'Key Informants' for the study. The criterion used was based on:

- Managers should be English speaking.
- Managers must have regular and consistent contact and communication with the nurses.

- Managers should be directly involved in working with in-patient care and also in charge of either the nursing unit or the HIV/AIDS services
- Managers should have the authority and ideals of making health services better and a desire to address the workplace stressors in an HIV/AIDS environment. The rationale was that managers would be in a better position to address the nurses' concerns thus providing vital information relevant to the study. A brief about the managerial roles from the hospital Matron guided the researcher in selecting the appropriate informants.

Two key informants were identified and participated in the study after obtaining their consent for the interview.



3.5. Data Collection Methods

Data was collected between September and November 2010. Face-to-face semi-structured interviews were utilised as the data collection method. A semi-structured open-ended interview guide (Appendix IV) was developed and used to collect data. This method allowed the researcher to build rapport and to obtain rich, in-depth descriptions of the nurses and hospital managers' experiences (Robson, 1993; Liamputtong and Ezzy, 2005). Through this technique, the researcher was able to make a follow-up and seek further descriptions on the issues, views and perceptions raised by the participants.

3.5.1. Data Collection

The researcher contacted the relevant authorities at Geita District Hospital informed them about the study, provided the necessary details of the study, purpose and process and requested their permission to conduct the study. After obtaining permission, the researcher contacted the Nursing Services Manager to facilitate the selection of suitable participants and making the initial contact with them.

My supervisor examined the content of the interview guide and some amendments were made. Changes were made to questions posed. Leading questions which had the potential to provide cues to the participants were rephrased. For instance, questions such as “Are you concerned about the risk of acquiring HIV at work?” This question was modified into a simpler and straightforward question “Tell me about your views on the risk of acquiring HIV infection at work?” In addition, biased questions were also rearticulated, as they had the potential to distort the participant’s response.

3.5.2. Pilot Study

A pilot study was conducted in order to pre-test the research instrument and identify its appropriateness. This was the best way to discover whether the interview guide was adequately prepared. It also provided a platform for refining the structure and order of the questions, rephrasing closed-ended questions to open ended questions as well as eliminating vague areas and repetitions (Blanche et al., 2006). As a result, in this study, the researcher tested for reliability by using semi-structured interview guide for the pilot study. This ensured

that the constancy of a measure (for instance, the reproducibility of responses), in its functioning to more than one period of time did not contrast.

The participants for the pilot study were identified as per selection criteria with the Matron. The pilot was conducted with two nurses: a registered and an enrolled nurse. Since the pilot study did not lead to major alterations in the interview guide, transcripts from the two nurses interviewed were included in the main study findings. The reason for this was that the participants were selected using the sampling criteria that was also applied in selecting the participants for the main study.

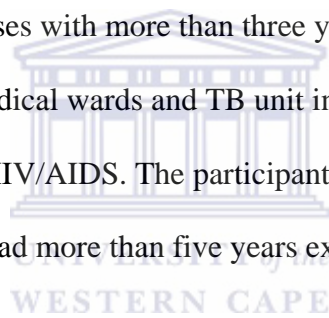
3.5.3. Data Collection Procedure

Twelve nurses and two key informants were all provided with the necessary information about the study a week before the data collection started. Face-to-face interviews were conducted in a secluded room at the hospital to provide privacy. The researcher briefed the participants on the research study and emphasised voluntary participation. The participants were assured of confidentiality. The information discussed would be used for the purpose of the research and that, in order to maintain anonymity, their names would not be used in the study. Appointments were made with the participants and information about the study was provided in verbal and written format. All nurses and key informants contacted agreed to participate in the study. The researcher obtained written consent, as well as permission to audiotape interviews, prior to interviewing the participants. The participants were assured that audio taping was purely for the purpose of data analysis, that the recordings would remain the property of the researcher. Data recorded would be destroyed after completion of the study. A total of 14 individual interviews were conducted during the study period. Interviews were conducted in English and the researcher made use of a semi-structured

interview guide to collect data. The interview guide included questions related to the participant's feelings, emotions and experiences with AIDS care, challenges encountered care and mechanisms utilised to cope with HIV/AIDS.

3.5.4. Participants

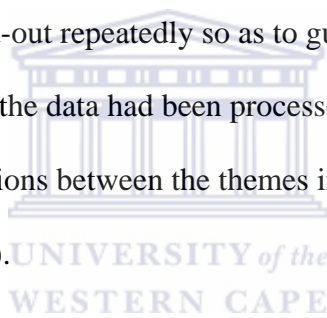
Patton (1990) noted that qualitative research methods utilise small samples to study a phenomenon in depth. The researcher utilises small sample sizes, the commitment of discovery is achieved through the use of multiple ways of understanding. The participants were chosen purposefully. Twelve nurses and two key informants participated in the study. The participants chosen were nurses with more than three years of experience in the nursing profession, who worked in all medical wards and TB unit in the last three years and had at least had two formal training in HIV/AIDS. The participants were aged between 30 and 52. The majority of the participants had more than five years experience.



3.6. Data Analysis

Patton (1990) noted that data analysis is a systematic process of organising transcripts, field notes and other materials encountered during data collection. To start up the process, the researcher familiarised herself with the raw data. The researcher listened to the audio-tape and transcribed the audio-recorded material verbatim. This process was done repeatedly so as to give an accurate account. After reading the transcriptions of the interviews, a thematic content analysis began. The focus was on identifying emerging themes from semi-structured interviews. Using the transcribed data, the researcher explored the participants' accounts and identified themes running through the data. Themes are described as units obtained from

patterns such as “conversation topics, vocabulary, recurring activities, meanings, feelings or folk sayings and proverbs” (Taylor & Bogdan, 1989, p.131 as cited by Aronson, 1994). The researcher then listed the emerging patterns related to the perceptions, opinions, feelings and experiences. This included direct quotes and paraphrased ideas. The next step was to identify all data that related to these classified patterns. A hierarchical coding frame was then developed. Codes were created by marking sections of the data that were relevant to one or more themes. Statements which fitted under specific themes were identified and placed with the related theme. These were colour coded, cut, pasted and adjoined to the main theme. This was followed by combining and categorising related patterns into sub-themes, which together formed a comprehensive picture of the participants’ collective experiences, perceptions and opinions. The process was carried-out repeatedly so as to guide the researcher in producing a precise account of the data. After the data had been processed, synthesis was initiated by writing an account of the associations between the themes in order to inform explanations of the findings (Blanche et al., 2006).



3.7. Trustworthiness of the Study

Mays and Pope (1995: 110) noted that one can ensure rigour by being “systematic and self-conscious in the research design, data collection, interpretation and communication” by providing plausible, detailed and clear explanations of the study. Qualitative researchers utilise unstructured formats to collect raw data, these formats include audio/video recording or field transcripts (Mays and Pope, 1995). The researcher ensured reliability by maintaining thorough records of interviews through transcripts and by documenting the data analysis process in detail (Mays and Pope, 1995). In addition, reliability was assured by using semi-structured interview guide which tested for reliability during the pilot study. Moreover, the

researcher set aside any preconceptions regarding the topic which might have influenced the outcome of the results.

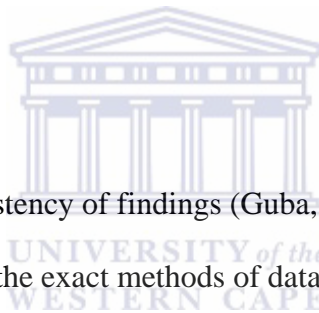
Various strategies were used to ensure the worth of the study. Credibility refers to the identification and description of the subject and requires a process of demonstrating that the enquiry was conducted in a manner that ensured the accuracy of how the participants were identified and described (Marshall and Rossman, 1995). Credibility was ensured by identifying the most appropriate participants and providing a description of them.

Gifford (1996) emphasises that triangulation in qualitative research to increase credibility. The researcher utilised triangulation to search for convergence so as to develop and confirm the overall interpretation. Two different sources of information were triangulated. The experiences and views shared by the health managers and nurses were revealed in order to identify patterns of convergence.

To address credibility the process referred to as member checking was used (Mays and Pope, 2000). This entails giving the participants an opportunity to check and approve particular aspects of data and interpretations (Creswell and Miller, 2000). At the end of each interview, the researcher summarised the main points raised by the participants and requested the participant to confirm the account as a true reflection of what had transpired during the interview (Creswell and Miller, 2000; Mays and Pope, 2000). The researcher clarified what might have been misinterpreted. The participants were given the opportunity to expand on the descriptions and develop new thoughts.

To enhance credibility, the researcher utilised peer debriefing. It utilises the same principle as member checking, however, the researcher discusses the research process and findings with neutral colleagues who have the know-how with qualitative methods (Krefting, 1991). The researcher exercised this criterion by constantly communicating and contacting the supervisor throughout the study.

Guba and Lincoln (1985 as cited by Krefting, 1991) noted that auditability describes the ease in which another researcher can clearly follow the “decision trail” used by the investigator in the study. The audit trail was ensured by providing descriptions of the research methodology. The decision trail has been provided through a clear and detailed description of the data collection and analysis process.



Dependability relates to the consistency of findings (Guba, 1981 as cited by Krefting, 1991). It includes a dense description of the exact methods of data collection, analysis and interpretation. Such description provides information on how reputable the study might be or how unique the situation is (Kielhofner, 1982 as cited by Krefting, 1991). In this study, the researcher provided a thick description of the process, the research methods and showed how certain beliefs and opinions were rooted in and developed out of contextual interactions. Krefting (1991) noted that triangulation and peer debriefing can be used to ensure dependability.

Guba (1981 as cited by Krefting, 1991) viewed neutrality not as a researcher objectivity, but as data and interpretational confirmability. Confirmability is guaranteed when the reader is

able to assess the adequacy of the research process. The researcher ensured confirmability by ensuring credibility, auditability and dependability as described above.

3.8. Ethical Considerations

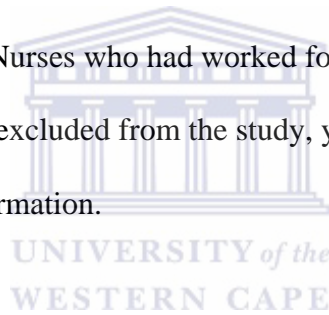
An application for ethical approval was submitted to the Ethics Committee and the Senate of the University of Western Cape (Appendix I). Further permission was sought from the Ministry of Health and Social Services in Tanzania and the authorities of Geita District Hospital. Participants in the study were provided with the Participant Information Sheet (Appendix II) explaining the scope of the study, including its aim, purpose and importance. The participants did not receive any immediate benefit from the study; however, it was envisaged that the study would yield valuable descriptions and insights into the complexities of health workers' experiences with occupational stressors and how they deal with these. The participants were informed of their right to terminate the interview if they wished to do so, without any prejudice. Participation in this study was entirely voluntary and refusal to participate in the study did not result in a penalty or withdrawal of any benefits entitled to the participants. During the briefing process, the participants were required to complete a consent form as evidence of their willingness to participate in the study (Appendix III). The participants were assured of the confidentiality of the information provided and that their identity would be kept confidential to maintain anonymity. Records of the interview and the consent form are kept in a safe and private place. Given the nature of the study, it was possible that the participants could become emotional. As a result, a local professional counsellor from the African Medical and Research Foundation (AMREF, a non-governmental organisation collaborating with the Ministry of Health to combat HIV) was available if any of the participants required emotional counselling as a result of the interview. In ensuring continuity of patient care, the Hospital Matron ensured that the wards were well

staffed during interviews. Nurses who were on nights off and were willing to work extra hours were asked to provide health care services.

3.9. Limitations

The researcher is not conversant with KiSwahili and this created a limitation as only English speaking participants were selected for the research study. This eliminated nurses who might have had valuable information since they could only converse in KiSwahili.

The study also focused on nurses who had more than three years experience in nursing and had worked in all medical units. Nurses who had worked for less than three years and had not worked in all medical units were excluded from the study, yet they could also have the potential to provide valuable information.



3.10. Conclusion

This chapter focused on the research methodology. The researcher utilised a qualitative paradigm. Semi structured interviews were used to collect data. The findings of the study are presented in the next chapter.

CHAPTER FOUR

FINDINGS

4.1. Introduction

This chapter presents the study findings utilizing thematic content analysis. A qualitative design was undertaken using a semi structured interview guide. Face to face interviews were conducted where participants reflected on their experiences on providing HIV/AIDS care.

4.2. Description of Participants

Purposive sampling was conducted. Fourteen participants (12 nurses and 2 key informants) were selected to participate in the study. Four nurses were chosen from each nursing category namely registered nurses, enrolled nurses and auxiliary nurses. Registered and Enrolled nurses held Nursing Diplomas and a Certificate in nursing respectively, while nurse auxiliaries did not possess any qualification as they had undergone in-service training. The two key informants interviewed, were part of the Hospital management team. Out of 14 participants, two were males while twelve were females (Table 1). The majority of the participants, five were in the aged between 30-35, while one was aged between 36 and 39, four were aged between 41-45years, three were aged between 46 and 50 and one was aged above 51. The mean age of the participants was 40.4. Eleven of the participants were married, two were not married, and one was divorced. Regarding the educational level of the participants, it was found that one had a medical degree, five had nursing diplomas, four had nursing certificates and the last four had no certificates but acquired their experience through

in-service training. The average years of experience were 14.9. The longest serving nurse had 32 years of experience. The majority of the nurses had between 3-10 years of experience.

Table 1: Demographic Characteristics

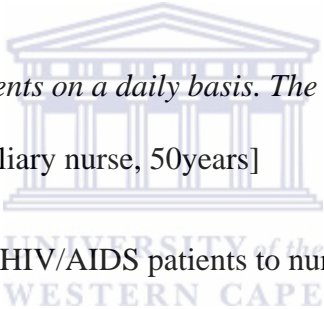
Characteristic variable	Participants (n=14)
Sex: Female	12
Male	2
Age: 30-35	5
36-40	1
41-45	4
46-50	3
>51	1
Educational Level: Certificate	4
Diploma	5
Degree	1
Others	4
Work Experience : 3-10years	7
11-20years	3
21-30years	2
31-40years	2
>41years	0

The thematic content analysis of the interviews identified three themes namely: The Caring Experience, Perceptions of Workplace Stressors and Coping Strategies.

4.3. The Caring Experience

4.3.1. Nursing HIV/AIDS Patients

Nurses framed their HIV/AIDS care experience within the context of the nursing practice. Participants were committed to nursing HIV/AIDS patients. They confirmed nursing patients with HIV/AIDS on a daily basis. Moreover, they expressed that nursing HIV/AIDS patients was no different from any other diseases.



“We nurse HIV/AIDS patients on a daily basis. The care we give them is the same as with other patients” [Auxiliary nurse, 50years]

Almost all nurses likened nursing HIV/AIDS patients to nursing patients with chronic diseases such as hypertension and diabetes.

“The nurses care for HIV patients just like any other patients. It’s our job to care for them. I have not heard nurses complaining, I think HIV is just like any other disease like diabetes, hypertension” [Registered nurse, 43 years]

Registered nurses mentioned that the nursing care rendered will depend on the patient’s condition. One nurse mentioned:

“The nursing care provided to these patients will depend on the stage or condition of the patient. If the patient is bedridden, the patient is supposed to be fed through a naso gastric tube or catheterised or to give all nursing care because you nurse this

patient in different method of nursing: total patient care. So it will depend on the stage of the patient condition” [Registered nurse, 34years]

However more than half (8 out of 12) nurses felt that HIV patients came to the hospital at an advanced AIDS stage where the nurses had to offer total patient care.

“We see patients with hypertension, diabetes but the care we give them is different from those with AIDS. We care for HIV patients by giving total patient care especially those who are very sick” [Auxiliary nurse, 50years]

4.3.2. Quality of Care

All nurses expressed concerns over the quality of care they rendered. They attributed this concern to the lack of basic supplies for caring for patients. This was expressed through lack of basic supplies such as food, beds and water shortage. In fact, the nurses highlighted that when the wards are full, patients have to share beds.

“That’s what we do here if the ward is full the patients share the bed sometimes 2 or 3 in the bed one face this side and one that side with the legs on the head of the other patient that’s our life here even the patients know.” [Auxiliary nurse, 32 years]

More than half of the nurses stressed that patients had to bring food and water from home as the hospital did not provide enough. This was perceived to be a draw back in providing nursing care as some of the patients did not have anyone to bring them food. Some expressed concerns such as

“In this hospital food is a problem we cannot provide for all patients only five patients in a full ward. We assess, we give first option to those who come from far. So

the other patients from Geita have to bring food from home.” [Registered nurse, 43 years]

The poor quality of health care was not limited to basic supplies only; all nurses claimed that staff shortage affected the quality of care. They described having to work alone or in pairs in a ward of thirty-five to forty-five patients. They reported having to work with chronically ill AIDS patients and non HIV patients which compromised the quality of care as patients had different needs. The nurses indicated that due to staff shortage, they could not provide HIV counselling as it was time consuming given the overwhelming numbers of patients. Some of the nurses said

“Because of staff shortage and plenty of work we don’t do that because in the ward I work alone and have plenty of patients I can’t get time to counsel and provide results...” [Enrolled nurse, 30years]

The key informants echoed the same sentiments; they felt that the quality of care had been affected by staff shortage, which in their opinion does affect the delivery and quality of health care. One of them mentioned that:

“...nurses face alot of challenges they are overworked. Given the staff shortage situation.... there are too many HIV patients especially the chronically ill so you find that with shortage of nurses it is difficult to give proper care...” [Key informant 1]

4.3.3. Counselling and Testing

Nurses understood that HIV counselling and testing was the cornerstone of HIV/AIDS health care. Nurses who had undergone HIV counselling and testing (HCT) training had a good understanding of the process. One key informant revealed.

“Most of our nurses have been trained in HIV counselling and I can say they handle counselling well. They counsel patients on a daily basis.” [Key informant 2]

Counselling helped nurses to connect with patients. They provided patients with emotional support through counselling and talking about their life experiences. However, counselling of patients was not easy. They indicated that they often had to counsel patients several times before they consented to an HIV test or accepting their results.

“It’s bad for me because I put lot of time to counsel this patient but the patient doesn’t want the result and again we have to do alot of work because sometimes we counsel one patient alot of times before they get their result”[Auxiliary nurse, 43 years]

More than half of the participants noted that some of the patients were in denial as they often refused their results.

“Sometimes you counsel and counsel the same patient maybe five times and still they refuse the results” [Enrolled nurse, 30years]

The majority of the nurses found it difficult to provide counselling when patients either declined an HIV test or did not accept one’s HIV status.

“Some patients are in denial and don’t want to talk and they are angry with us so they don’t want to talk about HIV” [Auxiliary nurse, 43years]

Nurses expressed frustration from patient's denial and refusal to accept HIV results. Patients were often tested for HIV despite a confirmed HIV positive status and taking ART.

"I feel angry, I don't know how to say this, the patient comes in and we test them for HIV again but the CTC people will tell us she is on ART. So every-time we have to repeat and repeat." [Enrolled nurse, 47years]

4.3.4. Stigma and Discrimination

Most nurses (8 out of 12) revealed that stigma and discrimination remains a major problem among patients with HIV/AIDS. It was thought to deter quality nursing care as patients were not open about their HIV status thus hindering quality care.

"Stigma and discrimination here is a big issue our people don't want to talk about their HIV status. After the test and you refer them to CTC and they say no, I don't want to go there, the other people will see me..." [Registered nurse, 43years]

Nurses raised concerns with regards to disclosure of HIV status. They indicated that patients still find it difficult to share their HIV status with relatives and friends.

"... most of the patients here are afraid of telling their partners." [Registered nurse, 34years]

At the same time, most nurses expressed that patients in denial could not share information with regards to their ART. There are cases where nurses had to test patients on ART for HIV due to lack of disclosure.

“Patients here still don’t want to share information about their status or treatment. Sometimes we do HIV test on patients on ARV.” [Enrolled nurse, 47]

Nurses noted that patient’s denial state indicated that they did not understand the importance of communicating vital information to nurses.

“If the patients know we have to help them, then they should tell us so we can help them with ARVs and so they cannot miss the treatment.” [Enrolled nurse, 30 years]

Nurses were concerned about patients’ behaviour of not sharing information as this meant they were missing therapy while under hospitalisation

“The patients do not tell the truth and this make them to miss their treatment...”
[Registered nurse, 34years]

Less than half of the nurses (5 out of 12) highlighted that some patients still believed that traditional medicine was more potent than western medicine, hence the notion that HIV was an ailment that could be cured by consulting traditional healers.

“Sometimes they don’t agree and say there is no need to check the HIV status because there is a wizard in their village wanting us. Others stay at the hospital and abscond and go to the traditional doctor so as to solve their problems as they believe.” [Enrolled nurse, 30 years]

Due to the various stigmas involved in HIV/AIDS, health workers may also face secondary stigma from relatives and friends. This might be due to perceptions about HIV transmission. The study findings revealed that, the majority of nurses were completely supported by friends, families and relatives. One nurse reported

“My husband tells me to continue working with these people. He supports me in my work and understands about HIV.” [Enrolled nurse, 30years]

4.3.5. Relationships with Patients: Identification and Death

In nearly all the interviews, nurses expressed commitment to nursing HIV/AIDS patients. Direct contact with patients over long periods facilitated a nurse-patient personal relationship. Moreover, nurses highlighted that meeting up with patients’ family and relatives created some form of relation.

“One gets close to patients especially the chronic ones that stay here for a very long time, they become our friends and as we see the relatives, we understand where they are coming from.” [Registered nurse, 34years]

One auxiliary nurse said:

“Some of these patients are left here by the relatives they do not come back to care for them so we have to show them love and care for them.” [Auxiliary nurse, 50years]

Emotional attachment made it difficult for some nurses to deal with patients’ death. Nine nurses expressed an array of emotions with regards to patients’ death which included hopelessness and helplessness as there was nothing they could do.

“I feel very bad to lose a patient to HIV. I feel hopeless, I feel angry that I didn’t do more to help the patient. It is very sad for me and I ask myself why the patient died.”
[Registered nurse, 43years]

“It is painful because it’s not good to see the patients die.” [Auxiliary nurse, 45years]

Nurses felt that HIV/AIDS care was complex and responsible for the majority of deaths.

“We nurse patients with AIDS and most of them never make it, they die of AIDS with opportunistic infections.” [Enrolled nurse, 42years]

However, some nurses felt that death should not impede their work routine. Nurses indicated that they should be a clear provider/client boundary. Three nurses maintained a personal distance from clients. Indication was made to provide a balance between empathizing with patients and maintaining emotional distance.

“I feel bad but I have to keep good emotion. I cannot sit and think about the patient’s death I have to continue to help other patients.” [Auxiliary nurse, 50years]



4.4. Perceived Workplace Stressors

4.4.1. Staffing Levels

All the participants mentioned a shortage of nurses. They expressed that staff shortage required them to work extra hours to perform the duties required in other wards to meet the needs of the patients.

“...in the other wards the work is too much and the nurses are not enough so we work extra hours to help the patients.”[Registered nurse, 34years]

“The nurses are not enough and we work long hours. We work all day sometimes even one nurse on duty. Sometimes we work day and start night without rest.”

[Enrolled nurse, 43 years]

Management raised concerns about staff shortage. The health facility was experiencing a shortage of nurses and that management is still trying to resolve the staff shortage issue.

“They just tell us that maybe next time. If the ministry offers nurses, they will send nurses to us. Maybe our district is a large district, we have 8 health centres, dispensaries (32) and all of them have staff shortage. If the staff is appointed to the district we will staff to health centres first because of shortage.” [Key informant 1]

The other key informant indicated that HIV/AIDS also affected nurses in their daily lives thus exacerbating the shortage problem

There are nurses who are sick, nurses who are dying, and nurses who are transferred in other provinces. So we still remain with a shortage.” [Key informant 2]



4.4.2. Role Extension and Lack of Appropriate Skills

Most nurses (8 out of 12) expressed that their nursing roles have been affected by HIV/AIDS. They reported that HIV and AIDS have changed the nursing services provided to HIV/AIDS patients. Nurses reported having to organise for home based care support services, linking HIV/AIDS patients with food banks and conducting HIV counselling and testing.

“Our services have changed, we are used to providing care to patients but now we have to counsel them and also provide a link with other support groups in the community.” [Enrolled nurse, 30years]

More than half of the nurses felt that they were not well equipped to provide HIV nursing care and counselling. Frustrations emanated from the fact that most of them had not received

any refresher courses, despite having HIV related trainings about four years ago while some have not attended any formal training at all.

“...we were told that every nurse should be trained in HIV but I did not receive any training...” [Registered nurse, 31 years]

“... I don't counsel patients, I was not trained in HIV but I only give information about HIV...” [Registered nurse, 34 years]

Nurses who had undergone training echoed that there was insufficient support with regards to refresher courses hence indicated that the current practices might not be in-line with the knowledge acquired several years ago. Nurses expressed these view:

“...you see HIV things are changing and as nurse in-charge sometimes I need to know the new things so I can help my other nurses.” [Registered nurse, 43 years]

“I feel very bad because I want to go; things are new and coming so I have to go to training and get new information to help the patients.” [Enrolled nurse, 42years]

In addition, nurses felt they were not equipped to deal with ART as some lacked training.

“We don't know much about ART we ask CTC to come and help.” [Enrolled nurse, 52]

4.4.3. Workload

Nurses noted that the nature of nursing care rendered to HIV patients increased their work as they have to deal with increased numbers of AIDS patients. They considered themselves overworked and overwhelmed by patient numbers and the amount of work they have to do.

“We see alot of HIV patients here who are in the AIDS stage. Most of these patients are very sick and caring for these patients takes alot of our time and the numbers of patients with AIDS increases all time and our work becomes more and more.”

[Registered nurse, 34years]

Nurses revealed that due to the numbers of patients they had to prioritise nursing of patients.

Nurses had to attend to very ill patients before attending to other patients with minor illnesses. One nurse said:

“... you deal with the special case the serious one is the one you wash or feed, it comes a time we ask who is getting fine and wants to go home so to reduce patient numbers...” [Enrolled nurse, 30years]

The key informants echoed the sentiments that HIV/AIDS has indeed increased the workload of nurses. A key informant said:

“HIV/AIDS has increased the duties in the wards because as you know we are living in a place with so many people affected and infected by HIV, there are many complications of HIV, so that’s why it increases the work of nurses...” [Key informant 1]

4.4.4. Unsafe Setting

Nurses expressed concerns with regards to HIV nursing as they felt the environment was not conducive for them to carry out their duties. Medical procedures such as wound dressing, giving injections and deliveries were thought to increase their risk to HIV.

“When working with HIV positive patients you have to be careful, you can get injured or by pricking yourself. Procedures in theatre or suturing of episiotomies can increase the risk of getting HIV. One can get accident you can prick or even cut yourself and get HIV from that patient...” [Registered nurse, 34years]

Almost all nurses recognised the unavailability of protective clothing as stressor as some of the nurses refused to look after AIDS patients or worked in fear.

“We are scared of helping these patients when we don’t have gloves, sometimes we ask patient to buy gloves if they cannot then the relatives have to help the patients in bathing and feeding.” [Registered nurse, 31years]

Protective wear is supposed to be utilised while carrying out procedures and caring for patients, however personal protective equipment was minimal. Gloves were the most available measure though at times they ran out of stock whilst aprons, masks and goggles were in short supply. Nurses revealed that they had to share aprons especially in maternity ward and expressed concerns such as:

“In maternity ward we don’t have enough protective equipment, it is the only ward that has aprons but still we have to share that apron when one finishes a delivery you clean and give another.” [Enrolled nurse, 30years]

Nurses expressed concerns over the risk of HIV transmission since some patients were not tested or refused to test for HIV, as a result the nurses worked cautiously.

“...I nurse patients and I don’t know if the patient is reactive or non reactive. So I am careful all the time...” [Enrolled nurse, 30years]

4.5. Coping Strategies

Nurses expressed various ways in which they coped with HIV/AIDS issues and problems affecting both personal wellbeing and service delivery. Nurses utilised both emotion focused and problem focused strategies to deal with workplace stressors. Emotion focused strategies included rationalisation by accepting death, taking time off, spirituality pushing ahead with work and self control. Problem focused strategies included accepting responsibility, colleagues support, talking to other nurses, transferring some duties to patient's relatives and going for counselling.

4.5.1. Strategies to Deal with Patient's Death

Nurses utilised spirituality, seeking workplace support, and accepting death to deal with patients' death. Nurses found peace and comfort by praying as this helped them to deal with patient's death.

"...I've seen alot of people dying just pray to God and because everyone comes from God and we will go back to god. I continue to care for the remaining one I cannot sit down and start crying for that patient." [Enrolled nurse, 30years]

More than half of the nurses indicated that they discussed death issues and tried to find out any shortcomings in the care rendered.

"It is the way that everybody goes because we can try the source of why she is dead or to look if they are mistakes in the care and to discuss with other nurses about that death. But we know they will die so we just accept it."[Auxiliary nurse, 30years]

Some nurses (4 out of 12) reported that death was an inevitable experience that sometimes is anticipated especially if patients are critically ill.

“I just continue to work I cannot think about the patient sometime we can see the patient will die we cannot help” [Auxiliary nurse, 50years]

4.5.2. Strategies to Deal with Workload

All nurses revealed that despite having increased patient numbers, it was their duty to provide care to patients.

“I just continue to work, I cannot say because there are no nurses, I will not work I have to help the patients.” [Registered nurse, 31years]

“We do our work; I cannot say no to the patients, I have to work because it’s my job and to help our people.” [Auxiliary nurse, 50 years]

Three nurses revealed that they take some time off; “escape” when they feel overwhelmed. This break varied from one nurse to another. For one, it meant taking a few minute breaks, while others asked for a day off from the matron. In one nurse’s words,

“I just take a few minutes, stand outside or go and talk to other nurses and come back and continue.” [Enrolled nurse, 30years]

Some nurses mentioned that the nurses shortage has made them rely on patients’ relatives to relieve the workload. Relatives were therefore required to provide physical care to patients such as bathing and feeding. Nurses indicated that they felt bad about this arrangement since it was their duty to look after sick patients.

“...But if the relative is there they can help so we can do the other job because sometimes we have a lot to do and forget so if the relative can help we want that.”

[Registered nurse, 31 years]

“ Because we assess the condition of patients, for example if the patient is unable to move we ask the relatives if they can bath the patient, so it is done by relatives and the nurse can do other things on another patient.”[Registered nurse, 34 years]

4.5.3. Workplace Support Systems

All nurses expressed that they did not have any formal support structure to help them cope with HIV at work.

“We don’t have any support group we just talk in the ward about patients but the nurses don’t have any support group.” [Enrolled nurse, 42years]

One of the key informants revealed that indeed there is no support group or structure for nurses to address their HIV/AIDS concerns. The only support provided was through issuing of post exposure prophylaxis (PEP) to nurses accidentally exposed to HIV.

“We don’t have any support groups here. We only offer support to those exposed accidentally to HIV. They go to CTC clinic, follow the procedure and get PEP.” [Key informant 1]

More than half of the nurses indicated that the support they received from the managers was through meetings, though the meetings were entirely to discuss HIV/AIDS data.

“The only support we get from management is through staff meetings were we get feedback about HIV program and solving problems. I can say we just report on statistics.” [Auxiliary nurse, 50years]

One of the key informants said:

“The only support I give nurses is just to give them new materials which are coming concerning HIV such as using books, seminars and videos to the nurses.” [Key informant 1]

Most nurses expressed that since there was no formal support to help them deal with HIV/AIDS issues affecting them, they liaised with each other to solve patient related problems.

“We talk about it and advice each other, during report rounds we discuss patients that are HIV positive but not in-front of patients because there are other patients who know the medical language so we discuss in nurses station.” [Enrolled nurse, 30years]

The CTC clinic was mentioned as a source of support for nurses accidentally exposed to HIV. Nurses revealed that if one was accidentally exposed to HIV; they received counselling and testing support from CTC staff.

“Once you get a needle stick injury there is a policy to be followed. The CTC staff offer us psychological support. They talk to us and offer support and PEP.”[Enrolled nurse, 42years]

Three nurses indicated that they were aware of financial support services from the District Executive Director (DED); however this facility was not limited to health workers but extended to all state employees in the district infected with HIV.

“If somebody working has that disease they are given the money for getting HIV at work. I heard from other people and food. Somebody with that disease should be registered with DED.” [Registered nurse, 31 years]

Despite having a workplace policy, the researcher noted that the majority of the nurses were either not conversant with the policy or not fully aware of its existence. Only two participants managed to enumerate and described two workplace policies utilised in the hospital. Most of the nurses were unaware of the HIV/AIDS policy. Moreover, out of twelve nurses only two nurses explained the Infection Prevention and Control Policy which also addresses HIV in the workplace.

“HIV policy; no, I don’t know any policy” [Auxiliary nurse, 43years]

4.6. Conclusion

This chapter presented the main findings of the study. The next chapter will discuss the research findings in relation to already known studies. It will also cover the conclusion and the study recommendations.

CHAPTER FIVE

DISCUSSION, CONCLUSION AND RECOMMENDATIONS

In this chapter, the findings of the study are discussed in relation to the aims and objective of the study. Moreover, the chapter presents the summary, the conclusion of the study and a set of recommendations on workplace stressors and coping strategies in the context of Geita District Hospital.

5.1. The Caring Experience

5.1.1. Nursing of HIV/AIDS Patients

Nurses considered HIV/AIDS as a chronic disease. This was attributed to the fact that HIV-positive people can now live with the infection for many years with appropriate health care and positive living. Nurses expressed an opinion that nursing of HIV and AIDS patients was like nursing patients with any other chronic diseases, such as diabetes or hypertension. This finding is supported by UNAIDS (2011b:6), who noted that “HIV and non-communicable disease programmes share many challenges, both in start-up and maintenance...” Moreover, caring for patients with HIV or non-communicable diseases entails ongoing regular attendance, adhering to examinations and medications, positive living and self-management (UNAIDS, 2011b). In fact, patients with HIV and non communicable diseases use comparable approaches, such as patient follow-up systems, treatment reminder methods, patient education, referrals, accompanying patients when appropriate, and counselling to support adherence and ongoing behavioural changes (UNAIDS, 2011b).

Despite the similarities in care of patients with HIV and non communicable diseases, the nurses expressed concerns regarding HIV/AIDS care. They felt that HIV/AIDS patients were reluctant to access health services and were reporting to the hospital only in the AIDS stage. This is in accordance with findings from van Dyk (2007), who noted that the prevalence of HIV-related illnesses challenged healthcare workers as patients reported late to health facilities.

Poor health seeking behaviour did not deter nurses from rendering nursing care. Nurses were committed to nursing HIV/AIDS patients. The nurses felt that persons suffering from AIDS related illnesses should enjoy the same attention and care as patients with any other disease. They expressed a sense of self-fulfilment and empathy, as well as a positive attitude towards HIV/AIDS patients. These feelings could have been the result of their professional values and the nursing ethos of caring for individuals regardless of the disease process. Literature suggests that nurses articulated the satisfaction of AIDS care, expressed the desire to help AIDS patients and took pleasure in their work, thus experiencing job fulfilment (Demmer, 2002; Shisana et al., 2002). Similarly, Sherman (2000) found that AIDS-dedicated nurses experienced commitment to alleviating the suffering of patients experiencing a rapid physical and health decline.

5.1.2. Quality of Care

Nurses were concerned about the quality of care provided. They raised issues over inadequate provision of basic supplies, protective materials and equipment for nurses. This finding has been reported in many countries in sub-Saharan Africa (Moore, 2001; Shisana et al., 2002; Fournier et al., 2007, Mkhabela et al., 2008). The nurses in the current study were confronted with limited resources when providing nursing care. The unavailability of basic needs

hindered the quality of care. Basic supplies such as food, water and bedding were constantly in short supply. Feelings of hopelessness, disappointment and frustration were expressed, because the nurses felt they could not make a difference. Supporting these findings are Fournier et al. (2007) and Turan et al. (2008) who have revealed that the nurses face challenges in providing quality care due to limited resources such as protective clothing, beds and food. Similarly, Smit (2005) noted that the majority of the participants in his South African study were concerned about the deterioration of hospital infrastructure, with nurses having to work in overcrowded wards. As nurses expressed frustration over lack of basic supplies, they also had to bear new responsibilities in situations they were not trained for.

5.1.3. Stigma and Discrimination

Despite extensive HIV awareness campaigns, nurses revealed that stigma and discrimination remained a hindrance and hampered efforts to provide comprehensive HIV/AIDS care. The nurses understood that they had no right to infringe on a patient's privacy and expressed this knowledge. The nurses in this study recognised the consequences of denial and disclosure, as patients continually refused to either accept their results or to disclose their HIV status. Likewise, van Dyk (2007) in his study recognised that primary stigma and discrimination pose a threat to HIV/AIDS care. Nurses in his study expressed concerns over confidentiality issues as they believed this hindered HIV/AIDS care.

Stigma and discrimination not only hindered HIV/AIDS care, it also encouraged concurrent use of both western and traditional medicine among HIV/AIDS patients. Nurses in the current study expressed concerns over the simultaneous use of traditional medicine and western medicine. In Africa, several people visit traditional healers prior to or concurrently with

formal health care (Ehlers, 2006). The author noted that some misconceptions about HIV remained rooted in cultural perceptions. HIV was viewed as a result of witchcraft, something that cannot be addressed by modern medicine (Ehlers, 2006). The perceived threat of compromising care was real, and the nurses expressed frustration and helplessness when patients attributed HIV to witchcraft (Ehlers, 2006). This has been noted as a potential hindrance and a threat to providing comprehensive care to AIDS patients. The nurses did not admit to any secondary stigma, as indicated by other studies (Smit, 2005; van Dyk, 2007).

5.2. Perceived Workplace Stressors

5.2.1. Workload

AIDS affects the health sector by increasing demand on service provision as people become sick, thus placing a heavier workload on the nursing staff. Findings of the current study indicated that the nurses were bearing a heavy workload as there was an exponential increase in demand for health care services owing to a growing number of HIV and AIDS patients. Additional responsibilities that come with roll-out of HIV/AIDS services were thought to increase the workload. Nurses indicated that ineffective and repetitive counselling had increased workload. This finding confirms that of the effects of HIV/AIDS on maternity care providers in Kisumu, Kenya (Turan et al., 2008). It was found in Kisumu that additional duties that come with the scale-up of HIV programmes increase workload, as testing patients with unknown HIV status and subsequently providing counselling to HIV-positive patients was considered additional responsibilities (Turan et al., 2008). Similarly, Delobelle et al. (2009) made known that HIV/AIDS had increased the health workers' workload due to lengthy counselling procedures.

Aggravating the issue of increased workload was the problem of chronic staff shortage. Staff shortages are challenges that cannot easily be triumphed over and often results in poor quality care (Dieleman et al., 2007). The shortage of nurses was mentioned consistently throughout the interviews. The nurses regarded this as a persistent problem that has failed to be resolved. Nurses in the hospital are failing to cope with increased workload; as a result they experience stress. Nurses expressed both physical and emotional fatigue, which can be attributed to the increased workload. WHO (2007) revealed that the world is experiencing a chronic health worker shortage, especially in sub-Saharan Africa. Nurses in Swaziland, for example, have battled with providing quality care owing to staff shortages (Mkhabela et al., 2008). This finding has been substantiated by many researchers in the field, who have reported shortages of health nurses with resultant decline in health care (Fournier et al., 2007; Shisana et al., 2002).



Sub-Saharan Africa studies indicate that HIV/AIDS is affecting nurses, as they are in short supply and overworked (Dieleman et al., 2007; Turan et al., 2008). Healy and McKay (2000) revealed that the Nursing Stress Scale (NSS) indicated that workload was the highest perceived stressor among nurses. The NSS also revealed that inadequate staffing levels and insufficient time to complete tasks were stressors experienced by nurses. In this study, nurses reported an increase in workload against nurse shortage. They had to nurse debilitated AIDS patients and at the same time provide HIV and ongoing counselling. Such findings are expected, since nursing is highly demanding and HIV and AIDS have changed the landscape of patient care. The identification of workload as a stressor in this study and in previous studies probably suggests that, in spite of culture, workload is the principal workplace stressor for nurses.

5.2.2. Lack of Knowledge and Skills in Managing HIV/AIDS Patients

Shisana et al. (2002) noted that nurses were inadequately knowledgeable about managing HIV/AIDS patients. The authors expressed concerns on the subject of training support and expressed the need to attain knowledge and skills in managing HIV/AIDS patients. Nurses in the current study felt that they were ill-prepared in providing HIV/AIDS nursing care and counselling, as some of them had not attended any formal training. Shisana et al. (2002) revealed that nurses in his study lacked training in vital elements of HIV/AIDS care. Similarly, Delobelle et al. (2007) revealed that many nurses in South African expressed concerns about their lack of knowledge regarding HIV care and treatment, and advocated the training of all nurses, regardless of rank. Moreover, Dieleman et al. (2007) noted that nurses were faced with a challenge of counselling patients without training. Nurses who had undergone training echoed that there was insufficient support with regards to refresher courses. They articulated that the current practices might not be in line with the knowledge they had acquired several years previously. These findings confirm those of Delobelle et al. (2009), who found that nurses expressed frustration about the lack of resources, such as training and information. Similarly, a New York study revealed that a lack of training was associated with higher stress levels (Demmer, 2002). Training plays a significant role in professional development and in ensuring competencies.

5.2.4. Role Discomfort

Nurses in the current study overtly articulated role discomfort. Role discomfort contributed to some feelings of stress because nurses had to counsel patients without themselves undergoing HIV-related training. The nurses expressed feelings of helplessness, as they were exposed to

monotonous counselling. They provided emotional support to patients through counselling and talking about their life experiences. Some of the participants reported working outside their roles. This was noted especially among nurses in the lower ranks, such as enrolled nurses and auxiliary nurses who had to counsel patients without HIV related training. van Dyk (2007) and Tawfik and Kinoti (2006) found that nurses express major concerns regarding their increased workload and role expansion and having to work outside of their comfort zone by carrying out duties not normally required of them.

5.2.5. Risk and Fear of Contracting HIV in the Workplace

Fear of infection at work was another important issue. The nurses expressed that working in an environment in which resources are scarce, proved challenging as they could not adhere to universal precautions. Compounding the issue of adherence to universal precautions was that the guidelines on HIV prevention and infection control were not readily available. Consequently, the nurses lacked concrete knowledge of their use. In addition, nurses felt they were not safeguarded against HIV due to an inadequate supply of universal precautionary measures and lack of consistent infection control measures. There was inadequate supply of disinfectants that support aseptic techniques and a lack of sterile medical supplies and equipment for patients. The subject of an inadequate supply of barrier precautions and equipment for nurses has been reported by various authors (Fournier et al., 2007; Smit, 2005; van Dyk, 2007). Smit (2005) reported a low quality and an infrequent supply of protective clothing such as gloves, aprons and masks, which the nurses believed would increase the risk of transmission. As a result, nurses were reluctant to treat patients with HIV due to the shortage of supplies. The nurses' apprehension emanated from previous exposure to HIV and bad encounters with patients.

Fear of infection has been confirmed in other studies (Dieleman et al., 2007; Kalichman et al., 2000; Shisana et al., 2002; Turan et al., 2008). Gueritault-Chalvin et al. (2000) noted that there are demands specific to AIDS care that may account for the greater intensity and more rapid development of burnout. One major stressor found in many AIDS caregivers is apprehension over safety practices and fear of occupational contagion (Gueritault-Chalvin et al., 2000). Nurses in the current study expressed concerns over safe practices and the fear of occupational contagion. They expressed concerns of nursing patients with both confirmed and unconfirmed HIV. One could then assume that these concerns might be very stressful and, if not addressed, may lead to burnout.

5.3. Occupational Burnout

Nurses have increasingly occupied important roles in the comprehensive care of HIV/AIDS. However, they are vulnerable to occupational burnout due to the nature of their work. Caring for critically ill and dying patients can generate moral distress and if not managed correctly, can result in burnout. The chronic and complex nature of AIDS poses a myriad of challenges for caregivers in AIDS care (Gueritault-Chalvin et al., 2000). Consequently, health professionals face unique clinical and social demands that make them more vulnerable to experiencing burnout (Gueritault-Chalvin et al., 2000). Burnout has been described widely in the developed world, but little is known about the concept in Africa (Fournier et al., 2007). One study found that nurses who experienced lack of resources, both human and material are at risk of suffering burnout (Fournier et al., 2007). The nurses in the current study were concerned about physical exhaustion, as they did not get time off and at times worked continuously without rest. Moreover, caring for chronically ill patients and dealing with disease progression issues and patient deaths are among major sources of emotional

exhaustion. The association of a lack of resources with the experience of physical exhaustion leading to burnout seems to be relevant to this study.

5.4. Coping Strategies

Caring for HIV/AIDS patients is physically, mentally and emotionally challenging (Bennett et al., 1996; Fournier et al., 2009). Nurses in this study felt that they were unable to provide quality nursing care due to the challenges they encountered. Effective coping strategies are believed to benefit health professionals by decreasing the risk of burnout. Lazarus and Folkman (1984 as cited by Lambert and Lambert, 2008) noted that when confronted with stress, nurses utilised both primary and cognitive appraisal and gradually developed strategies to cope.



5.4.1. Self Control

Nurses expressed the need to make themselves strong- putting on a brave face (Callahan, 1993), especially when facing imminent death. They believed that showing real feelings of distress could affect the way they cared for other patients. This shows that, most of the time, the nurses put the patients' wellbeing first and realised that, by controlling their feelings, they were protecting themselves from stress, which might negatively affect their mental state (Callahan, 1993). According to Lazarus and Folkman (1984), one factor that influences an individual's coping strategy is self-control. Several researchers have observed the issue of self-control in caregiving (Gueritault-Chalvin et al., 2000; Fournier et al., 2007). Callahan (1993) found that nurses tried to control their feelings as a way of coping. Putting on a brave

face and concealing their hurt, anger, disappointment or anxiety helped them to function best (Callahan, 1993).

5.4.2. Self Fulfilment

Although caring for patients with HIV/AIDS may be physically and emotionally draining, the nurses described how caring provided the experience of self-fulfilment. Fabre (2002) noted that nurses who reach and achieve self-fulfilment benefit substantially as their positive image, innovativeness and efficiency has a positive influence over their performance and wellbeing. Working in a poor-resource country such as Tanzania, nurses are faced with the dilemma of how to fulfil their role and responsibilities to promote health, prevent illness, restore health and alleviate suffering. To many nurses, the experience of self-fulfilment was related to giving nursing care and being morally obliged to provide care in a nonjudgmental and non-discriminatory manner. Similarly, Sherman (2000) revealed that nurses found meaning in their roles and expressed self-fulfilment while nursing AIDS patients. This enhanced wellbeing and growth.

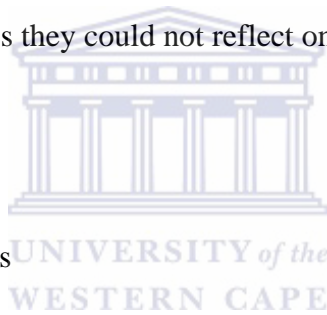
5.4.3. Transferring Care to Relatives

Transferring some of the nursing duties to the patients' relatives helped nurses cope with their workload. The nurses in the current study felt it was their duty to care for patients; however, the overwhelming numbers of patients against staff shortages necessitated them to train patients' relatives in basic care so as to alleviate the burden. Fournier et al. (2007) revealed that nurses encountered challenges while providing nursing care. These challenges included structural issues, such as inadequate human resources. The nurses transferred some of their

daily duties to relatives of patients in order to cope with staff shortages and demands of the patients (Fournier et al., 2007).

5.4.4. Pushing Ahead with Caring Work

Nurses who identified with workload and staff shortages expressed the need for more staff to cope with the demand of HIV/AIDS care. However, nurses continued to provide care despite the workload and shortage. The findings of the current study revealed that nurses used playful problem solving and self-control to cope with these workplace stressors. Nurse focused on their duties and provided care to patients. Some of the nurses reported that death was inevitable and part of life, and thus they could not reflect on patients who had died, as they had other patients to care for.



5.4.5. Modifying Sources of Stress

Fear of contagion remained a concern, as the nurses were worried about getting HIV infection from patients living with HIV/AIDS. Nurses' fear of contagion has been discussed by various authors (Kalichman et al., 2000; Shisana et al., 2002; Turan et al., 2008). The nurses dealt with the physical risks of AIDS care giving by utilising problem-focused coping. The nurses expressed that HIV risks were part of their work life however; preventing HIV exposure enabled them to reduce the perception of risk in AIDS care giving.

5.4.6. Spiritual Support

The majority of nurses utilised acceptance and seeking social support to cope with the death of their patients. The nurses pointed out that their spiritual beliefs and practices were a way of

coping with death. They believed that praying individually, or with members of the church and/or community for spiritual support and giving praises to God provided some form of guidance in their work. The use of faith as a coping mechanism has been supported by Folkman (1997) as she studied gay caregivers' coping processes and noted that spiritual beliefs and practices intensified as patients has passed on. Also, Sherman (2000) found that nurses exercised spirituality and the seeking of social support in dealing with the death of patients. In the present study, spiritual coping was observed in the sense that nurses prayed for their patients' wellbeing and passing.

5.4.7. Workplace Support

5.4.7.1. Colleagues Support

Colleagues support was highlighted as an important source of support. This was vital in solving both patient-care and personal challenges. Liaising with colleagues allowed for the sharing of feelings and solving of challenges. The nurses appreciated this form of support, as it enhanced group cohesion and respect for each other and facilitated information sharing and the value of knowledge and competencies. In essence, it boosted morale and contributed towards coping.

5.4.7.2. Managerial Support

One of the major stressors mentioned across the board was the lack of managerial support. The nurses could not count on organisational support; there was no form of support to help them deal with the HIV/AIDS issues affecting them emotionally. Nursing managers were seen as an important resource in managing HIV/AIDS issues; however, many nurses were critical of their contribution to psychological or emotional support. Support from managers

was in the form of training and compliance with universal protection. Clearly, support is geared towards empowering nurses to improve on patient care. Dieleman et al. (2007) reported similar results in Zambia, where the managers did not really know how they could help health workers and the nurses indicated that support such as offering professional counselling and professional advice support was absent (Dieleman et al., 2007). Likewise, Held and Brann (2007) noted that the absence of formal support was seen as a major drawback among health workers, as they were not adequately prepared to deal with emotional stressors. A study in Kenya revealed that a lot of health workers were ill equipped to cope with the emotional stress of occupational exposure to HIV (Horizons Report, 2006). Most facilities had professional counsellors, but there was a lack of systematic support to deal with HIV-related issues (Horizons Report, 2006).



5.4.8. External Support

Support from family and religious leaders provided a stable supportive environment to talk about feelings and experiences. Sharing experiences with friends who are nurses provided support and helped them cope with their daily work demands. This finding is supported by Dieleman et al. (2007) who revealed that health workers utilised external support to deal with HIV/AIDS related issues.

5.5. Summary

The HIV epidemic has placed a tremendous burden on nurses. As the District Medical Officer noted, large numbers of newly diagnosed clients, as well as the many sick and dying in Geita Hospital, pose various challenges for nurses. Nurses expressed a commitment to alleviate the suffering of their patients, who were experiencing rapid physical decline. A sense of self-fulfilment, empathy and a positive attitude was expressed towards the HIV/AIDS patients. The nurses empathised with their HIV/AIDS patients, who experienced stigma, and also reflected on the effect of stigma when providing care. The effect of stigmatisation most commented on by the nurses was the occupational frustration they felt stemming from confidentiality issues. Although they invariably understood the need for confidentiality, many believed that HIV/AIDS care is hindered by stigma and confidentiality issues (van Dyk, 2007).



All the participants experienced HIV/AIDS care-related stress, irrespective of age and sex. The nurses were confronted with challenges when providing quality nursing care. They commonly struggled with issues of death and dying, feared occupational exposure and found it difficult to cope with nursing shortage, increased workload, inadequate training and role expansion. In the light of providing the best possible and available care, the nurses openly articulated role discomfort and communicated worry relating to increased workload and having to perform duties not previously required. The nurses were generally disturbed by lack of organisational support and unavailability of resources such as basic supplies and protective equipment. The nurses expressed concern about the lack of preventive and protective supplies and communicated that universal precaution cannot always be followed when supplies are

scarce. Many nurses felt unsupported by their managers, as they felt compelled to give HIV/AIDS care without proper training.

5.6. Conclusion

In conclusion, a combination of organisational, logistical and occupational factors contributes to the stress of nurses in HIV/AIDS care. Regardless of culture, context and staff dynamics, nursing is by nature demanding and nurses are exposed to stressful and challenging circumstances. Nurses in the study experienced occupational stress as they felt overworked, overburdened and unsupported by their managers. Moreover, limitations in recruitment and retention of nursing personnel complicate the task of providing a conducive work environment. The absence of protective measures compromised patient care, at the same time increasing fear of infection among nurses. Despite the workplace demands encountered by nurses, they remained enthusiastic and hopeful and had the desire to help patients. To counterbalance the effects of a taxing workplace, nurses adopted an array of coping strategies such as discussing with others, self-control, transferring care, and spirituality. Moreover, managerial and colleagues support have been identified as important buffers in dealing with HIV/AIDS challenges. To avert burnout and the effects of health worker attrition, health managers should reflect on the caveat of Lehman and Zulu (2005:47 as cited by van Dyk, 2007), that “the psychological health of caregivers merits special concern: if we anticipate health workers to continue to bear a disproportionate burden in the fight against the HIV/AIDS epidemic, we have to take notice of the urgent call for help and support, and realise that we have to take seriously the need to care for our caregivers.”

5.7. Recommendations

Caring for nurses should be integrated into the organisational culture. Managers should consciously ensure that every effort is made to keep the stress of nurses to reasonable limits. While it might be impossible to reduce the demands of the job, a number of issues can be addressed by providing support and improving working conditions. Taking the study findings into consideration, the following recommendations are proposed:

5.7.1. Recommendations for nursing managers

1. Managers should devise or reinforce organisational support mechanisms such as workplace support groups and stress reduction workshops.
2. Managers should ensure that nurses are conversant with policies communicating universal precautions, HIV counselling and testing and post-occupational exposure prophylaxis.



5.7.2. Recommendations for nurses

1. Nurses need to form support groups that will enhance communication and strengthening coping with the demands of HIV/AIDS care. This will facilitate problem solving, enhance emotional wellbeing and effectiveness in HIV/AIDS care.
2. Nurses should formalise and reinforce collegial support as part of the support systems that will enhance problem solving and coping.

5.7.3. Recommendations for the organisation's management

1. The institution should provide structural and infrastructural interventions to ensure that nurses have enough space (private counselling space,) and supplies (nursing and

patient care equipment, protective supplies and disinfectants) to provide confidential HIV-related services and to protect themselves from HIV infection respectively.

2. The development of an institutional policy on the implementation of continuous professional development (CPDs) to upgrade the knowledge of all health personnel on HIV/AIDS issues in both the ministry of health and nongovernmental organisations (NGO) running HIV/AIDS programmes. This should encompass initial training, refresher courses, and workshops to upgrade skills and on-the-job mentoring and coaching.
3. The hospital management should devise interventions aimed at reducing the impact of the workload on nurses by increasing the number of staff. However, as noted in the introduction, Tanzania faces a challenge in nurse staffing levels suggesting that nurses may not be available. I, therefore propose that the Ministry of health should consider training more auxiliary nurses to alleviate the nurse shortage. This will ease the workload and allow other nursing cadres to concentrate on their roles. Furthermore, the ministry of health should consider employing complementary staff such as community counsellors or home based care providers to support HIV/AIDS programmes.

5.7.4. Recommendations related to nursing education

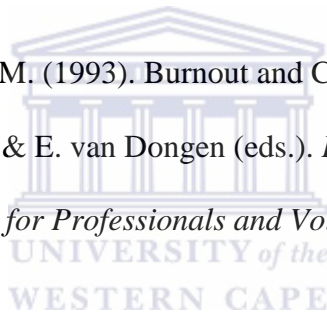
1. Nurses should be engaged in continuous professional development programs. Regular in-service training and refresher courses should be provided so as to keep nurses up to date with the current HIV/AIDS practices.

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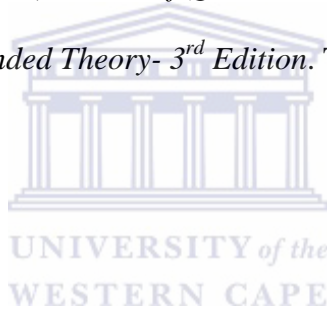
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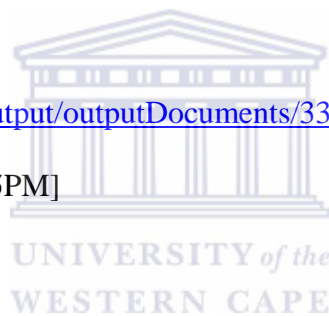
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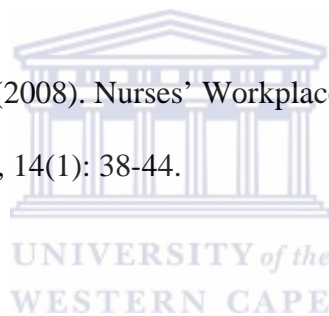
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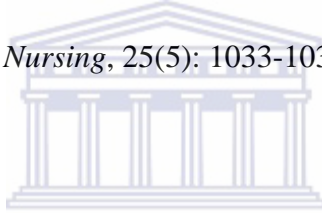
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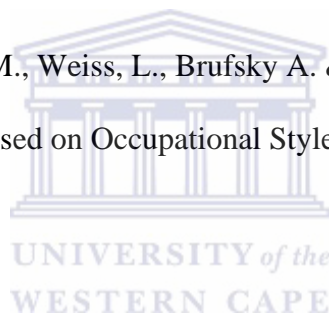
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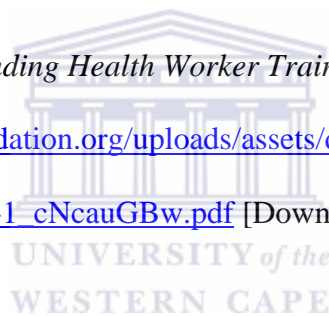
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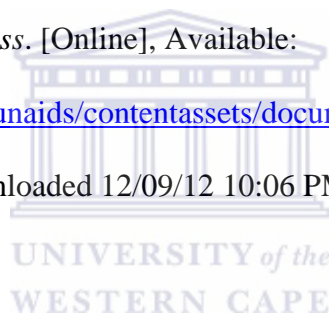
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APPENDIX I: Ethical Clearance

**OFFICE OF THE DEAN
DEPARTMENT OF RESEARCH
DEVELOPMENT**

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Website: www.nwc.ac.za

18 May 2010

To Whom It May Concern

I hereby certify that the Senate Research Committee of the University of the Western Cape has approved the methodology and the ethics of the following research project by:
Ms C Mubekapi (School of Public Health)

Research Project: Nurses' experiences and coping within the context
of HIV/AIDS care in Geita District Hospital,
Tanzania

Registration no: 10/4/8

UNIVERSITY of the
WESTERN CAPE


Peter Syster
Manager: Research Development Office
University of the Western Cape



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APPENDIX II: Participant Information Sheet



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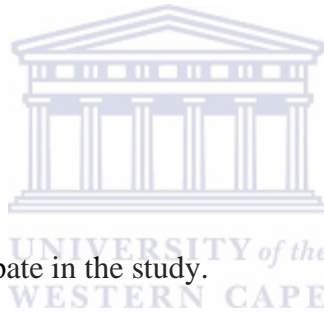
School of Public Health

Private Bag X17 • **BELLVILLE** • 7535 • South Africa

Tel: 021- 959 2809, Fax: 021- 959 2872

Participant information sheet

Thank you for agreeing to participate in the study.



Interviewer's details

My name is Constance Mubekapi, a Registered General Nurse by profession. I am currently studying at the University of Western Cape for a degree in Masters in Public Health.

Conducting a Mini-Thesis is one of the requirements that entitle one to the degree aforementioned. Please feel free to contact me if you have any questions and need clarity on certain issues. My contact details and those of my supervisor are found at the end of this memo.

Research Title: Nurses Experiences and Coping Strategies within the Context of an HIV/AIDS work Environment in Geita District Hospital, Tanzania.

Purpose of the study

The purpose of the study is to contribute to the growing body of knowledge of health workers' experiences in HIV/AIDS care and the coping strategies to deal with HIV in the context of the workplace. Documentation of the findings will provide empirical data that will enable policymakers to instigate or advocate for better or improved HIV/AIDS support services on health personnel.

Interview process

I will ask questions written down on the interview guide and I will take notes were appropriate which will also add value to the study. In addition, our conversation will be audio tapped this will enable me to transcribe the data accurately. The interview will last approximately 40 minutes.



Confidentiality

Your identity will be kept confidential. All issues discussed will be treated with respect and confidentiality, therefore feel free to respond as accurate as possible to the questions.

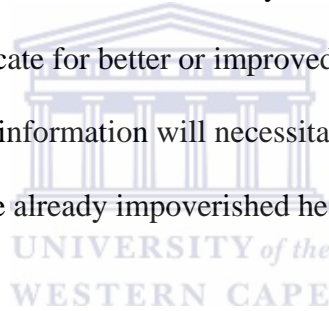
However, since I am a student, I shall be liaising with my thesis supervisor throughout the thesis write up. As such she might require me to provide her with some of the data. Records of the interview and the consent form, if you choose to participate will be kept under lock at all times. These will be destroyed once the research process has been completed.

Participation in the study

Participation in this study is entirely voluntary. Refusal to participate in the study will not result in a penalty or withdrawal of any benefits that you are entitled to. If you choose to participate and should you at any stage feel uncomfortable and wish to terminate the interview please do not hesitate to do so. Moreover, should any questions make you feel uncomfortable and you are not able to respond to; please let me know.

Benefits from the study

You shall not receive any direct benefits from the study. However the information gathered will enable policymakers to advocate for better or improved HIV/AIDS support services on health personnel. In essence, this information will necessitate appropriate measures to be taken so as to respond effectively on the already impoverished health services and health care human resources



Interviewee's agreement.

Attached to this information sheet is a consent form. I will need you to sign it to acknowledge your voluntary participation before we proceed with the interview. You can review it and decide whether you would like to participate.

Any questions can be directed to me on the following contact details:

Constance Mubekapi

Student Number: 2616541

Cell phone: +255 76 551 5344

Email address: cmubekapi@classicmail.co.za

I am accountable to my supervisor Verona Mathews. Her contact details are as follows:

Verona Mathews

Lecturer

C/o School of Public Health

University of the Western Cape

Work: 021 959 2809

Fax: 021 959 2872

Cell: 0832582802

E-mail: vmathews@uwc.ac.za



APPENDIX III: Informed Consent Form

Date:

Interviewer:

UWC Student Number:

Tel:

Email:

Institution:

Place at which interview was conducted:

Firstly I would like to thank you for taking part in this study and allowing me the opportunity to interview you.



Information about the interviewer

My name is Constance Mubekapi, a Registered General Nurse by profession. I am currently studying at the University of Western Cape for a degree in Masters in Public Health.

Conducting a Mini-Thesis is one of the requirements that entitle one to the degree aforementioned.

Research Title: Nurses Experiences in HIV/AIDS Care and Coping Strategies in the Context of Occupational Exposures in Geita District Hospital; Tanzania.

The aim of the study is to explore nurses' experiences in HIV/AIDS care and the strategies employed to cope with the risk of occupational HIV. I hope that the information gathered will enable us to gain insight to the way HIV/AIDS has an impact on health workers. This enables the policy to advocate for better or improved HIV/AIDS services on health personnel.

I will ask questions written down on the interview guide and I will take notes were appropriate which will also add value to the study. In addition, our conversation will be audio tapped this will enable me to transcribe the data accurately.

Participation in this study is entirely voluntary. Refusal to participate in the study will not result in a penalty or withdrawal of any benefits that you entitled to. If you choose to participate and should you at any stage feel uncomfortable and wish to terminate the interview please do not hesitate to do so. Moreover, should any questions make you feel uncomfortable and you not able to respond to; please let me know. All issues discussed will be treated with respect and confidentiality, therefore feel free to respond as accurate as possible to the questions.

I understand that I am fully obliged to withdraw my consent and discontinue the interview in this study anytime without prejudice to me. I have read and understood the contents of this form and received a copy. I have had the opportunity to ask questions and fully understand the contents of this paper.

I therefore voluntarily give consent to participate in the study and understand that I have the right to terminate the interview at any given time and choose to answer questions I am comfortable with.

Participant: Date:

Signature:

I Constance Mubekapi have explained the research procedure to the participant and guarantee that I shall keep the contents of the research interview confidential. The contents will be utilised for the purpose referred above.

Signature..... Date.....



APPENDIX IV: Nurses Interview Guide

Nurses Interview Guide

1. Age, marital status and gender.
2. History of qualifications and work experience
3. How long have you been working in HIV/AIDS care setting?
4. Tell me about your experience in caring for PLWHA?
5. How prepared are you to deal with physical and emotional needs of HIV/AIDS patients?
6. How comfortable are you in discussing sex and sexuality with patients?
7. In your experience how has HIV/AIDS affected your work?
8. How has your role as a nurse changed?
9. Tell me about your views on the risk of acquiring HIV at work?
10. What are the challenges do you encounter while caring for HIV/AIDS patients?
11. What would you like to see improve in the care of PLWHA?
12. How would you describe the atmosphere among staff members caring for HIV/AIDS patients?
13. What parts of HIV/AIDS caregiving do you consider stressful?
14. How do you share your feelings and views with your colleagues about HIV/AIDS care?
15. HIV is debilitating in nature, how do you cope with seeing patients condition deteriorate?
16. Describe the feelings/emotions you experience when you lose a patient to HIV/AIDS?

17. Tell me about the hospital managers' role as supporters in HIV/AIDS caregiving?
18. How does your family feel about you caring for HIV/AIDS patients?
19. What support structures are available for nurses to address their concerns towards HIV/AIDS?
20. Describe the workplace policies on HIV/AIDS in the workplace?
21. Do you have any comments you would like to add regarding HIV/AIDS in this hospital?



APPENDIX V: Key Informant Interview Guide

1. What is your profession?
2. How long have you been working in this facility?
3. In your experience as a facility manager has HIV/AIDS had an effect on service delivery?
4. How has HIV/AIDS had an impact on nurses' performance?
5. As a health manager, how has the nurses' role in HIV/AIDS care changed?
6. How has HIV/AIDS created a unique challenge for nurses?
7. What aspects of HIV/AIDS care stressful do you find stressful?
8. How does the environment of your health facility encourage or discourage stress?
9. Tell me of any nurses' concerns towards HIV/AIDS care stress?
10. Tell me about the measure available to assist nurses in deal with HIV/AIDS stress?
11. Can you tell me about the measures available for health workers to protect themselves from HIV?
12. How prepared are the health managers in addressing health workers' concerns regarding HIV/AIDS?
13. Can you tell me about formal support services for health workers to address their HIV/AIDS concerns?
14. Do you have any comments or concerns you would like to add regarding HIV/AIDS issues in your hospital?